House of Commons

Home Affairs Committee

Drugs: new psychoactive substances and prescription drugs

Twelfth Report of Session 2013–14

Report, together with formal minutes, oral and written evidence

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Contents

Report

Key Facts

- Deaths involving new psychoactive substances ('legal highs') such as mephedrone increased by 79% from 29 in 2011 to 52 in 2012.
- The number of new psychoactive substances reported by Member States to the United Nations Office on Drugs and Crime rose by 51% from 166 at the end of 2009 to 251 by mid-2012. This exceeds the total number of psychoactive substances (234) currently controlled by the international drug conventions.
- Operation Burdock, a multi-force operation in 2013 which targeted suppliers of new psychoactive substances across the country, resulted in
    - 73 warrants being executed and 44 arrests made.
    - The seizure of: half a kilogram of controlled new psychoactive substances in Huddersfield and Oldham, a firearm in London, £6,000 from a search in Cumbria, and the discovery of a drugs factory in Hampshire.
    - Police officers making personal visits to 274 people who had purchased new psychoactive substances from online distributors and writing to a further 574 to warn them of the dangers of using products labelled as 'legal highs.'
- Deaths involving the prescription painkiller Tramadol have increased by 300%, from 43 a year in 2004 to 175 a year in 2012.
- The total number of drug-related deaths in 2012 was 2597.

1 Introduction

1. In December 2012, we published a report entitled *Drugs: Breaking the Cycle*[1], which contained a number of recommendations relating to drugs policy, all of which are reproduced in the annex below. In November 2013, we undertook to follow up on two of the specific issues raised within that report—new psychoactive substances and addiction to prescription drugs. At the same time, we took evidence on the proposal to control khat under the Misuse of Drugs Act 1971. Our findings on khat were published as a separate report in November 2013.[2]

2. As part of this follow up inquiry we held oral evidence sessions with:

- Chief Constable Andy Bliss, ACPO lead for drugs and Commander Simon Bray, ACPO lead for psychoactive substances;
- Maryon Stewart and Jeremy Sare, the Angelus Foundation;
- Dan Reed, Producer, Legally High: True Stories: and,
- Norman Baker MP, Minister for Crime Prevention, Home Office.

We also sought written evidence from:

- The Advisory Council on the Misuse of Drugs;
- Public Health England;
- The British Medical Association;
- The Royal College of General Practioners: and,
- The Royal College of Psychiatrists

1 Home Affairs Committee, Ninth Report of Session 2012–13, *Drugs: Breaking the Cycle*, HC 184-I

2 Home Affairs Committee, Eleventh Report of Session 2013–14, *Khat*, HC 869

2 New Psychoactive Substances

3. New psychoactive substances (sometimes referred to as 'legal highs') are chemicals which have been synthesised to cause similar reactions to those produced by taking conventional drugs which are controlled under the Misuse of Drugs Act. These chemical substances are newly created, and hence, are not automatically controlled under legislation. If, therefore, the display of new psychoactive substances includes the disclaimer 'not fit for human consumption', they can be bought and sold legally. The concern surrounding use of new psychoactive substances (NPS) is a fairly recent phenomenon. Prior to the rapid growth in the consumption of the club drug mephedrone in late 2009, new psychoactive substances were not a widely recognised issue within drugs policy. However, between 2005 and 2012, some 236 new psychoactive substances were formally identified and logged on the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) early warning system. In 2012, for the fourth consecutive year, a record number of new substances (73) were detected in Europe, up from 49 substances in 2011, 41 substances in 2010 and 24 in 2009.[3] The United Nations Office on Drugs and Crime (UNODC) World Drug Report notes that, worldwide, the number of NPS reported by Member States rose from 166 at the end of 2009 to 251 by mid-2012.[4] This exceeds the total number of 234 psychoactive substances currently controlled by the international drug conventions. In terms of popularity, the European Monitoring Centre's annual report 2012 highlighted that

> in 2011, a European survey of youth attitudes, which interviewed more than 12,000 young people (15–24), estimated that 5 % of young Europeans had used 'legal highs' at some time, with about half of the countries falling in the range 3–5 %. The highest estimates were reported by Ireland (16 %) followed by Latvia, Poland and the United Kingdom (all at nearly 10 %).[5]

4. A recent survey carried out by the charity DrugScope found that new psychoactive substances are widely and freely available. They have been found on sale at petrol stations, takeaways, tattoo parlours, newsagents, tobacconists, car boot sales, sex shops, gift shops, market stalls and pet shops.[6] Commander Bray, the ACPO lead for New Psychoactive Substances, added cobblers and pop-up shops to that list[7] and the Angelus Foundation told us that there had even been cases where ice-cream vans were used to sell them.[8]

5. Maryon Stewart of the Angelus Foundation described the use of new psychoactive substances as an "epidemic". She talked of the number of letters, emails and phone calls the Foundation had received in regards to deaths and other harms which have occurred as a result of their use.[9] We note with concern that the number of deaths relating to new psychoactive substances has doubled in the past five years, with a sharp increase seen

3 http://www.emcdda.europa.eu/attachements.cfm/att_190854_EN_TDAC12001ENC_.pdf, P89

4 http://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf, P59

5 Ibid., P91-2

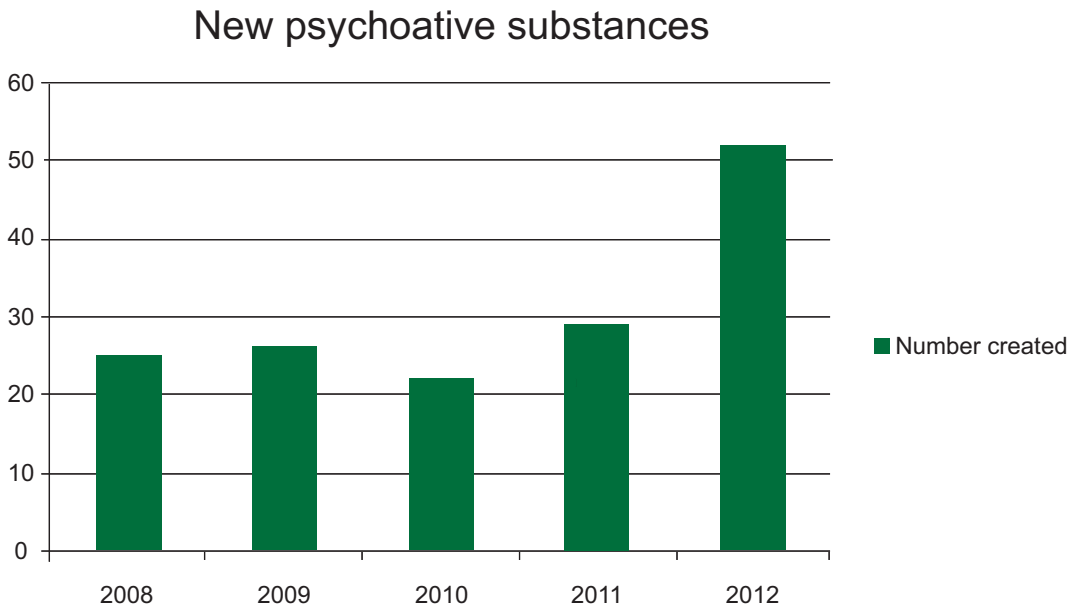
6 Druglink November/December, p7

7 Q20

8 Q54

9 Q71

between 2011 and 2012, as set out below. 'However, we note that this remains a very small component of the 2597 total number of drug-related deaths.



	2008	2009	2010	2011	2012
New psychoactive substances	25	26	22	29	52

Deaths Related to Drug Poisoning in England and Wales, 2012, Office of National Statistics

6. It is thought that the popularity of new psychoactive substances stems from the lack of availability of high-purity conventional drugs and the fact that many of these substances are not controlled by statute so suppliers and consumers believe that they can be bought and sold freely. However, as the Minister pointed out, almost a fifth of these substances contain a chemical which is in fact controlled under the Misuse of Drugs Act 1971.[10]

7. Consumption of new psychoactive substances appears to be more prevalent outside major towns and cities, in areas where it is more difficult to acquire conventional drugs. The police services that are dealing with the frontline of the new psychoactive substances problem are therefore less likely to command a significant budget for drug-related policing. Chief Constable Bliss highlighted the importance of discussing their work with Police and Crime Commissioners who control police budgets in order to ensure that they understood the nature of the problem.[11] **Chief Constables and other law enforcement agencies are failing to understand the impact of psychoactive substances. We are deeply concerned that there is not enough data collated by each local police area regarding the usage and effect of these types of substances. We recommend that police forces start a process of data collection immediately in order to have established, within 6 months, the challenges they face locally. This will enable them to develop an effective strategy in**

10 Q186

11 Q29

tackling the problems presented by psychoactive substances, both in pursuing those who are selling substances which may contain illegal drugs and also producing an appropriate education strategy for potential users.

8. The UNODC World Drug Report 2013 used the example of mephedrone as proof of the effectiveness of banning a drug in reducing its consumption. In the Drug Misuse Declared survey for 2010–11, mephedrone was the third most popular drug amongst people aged 16–59 and the second most popular drug amongst those aged 16–24. However, following its classification (which made the drug a controlled substance under the Misuse of Drugs Act), that popularity dropped by a fifth amongst 16–59 year olds and by a quarter amongst 16–24 year olds. The UNODC noted that internet surveys among clubbers in the United Kingdom also confirmed the downward trend. A 2011 EMCDDA "snapshot" identified a major decrease in the number of online shops offering mephedrone in Europe, notably in the United Kingdom.[12] This decrease is further evidenced in the 2012–13 edition of Drug Misuse Declared, which found that last year use of mephedrone amongst adults aged 16–59 decreased from 1.1% in 2011/12 to 0.5% in 2012–13. For young adults aged 16–24, last year mephedrone use decreased from 3.3% in 2011–12 to 1.6% in 2012/13.[13]

9. However the apparent decrease in the use of mephedrone is not necessarily a sign of an overall reduction in the use of new psychoactive substances. It is at least as likely to be a result of the substitution effect we have discussed in our previous reports on this subject, whereby users switch to alternatives when a particular intoxicant is banned. Since January 2011, the Home Office's Forensic Early Warning System has found 27 completely new substances through testing that have never been seen before. The rate at which these new substances come onto the market makes it difficult in practice for the Misuse of Drugs Act regime to keep track of them: when one substance is controlled, an analogue with similar effects but sufficient structural differences to evade the ban can quickly be brought to market. As part of the documentary, *Legally High: True Stories*, "Dr Zee", a man who creates new psychoactive substances was asked if he was starting to run out of chemicals to make. He responded

> The brain ... uses about five hundred, maybe more, different indigenous materials. It's very likely that any one of these chemicals will have ten to one thousand different analogues so there is no shortage of material to explore.[14]

The filmmakers say that for every new psychoactive substance that is banned, there is another one ready to be launched to take its place. **We conclude that there is currently an epidemic of psychoactive substances and it is highly likely that the creation of new psychoactive substances will continue to increase in the future unless immediate action is taken.**

10. Legislation may decrease the use of one drug but the increase in deaths related to new psychoactive substances also suggests that that it is the substitution effect that is being observed. This then creates its own issues including those that were highlighted by one of

12 UNODC, P98-9

13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225122/Drugs_Misuse201213.pdf

14 Channel 4, *Legally High: True Stories*, broadcast 8 August 2013

our witnesses, Dan Reed—that users may not be able to judge what a correct 'dosage' of a new substance is or how it might interact with other substances (including alcohol).[15] Mr Reed also pointed out that many branded products were blended, with the composition differing from packet to packet.[16] This is supported by the forensic Early Warning System which has found that substances sold as a single 'branded' new psychoactive substance can contain up to three active drugs.[17]

11. The Angelus Foundation told us that the way to protect young people was to emphasise the dangers of new psychoactive substances, rather than banning them, a view shared by the British Medical Association. The Angelus Foundation was critical of the Government's action plan to tackle new psychoactive substances which was published in May 2012, especially in terms of the lack of work done on raising awareness of the harms of new psychoactive substances.[18] Maryon Stewart noted that this had to be done carefully as previous experience had shown that talking about a new drug was likely to encourage its sale rather than dissuade consumers from purchasing it. Instead, she suggested that discussing cases where somebody had died from a new psychoactive substance might have an impact and that there ought to be more information available for parents.[19] She endorsed the approach taken in New Zealand, where all psychoactive substances are banned unless they are approved by the appropriate regulator.[20] This places the onus on manufacturers to prove that a product is relatively low-risk before it can legally be sold, and is accompanied by place-of-sale restrictions, other consumer protection measures such as health warnings on packaging and restriction on sale to under-18s, and localised decision-making over whether and where these substances may be sold.

12. **We congratulate the work done by the Angelus Foundation on raising the profile of the problems associated with psychoactive substances and educating others about the risks. However, we believe that there should be more engagement between the Government and the Foundation and that either the Home Secretary or Norman Baker, the new Minister with responsibility for drugs, should meet with the organisation. Education of young people is crucial in order to prevent further deaths from psychoactive substances. We recommend that schools and colleges extend the current educational sessions they run on drugs policy with effective evidence-based sessions.**

13. We welcome the Government's terms of reference for a review into the legislative options to tackle new psychoactive substances. Although much of the media relating to the story cites the example of New Zealand, we note that the written ministerial statement and the review fail to specify that country, with the terms of reference simply stating that the review will consider the opportunities and risks of legislative options, informed by international evidence. The ACMD have also been asked specifically to look at the

15 Q105

16 Q98

17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98031/fews.pdf, p9

18 Q69

19 Q73

20 Discussed in our earlier drugs report, [HC 184-I 2012-13] p65

American system of analogue legislation. We take this opportunity to highlight that in written evidence to this inquiry, the ACMD told us that it understood that

> that the US Government have encountered legal difficulties in implementing the Analogue Act in controlling NPS and are considering a revision of this.[21]

Furthermore the UNODC noted in the 2013 World Drug Report that analogue legislation (which bans any substance that has a similar chemical structure and similar effects to a controlled substance) has not always been implemented successfully.

> From the beginning, there have been issues related to the clarity of the statutory definition. The issues related to "similarity" are not always clear-cut. A court judgement is required. In this context, it has been argued that a retrospective process undermines the right of a defendant to know from the outset whether or not an offence has been committed. This led to a court case in which the law on the analogue system was upheld. Nonetheless, the question as to whether a substance is "substantially similar" has repeatedly led to experts butting heads. The situation has been aggravated by the fact that no United States court has ever issued detailed guidelines to establish the criteria to be applied.[22]

14. **It is clear that simply controlling new psychoactive substances under current legislation will not work. We welcome the Government's announcement that they are going to review other countries' systems and the Minister will be recalled to the Committee in 4 months time to give a full account on the potential costs and benefits of introducing these types of regulatory system within the UK. We believe that the burden of proof ought to be removed from enforcement authorities and placed on those who are selling the new psychoactive substance. The Home Office should introduce a new legislative model, taking into account the benefits of other systems in use abroad. The new model should shift the evidential responsibility, of proving the safety and the non-narcotic purpose of a substance, onto the seller for all new psychoactive substances. It should also be specifically related to the new psychoactive substances problem and not impinge on current legislation which controls illicit drugs.**

Use of alternative legislation

15. In July 2010 ACPO issued guidance which contained the following advice to police officers.

> Head shops[23] may be found to be selling products that are NOT controlled under the Misuse of Drugs Act 1971. In those circumstances there is legislation enforced by Trading Standards that could provide opportunities for prosecution if offences are disclosed. Whilst not an exhaustive list, possible alternatives include:
>
> - Consumer Protection from Unfair Trading Regulations 2008 (CPR's);

21 Ev 34

22 World Drug Report, p110

23 Head shops are retail outlets which sell drug paraphernalia and new psychoactive substances

- The General (Product) Safety Regulations 2005;
- The Consumer Protection Act 1987, which includes The Cosmetic Products (Safety) Regulations 2006;
- The Medicines Act, 1968 is also a potential legislative tool. The Medicines and Healthcare Products Regulatory Agency (MHRA) is responsible for administering and enforcing medicine legislation.[24]

In October 2011, the Advisory Council on the Misuse of Drugs made the following recommendation.

> Specific legislation, namely the Consumer Protection from Unfair Trading Regulation and General Product Safety Regulations (2005), should be applied to the sale of legal highs, and the Advertising Standards Agency should investigate claims made by the websites selling legal highs.[25]

In December 2012, when we published our original report on drugs, we noted that the traditional policing approach towards drugs would not work with new psychoactive substances as many are not controlled under current legislation. We therefore recommended that the Government issue guidance on using trading standards legislation to tackle these products. We are glad to see that there have been some examples of alternative legislation being used against suppliers of new psychoactive substances.

16. In the last week of November 2013, police forces, the National Crime Agency, Border Force, HM Prison Service and trading standards officers took part in a joint effort to target suppliers of new psychoactive substances. Operation Burdock resulted in 73 warrants being executed and 44 arrests made. Half a kilogram of controlled new psychoactive substances were seized in Huddersfield and Oldham, the Metropolitan Police Service recovered a firearm, £6,000 was recovered from a search in Cumbria and a drugs factory was identified in Hampshire. Police officers across the country visited head shops, to highlight to staff and owners that new psychoactive substances cannot be assumed to be safe or legal and that many of these products either contain controlled substances which are illegal or uncontrolled substances whose side-effects cannot be predicted. A number of head shops handed over the products which they had on sale for analysis, with one shop in Kent handing over nine kilograms as they were unable to prove the origin or content of the products on their shelves. Other shops in Avon and Somerset removed all their products. Information seized from suppliers meant that police officers were also able to make personal visits to 274 people who had purchased new psychoactive substances from online distributors and wrote to a further 574 to warn them of the dangers of using products labelled as 'legal highs.'

17. ACPO also highlighted the work by West Yorkshire Police and the Crown Prosecution Service who used the Intoxicating Substances (Supply) Act 1985 to secure convictions of two market traders who had sold a synthetic form of cannabis to a person who was under 18. The legislation makes it illegal for the vendor to sell an intoxicating substance which is

24 http://www.acpo.police.uk/documents/crime/2010/201007CRIPPS01.pdf

25 NPS report

inhaled to a person under 18. Originally designed to reduce the abuse of solvents amongst minors, the innovative use of such legislation is impressive. Commander Bray also told us that he thought there had been a prosecution in Norfolk under the General (Product Safety) Regulations 2005.[26]

18. On 12 December 2013, the Home Office produced guidance for local authorities on taking action against head shops selling new psychoactive substances as per our recommendation in December last year. We welcome this step although we are concerned by the length of time it took the Home Office to produce a five-page guidance note. Given that we published our report on 10 December 2012 and the Government response to our report in March 2013 contained approval of our recommendation to produce guidelines on using alternative legislation, it is disappointing that such guidance has only just been published. The people who create new psychoactive substances can respond to the control of a substance by creating and marketing a new one in its place in a very short space of time, the Government needs to have a much quicker reaction time if they wish to tackle the problem of new psychoactive substances.

19. **We welcome the use of alternative legislation to prosecute suppliers of new psychoactive substances and congratulate West Yorkshire Police and the Crown Prosecution Service on their use of the Intoxicating Substances (Supply) Act 1985 to secure convictions of two suppliers of new psychoactive substances—the innovative use of such legislation is to be commended. We also commend all of those involved in Operation Burdock and would highlight the cohesive nature of such an operation. Until the law has been amended we expect to see similar operations taking place as the benefits of such an approach are clear and we will be writing to every Police and Crime Commissioner to highlight the work done on this case. We are concerned by the length of time it has take the Government to produce guidance on the use of alternative legislation. When new substances are emerging at a rate of more than one a week, taking twelve months to produce a five page note is an unacceptably slow reaction time. The use of alternative legislation, however, in order to cover this increasingly blurred legal area is insufficient. The Government's inability to establish an effective legislative response is indicative of its sluggish response to this problem. The issue of new psychoactive substances is unique and needs an immediate and tailored response. We recommend that any new legislation, brought in to address the problem of 'legal highs', is specific and focused. The law must ensure that the police and law enforcement agencies can take action comprehensively against those who sell new psychoactive substances and remove the reliance on existing legislation which is ill-suited to comprehensively tackling this problem. The legislation needs to allow sellers of new psychoactive substances to be prosecuted for an offence which is equivalent in sanction to that of the Misuse of Drugs Act 1971.**

Festivals

20. Both ACPO and the Angelus Foundation highlighted the danger of new psychoactive substances being taken at festivals and the work that was taking place to improve upon that situation. The Angelus Foundation told us that they had met with 30 Festival owners

26 Q48

recently[27] and ACPO described using information collated at festivals to keep up to date with the different types of substances. Chief Constable Bliss told us that ACPO were already starting to draw up a plan for next year's festivals and that they hope to have the support of Public Health England officials working with them at festivals, focusing specifically on the educational angle.[28]

21. **We welcome the news that ACPO and Public Health England are already beginning to plan for the 2014 festival season. We recommend that, as well as raising awareness around the harms that new psychoactive substances can cause, police and trading standards officials also implement a joint operation, testing and monitoring the sale of substances at such events. We recommend that the police introduce quick turnaround mobile laboratory drug testing facilities at these types of event in order to facilitate the removal of potentially harmful or illegal substances from the site immediately.**

27 Q56

28 Q32

3 Prescription drugs

22. As part of our previous inquiry in to drugs policy, we also took evidence on the work being carried out to counter addiction to prescription drugs. A survey carried out jointly by *The Guardian* and *Mixmag* in 2011 indicated signs of an emerging 'grey market' in legally prescribed painkillers and antidepressants, often acquired from friends or dealers, or through the internet. A third of the 7,700 people from the UK who took part in the survey took prescription sleeping pills—22.4% had taken benzodiazepines such as diazepam or temazepam in the last year and 7.2% had taken the newer drugs zopiclone and zolpidem. The Global Drug Survey found that a quarter of responders had taken prescription opioid painkillers and 9% had taken other painkillers. More than three-quarters said they took them for pain relief, 24% said they took them to get to sleep and 18% said they took them for mood-changing purposes. A survey by the Family Doctor Association in 2011 had found that over half of GPs surveyed were worried about prescription drug abuse in their area. Eighty percent of the 197 GPs who responded to the survey said they were aware of prescribing to people who they thought were addicted. Half were aware of occasions when prescriptions had been sold on.[29] The 2011 Street Drug Trends survey provided further evidence of this trend with increases in the use of diazepam, Tramadol and phenazepam, in 16 of the 20 areas investigated.[30]

23. In our 2012 report we noted that support and treatment for people who develop problems in relation to prescription-only or over-the-counter medicines would be provided by GPs, many of whom do not report to the National Drug Treatment Monitoring Service (NDTMS) and so it would be difficult to obtain a clear picture of the scale of addiction to prescription medicines.[31] This is supported from evidence from the British Medical Association which has recently started a project examining the role of medical professional in relation to addiction to prescription drugs. The project will

> collate evidence on the scale of the problem, raise awareness of the harm caused by involuntary dependence to prescription medication, promote best prescribing practices, and identify policy changes necessary to improve the identification and management of patients affected by this issue.[32]

24. When we questioned the Minister on the misuse of prescription drugs he identified two issues. The first was whether addiction was a consequence of legalised prescription of drugs (which the Department of Health was looking at). The second was whether or not prescription drugs were being misused and if so, how they were being obtained, which was an inquiry which the ACMD would be carrying out shortly.[33]

25. **It is concerning that a year on from the publication of our previous report, which highlighted the lack of knowledge on this subject, there have been no improvements in**

29 http://www.theguardian.com/society/2012/mar/15/recreational-drug-users-medicines-survey

30 http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Publications/KZone.pdf

31 Home Affairs Committee, Ninth Report of Session 2012–13, *Drugs: Breaking the Cycle*, HC 184-I, Para 120

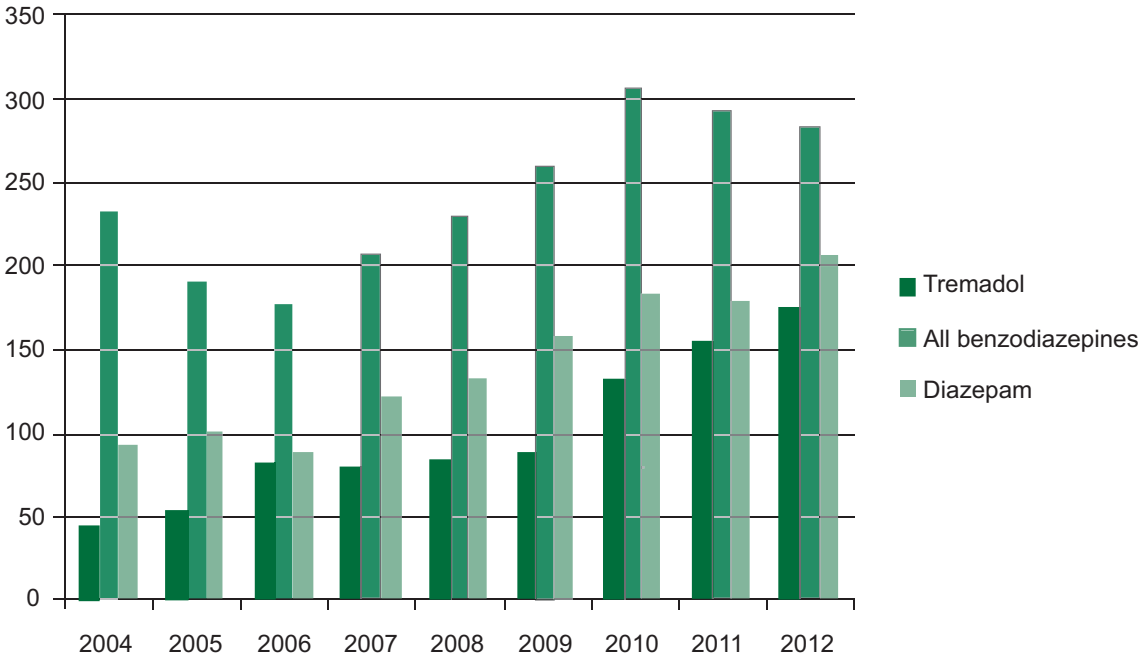
32 Ev 36

33 Q226

the understanding or the collection of data around the issue of dependence on prescription drugs. We welcome the announcements that the British Medical Association and the Advisory Council on the Misuse of Drugs will shortly carry out work examining dependence on prescription drugs. The geographical spread and the scale of the problem must be definitively established. We recommend that the Royal College of General Practitioners produce guidance for GPs who are treating addiction to prescription drugs stating that all cases ought to be recorded on the National Drug Treatment Monitoring System in order to further clarify the prevalence of prescription drug misuse.

ACMD reviews of prescription drugs and data on deaths by drug poisoning

26. The ACMD has reviewed and recommended controlling four prescription drugs this year: the opioid painkiller Tramadol in February 2013; lisdexamfetamine (Vyvanse), used in the treatment of attention deficit hyperactivity disorder, in September 2013: and the sleeping pills Zaleplon and Zopiclone in September 2013. In examining Tramadol, the ACMD found that NDTMS data indicated that 200 individuals with and addiction to Tramadol had been reported since 2004. However, according the Office of National Statistics, in that time 887 people had died with Tramadol mentioned on the death certificate (although this may occasionally be in conjunction with other substances). The Government launched a public consultation on whether Tramadol ought to be controlled under the Misuse of Drugs Act 1971 in July 2013.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
Tramadol	43	53	81	79	83	87	132	154	175	887
All benzodiazepines	233	190	177	207	230	261	307	293	284	2182
Diazepam	94	101	89	123	133	160	186	179	207	1272

Deaths by Drug Poisoning 2008 & 2012, Office of National Statistics

27. Despite a decrease of benzodiazepine prescriptions since the late 1980s, deaths related to the drugs have continued to increase since 2004. Deaths relating to a particular benzodiazepine, diazepam (Valium), doubled in the same period which, taken in conjunction with the findings of the 2011 Street Drug Trends survey, indicate an increase in its misuse. Chief Constable Bliss informed us that recently police forces around England and Wales were asked to report on the prevalence of prescription drug misuse and the involvement of organised crime in relation to supply. The collated information showed that diazepam misuse was particularly prevalent although there was little indication of organised crime group involvement in anywhere other than Northern Ireland.[34] He also informed us that when flights were grounded following the eruption of Eyjafjallajökull in 2010 and the importation of khat leaves was interrupted, there was anecdotal evidence that khat users temporarily diverted to using diazepam although there was no indication of how it was obtained.[35] Diazepam is already controlled as a Class C drug under the Misuse of Drugs Act 1971. However, both diazepam and Tramadol are easily available from online pharmacies.

Response to the misuse of prescription drugs by the police and general practioners

28. Chief Constable Bliss also provided us with an update on activity from the Metropolitan Police's Drugs Directorate which set out recent investigations in to the diversion of prescription drugs.

> In the past 18 months in the MPS we have had several investigations involving healthcare professionals where they have sold either prescription medicine or controlled drugs under the counter to patients. Most recently we have been investigating 17 people in the London area linked to the BBC undercover investigation of pharmacies. Here we had 7 pharmacies selling medication without prescriptions. We unfortunately we were only able to prosecute 3 due to CPS advice. We also have arrested nurses and doctors who have been prescribing for themselves or family members. The most common incident for us in the MPS, Suffolk and Dorset is the prescribing of prescription medication to be sent abroad. On one occasion a registered doctor asked for out of date stock to be left outside people's houses for him to collect (like a charity bag) this was then being sent abroad to be sold. Our biggest concern is the over prescribing of medication by doctors which may be diverted by their patients. However, due to the guidelines and advice of the GMC prescribing by doctors to their patients is a grey area.[36]

However, Chief Constable Bliss noted that given the lack of involvement of organised crime groups, the misuse of prescription drugs were unlikely to be a priority for Policing and Crime Commissioners.[37]

34 Q1-2

35 Q36 & 43

36 Ev 35

37 Q2

29. **We welcome the work of the All Party Parliamentary Group for Involuntary Tranquilliser Addiction and are deeply concerned by their estimate that there are currently 1.5 million people addicted to these type of drugs, a number which is far higher than those who are in treatment for addiction to controlled drugs. However, we recognise the lack of specific data on the misuse and supply of prescription drugs for non-medicinal purposes. We acknowledge the difficulties in collating this type of information due to the sensitivity of medical data, but immediate steps need to be taken to introduce a system whereby anonymous data can be collated to fully understand where the problem lies. When we visited America, as part of our previous inquiry into drugs, we were very worried that significantly more doctors and healthcare practitioners were able to be prosecuted for the illegal supply of prescription drugs there than in the UK. We are concerned that, despite the differences in medical care structures between the two countries, healthcare professionals in the UK are able to supply prescription drugs illegally without fear of prosecution. We recommend that medical practices start an anonymous data collection of those patients who have been proven to be, or a medical professional has reasonable suspicion of being, addicted to prescription drugs and how they are being supplied. This is a first step in the collation of this type of data and we will be writing to medical professionals, such as the BMA, to understand how this best can be implemented and further used.**

30. The British Medical Association noted that there were a number of unofficial practices in place to stop patients from 'doctor-shopping' a phenomenon which is one of the causes for such a high rates of dependency on prescription drugs in the US. These included GPs being unlikely to prescribe drugs associated with addiction to a temporary patient or a new patient whose notes had not been received from their previous practice. Under the previous health service structure, Primary Care Trusts would alert all practices in the local area if there was an individual visiting multiple practices to request specific drugs. The British Medical Association told us that although there was not a formal mechanism for this to continue, they would expect local area health teams to carry out this function in the new health service structure.[38] **We conclude that this practice must be formalised in order for it to continue with the structural changes in healthcare in UK. We recommend NHS England should issue guidance to local Clinical Commissioning Groups (CCGs), which will lead to them taking central responsibility for the collation of data on patients visiting multiple practices to request specific drugs. The administrative part of the CCG should be strengthened in order for them to facilitate sharing this information with all practices and thus informing all healthcare professionals in the area.**

31. The Royal College of General Practitioners and the Royal College of Psychologists produced an 'Addiction to Medicines Consensus Statement' in January 2013 which set out a number of actions needed to tackle addiction to prescription drugs and the expected behaviour of medical professionals who prescribe potentially addictive drugs.[39]

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39 http://www.rcgp.org.uk/news/2013/january/~/media/Files/News/RCGP-Addiction-to-Medicine-consensus-statement.ashx

32. **There are fewer deaths and criminal acts associated with prescription medicine or new psychoactive substances than with drugs such as heroin or cocaine. There also appears to be a lack of involvement of organised crime groups in the diversion of prescription drugs or the supply of new psychoactive substances. However, we remain concerned that it is an area which is not being tackled. We recommend that the medical Royal Colleges establish a joint working group to assess the effectiveness of their consensus statement and examine whether local area health teams are effectively communicating concerns around individuals visiting multiple practices to request specific drugs following the introduction of the new health service structure. This working group should also be responsible for starting the collection and collation of data by local healthcare practices. Due to the urgency of this issue we will revisit this topic in 6 months time.**

Annex: Recommendations from the last Home Affairs Committee report on drugs policy

The Department for Transport has set up a panel of experts to advise on those drugs which should be covered by the new offence driving with concentrations of drugs in excess of specified levels and, for each drug, the appropriate maximum permissible level of concentration in a person's blood or urine. We believe that this maximum should be set to have the equivalent effect on safety as the legal alcohol limit, currently 0.08 mg/ml.

We recommend that the Government continue to monitor the decisions of the Health and Wellbeing Boards as to allocation of treatment places, recording each request, monitoring waiting times to enter treatment and assessing the success rate of those dependent on different drugs. The Government should publish this information in an easily accessible and understandable format and consider developing a league table of Health & Wellbeing Boards' performance on local drugs provision while taking care in selecting assessment criteria not to introduce perverse incentives into the decision making process. This will allow Boards to benchmark their provision against each other, having due regard to local need.

New evidence which has emerged in the decade since our predecessor Committee's Report on drugs suggests that diamorphine is, for a small number of heroin addicts, more effective than methadone in reducing the use of street heroin. It is disappointing therefore that more progress has not been made in establishing national guidelines for the prescription of diamorphine as a heroin substitute. We recommend that the Government publish, by the end of July 2013, clear guidance on when and how diamorphine should be used in substitution therapy.

The aims of drugs policy

Drug use can lead to harm in a variety of ways: to the individual who is consuming the drug; to other people who are close to the user; through acquisitive and organised crime, and wider harm to society at large. The drugs trade is the most lucrative form of crime, affecting most countries, if not every country in the world. The principal aim of Government drugs policy should be first and foremost to minimise the damage caused to the victims of drug-related crime, drug users and others.

Current international drugs policy

The Committee saw for itself during its visit to Colombia the effect of the drugs trade on producer and transit countries—the lives lost, the destruction of the environment and the significant damage caused to governance structures by corruption and conflicts. We recognise and sympathise with the immense suffering and slaying of innocent people which tragically has taken place over the years in Colombia and other Latin American countries, as a result of the murderous rivalry between drug gangs.

We believe it is important that countries remain inside the Single Convention on Narcotic Drugs of 1961, rather than entirely outside it. We therefore believe that Bolivia should be allowed to re-accede to the Convention, with the reservation they require for traditional practices. We recommend that the UK Government support this position and encourage other countries to do likewise.

The impact of globalisation on the drugs trade

We were concerned to discover that the Maritime Analysis and Operations Centre (Narcotics) has seen a sharp fall in its rate of drug interdiction and now faces an uncertain future over its funding, 95% of which is currently provided by the European Commission. Gathering reliable intelligence about the maritime trafficking of illegal drugs is a crucial part of the international fight against the drugs trade. While recognising that this is not a matter for the UK Government alone, we urge the Government to work with both EU countries and other key international partners to ensure more effective drug interdiction in the future.

The balloon effect

Targeting supply at an early stage is the most effective way of reducing supply, as larger amounts can be intercepted higher up the supply chain. Even so, we do not believe that it will be possible to reduce the overall volume of the international drugs trade dramatically only by tackling supply — it is too easy for narco-criminals to respond by diversifying their supply routes.

The global nature of the drugs trade, and the potential for displacement of drug cultivation and supply routes in response to law enforcement measures, means that the international drug trade can only ever be tackled effectively by co-operative, co-ordinated international efforts. We must recognise that no one nation can do this on its own.

The potential for "substance displacement", where users switch from one drug to another in response to changes in supply, has clear implications for public policy. In particular, the Government must be mindful of the fact that tougher measures against one drug can lead to increased consumption of another. Where the drug that is being targeted is less harmful than its substitutes—and all recreational drugs are harmful to a greater or lesser extent—there is the clear potential for measures which are intended to tackle the supply and consumption of drugs to result in an overall increase in the harm they cause. We recommend that, where decisions about the classification of drugs are concerned, the opinion of the Advisory Council on the Misuse of Drugs should be sought on the potential for substance displacement, and the comparative risk associated with the likely substitutes.

Links between drugs, organised crime and terrorism

We are concerned that despite significant international efforts to disrupt supply of illegal drugs and bear down on demand, the illegal drugs trade remains a hugely profitable enterprise for organised criminals and narco-terrorists. In part this is due to the highly inflated prices of the drugs in question, inevitable in a high demand underground market, and in part due to very low production costs, arising from cheap labour costs where many workers are exploited and the fact that most illicit drugs are very simple and inexpensive to

make. This ultimately causes massive harm and deaths around the world. We urge the Government to continue to factor this unintended consequence into considerations on drugs policy.

Human rights abuses

The Government should not turn a blind eye to capital punishment and other human rights abuses affecting those involved in the drugs trade. In particular, we recommend that the Government ensure that no British or European funding is used to support practices that could lead to capital punishment, torture, or other violations.

Drug education in schools

The evidence suggests that early intervention should be an integral part of any policy which is to be effective in breaking the cycle of drug dependency. We recommend that the next version of the Drugs Strategy contain a clear commitment to an effective drugs education and prevention programme, including behaviour-based interventions.

We recommend that Public Health England commit centralised funding for preventative interventions when pilots are proven to be effective.

The Inter-Ministerial Group on Drugs

We believe that the current, inter-departmental approach to drugs policy could be strengthened by identifying a Home Office Minister and a Department of Health Minister, supported by a single, named official, with overall responsibility for co-ordinating drug policy across Government. We recommend that the Home Secretary and the Secretary of State for Health should be given joint overall responsibility for co-ordinating drug policy. By giving joint lead responsibility to the Home Office and Department for Health, the Government would acknowledge that the misuse of drugs is a public health problem at least as much as a criminal justice issue.

We recommend that the agenda, a list of attendees and minutes of each meeting of the inter-ministerial group on drugs be published on a government website. We would also welcome work addressing the harmful effects of drug consumption.

Current treatment options

Different treatment regimes will work for different patients. It is clear that, for some people, residential rehabilitation is the most effective treatment, backed by proper aftercare in the community. Although it is expensive when compared to treatment entirely in the community, it is cost-effective when compared to the cost of ongoing drug addiction. While we welcome the Government's focus on recovery in the Drugs Strategy 2010, we have consistently been told that there is a shortage of provision, and in particular provision for specific groups such as teenagers. We recommend that the Government expand the provision of residential rehabilitation places. In addition, we recommend the Government review the guidance for referrals to residential rehabilitation so that inappropriate referrals are minimised and amend the National Drug Treatment Monitoring System form so that where incidents of inappropriate referral do occur they can be captured and an accurate

picture of the effectiveness of residential rehabilitation as a treatment option can still be obtained.

Outcomes which range from 60% of patients overcoming their dependence to just 20% suggest that the quality of provision is very variable. We recommend that, in line with the publication of certain outcome statistics for National Health Service providers, publicly-funded residential rehabilitation providers should be required to publish detailed outcome statistics so that patients and clinicians can make better-informed choices of provider.

We make no comment on the relative merits of methadone and buprenorphine. It is for the individual prescriber to decide which drug is clinically indicated for each patient. However, we note that recent pharmacological advances in opioid substitution therapy mean that there are other options to patients being "parked" on methadone are notably treatment using buprenorphine which was less widespread when our predecessor committee published its report in 2002 and that it is possible that OST could in the future become a more effective route to abstinence than it has been in the past. Policy makers should understand the potential for more effective OST treatments and, rather than ignoring reports of the negative side effects of current OST drugs because they are available, familiar and cost-effective, should continue to keep sight of a greater emphasis on buprenorphine relative to methadone prescription to lead to better patient and societal outcomes.

Implementation of the Government's goal of recovery

Drug treatment in prisons is a point of critical intervention—if a drug-dependent offender is treated effectively then it greatly improves their chance of rehabilitation on release. Given that drug and alcohol dependence treatment in prisons has been so heavily criticised for the lack of co-ordination with treatment in the community, we are concerned that new structural changes may reverse the gradual improvement we have seen in treatment for drug-dependent offenders. We recommend the Government closely monitor the transition of treatment funding responsibilities to the Health and Wellbeing Boards and the NHS Commissioning Boards respectively.

The Government goal of recovery will require the co-ordination of several government departments: the Department of Health to ensure that effective treatment is being funded, the Department for Work and Pensions to support patients to re-enter the workforce and local authorities which must take responsibility for ensuring that they have appropriate accommodation. We believe that giving the Home Secretary and the Secretary of State for Health joint overall responsibility for coordinating drug policy (see paragraph 83) will help to improve the focus on the goal of recovery. We recommend that the Inter-Ministerial Group works with the Recovery Committee of the Advisory Council on the Misuse of Drugs to carry out an assessment of how the situation is working once the changes have been fully implemented, and to publish its findings by July 2013.

Payment by results potentially produces a very cost-effective system in which the taxpayer pays only for successful outcomes. However, past experience in other areas such as employment has shown that it is easy for the market to become dominated by a small number of large providers, leading to the marginalisation of smaller, innovative voluntary sector organisations. Another risk is that the most difficult to treat patients may be denied

access to services. We recommend that the Government establish ways to create provider diversity to ensure that smaller providers and civil society are not excluded and that a wide range of services are available. This could be achieved by ring-fencing a certain proportion of expenditure for such providers. The model will also need to ensure that providers are rewarded appropriately for taking on the most difficult patients, so that those who are harder to help will not be denied services.

Prescription drug dependence and the use of prescription drugs for non-medicinal purposes is widely and erroneously viewed as being less harmful and certainly more acceptable than drugs which are part of the classification system. Prescription drugs are becoming more widely available, through diversion of prescriptions and unregulated sales via the internet. This was not an issue which our predecessor committee looked at in 2002 but we are alarmed by the increase in availability of and addiction to prescription drugs. Having seen first-hand the scale and impact of prescription drug use in Florida, we recommend that the Government publish an action plan of how it intends to deal with this particular issue as part of the next version of the drug strategy to prevent the situation here in the UK deteriorating further.

It is unacceptable that no government agency can give us information on the prevalence of dependence on prescription drugs. We welcome the proposed review of prescription medicine diversion by the ACMD. The issue is one which has been highlighted as a growing problem and as the overall trends of drug use change, the Government must ensure that it has access to suitable treatment for dependence on all drugs rather than just focussing on a narrow sub-set. It is ultimately the responsibility of the medical profession to ensure that their prescribing decisions do not lead patients into drug dependency. However, the police and public should be aware of this deeply concerning trend, so they too can be vigilant in seeking to prevent it.

Misuse of Drugs Act 1971

Our predecessor Committee's recommendation for an independent assessment of the Misuse of Drugs Act 1971 was rejected on the basis that it gives effect to the UK's international obligations in this area. That is not, in our view, a compelling reason for refusing to review our own domestic legislative framework, particularly given the growing concern about the current international regime in many producer nations. The message from Colombia and other supplier and transit states is clear—what the international community is currently doing is not working. We are not suggesting that the UK should act unilaterally in these matters, but our Government's position must be informed by a thorough understanding of the global situation and possible alternative policies.

This inquiry has heard views from all sides of the argument and we believe that there is now, more than ever, a case for a fundamental review of all UK drugs policy in the international context, to establish a package of measures that will be effective in combating the harm caused by drugs, both at home and abroad. We recommend the establishment of a Royal Commission to consider the best ways of reducing the harm caused by drugs in an increasingly globalised world. In order to avoid an overly long, overly expensive review process, we recommend that such a commission be set up immediately and be required to report in 2015.

We endorse the praise from President Santos and others for the work of the Serious and Organised Crime Agency. In the countries we visited, it was clear that they did an excellent job and were well respected. We encourage the Government to find a way to retain the SOCA brand overseas, in the move to the National Crime Agency, perhaps as a Serious Overseas Crime Arm of the NCA. However, despite their best efforts and considerable success, we agree with President Santos and others that it is impossible for them to prevent drug trafficking completely.

Like any business, the international drug trade thrives on profit. Identifying and seizing the profits of the drug trade, wherever they are in the world, must be a central part of the global fight against drugs. In that context, the UK's approach to money-laundering has been far too weak. Whilst we recognise that the financial crisis has occupied the attention of the FSA since 2008, there is little evidence that it treated the issue of money laundering sufficiently seriously prior to that time. We welcome the creation of the Financial Conduct Agency and we recommend that it produce annual reports which show the prevalence of money laundering within the UK financial sector.

Being fined by a regulatory body is an inadequate a sanction for complicity—however peripheral, and whether it is wilful or negligent—in an international criminal network which causes many thousands of deaths each year. We recommend that the Government bring forward new legislation to extend the personal, criminal liability of those who hold the most senior posts in the banks involved where they are found to have been involved in money laundering.

The impact of austerity on drug-related policing

Drug-related policing is a vital component of reducing supply and the intelligence aspect, whether it be data on supply routes, the trend in available products or the location of markets, assists not just local police forces but other law enforcement agencies. Following the election of Police and Crime Commissioners, the use of police budgets will be decided with increased community input and local accountability. There is a risk that significant variations in the local approach to drugs could lead to geographical displacement of the drugs trade within the UK. Commissioners will therefore need to be fully briefed on the wider impact of decisions which they might take locally. We recommend that the National Crime Agency submit to every Police and Crime Commissioner and Chief Constable an annual, confidential briefing setting out the measures they could take to contribute to disrupting the drugs trade nationally and internationally.

Police time is always limited and needs to be carefully prioritised to have the most impact. As budgets get tighter going forward this situation will intensify. It is important that Police Commissioners carefully consider how best to target drugs crime in their local area. In particular, we encourage Police Commissioners to ensure they are fully informed about the relative effectiveness of different forms of drug-related policing, including cannabis warnings and other forms of diversion work, and to carefully consider the issue of how police time is best prioritised between different kinds of drug-related offences, whether simple possession, acquisitive crime, supply or trafficking.

Identifying drug-related crime is vital in order to ensure that the right approaches to reduce re-offending are targeted and effective. Drug-dependent offenders are often prolific

re-offenders—by identifying their prevalence, the Government and local authorities can make targeted interventions in the community.

New psychoactive substances

The market in new psychoactive substances is changing quickly, too quickly for the current system of temporary banning orders to keep up. Forty-nine new substances were found in Europe last year, a rate of development which makes additional measures critical. At the moment, businesses are legally able to sell these products until such time as they are banned with apparently no legal consequences when they lead to death or long-term illness. We recommend that the Government issue guidance to Local Authority trading standards departments, citizens advice bureaux and other interested parties on the action which might be taken under existing trading standards and consumer protection legislation to tackle the sale of these untested substances. A restaurant which gave its diners food poisoning, a garage which left cars in a dangerous state, or a shop which sold dangerously defective goods could all be prosecuted for their negligence. Retailers who sell untested psychoactive substances must be liable for any harm the products they have sold cause. It is unacceptable that retailers should be able to use false descriptions and disclaimers such as "plant food" and "not for human consumption" as a defence where it is clear to all concerned that the substance is being sold for its psychoactive properties and the law should be amended.

The effect of having a drugs conviction

We believe that former drug users should be encouraged to play an active part in society, and that making it harder for them to find employment is likely to hinder that process, and make it more likely they will be unemployed and supported by the state. We therefore recommend that the Government review the inclusion of convictions for offences of simple possession of a controlled substance (as opposed to offences relating to supply, or any other drug-related crime such as burglary) in CRB checks after they become spent, or after three years, whichever is shorter. The review should, in particular, take account of those areas of employment to which drugs convictions are directly relevant. We also recommend that cannabis warnings be treated as spent immediately.

Cross-Departmental strategy

Tackling drug use touches on issues of criminal justice, social justice, education, health and local authorities, which is why the formation of an Inter-Ministerial Group to coordinate Government policy on the subject makes sense. However, as with any other cross-departmental challenge, driving through reform requires clear, senior leadership. Our recommendation for the Home Secretary and the Secretary of State for Health to take joint overall responsibility for drugs policy will help to strengthen inter-departmental co-operation, with a focus on prevention and public health.

Availability of drugs in Prisons

We accept that prisons cannot be hermetically sealed and that it will never be possible to eradicate completely the availability of drugs within prisons. However, the fact that almost

a quarter of prisoners surveyed found it easy to get drugs in prison is deeply disturbing. The methods of reducing supply are only effective if they are implemented as intended. We recommend that the National Offender Management Service ensure that measures such as the installation of netting to stop 'throw-over' packages, regular cell searches and regular drug tests based on suspicion are put into operation.

We commend the work taking place on the drug recovery wings and the drug free wings in certain prisons. The examples that we saw of both were inspiring. If the evaluation of the pilots shows them to be successful, we recommend that they be rolled out nationwide as a matter of priority. We also recommend that the Government ensure that they remain fully funded. The matter of the lack of funding for voluntary drug testing in HMP Brixton's drug recovery wing is worrying and we ask that the Justice Secretary reassure us that such a vital strand of the recovery programme remains funded.

There is some very impressive work happening in some prisons at present with innovative approaches being formulated in regards to treatment and managing the transition of release but this is not the standard and there is considerable scope to spread best practice.

Treatment in prisons, just like treatment outside prisons, should be tailored to the individual. Some people will be able to enter abstinence programs, and should be encouraged to do so. For others, such as those who are already being maintained on methadone, prescription alternatives may be the best option, and should be made available.

Lack of reliable data

Producing an evidence base of effective interventions is one of the most vital building blocks of drugs policy. We recommend that the Ministry of Justice introduce mandatory drug-testing for all prisoners arriving at and leaving prison whether on conviction, transfer or release. Tests should be carried out for both illegal and prescription drugs. This should be in addition to the existing random testing regime, the principal purpose of which is deterrence. The information obtained from such a test would be very valuable in evaluating the effectiveness of the current systems in place and identifying those prisons which have a serious problem. Prisons are a key point in the cycle of drug addiction and if addicted offenders can be got off drugs, the monetary and societal benefits would be huge.

Release from prison is a critical intervention point in the cycle of addiction and re-offending. We welcome the Justice Secretary's recent announcement that prisoners will be "met at the prison gate" by mentors who can help them to settle back into the community. Successful rehabilitation is a challenging outcome to achieve, but it is worth investing the resources necessary to ensure that those leaving prison have the care and support they need in the community, including suitable and stable housing, to provide them with the best possible chance of a long-term recovery. Under the our recommended regime of universal drug testing on release, those who test positive—however long they have served—should be automatically referred to the appropriate community drug rehabilitation service. Given the importance of this point of critical intervention, we intend to return to this issue in the near future to assess whether there has been an improvement following the implementation of the Justice Secretary's policy.

Decriminalisation and Legalisation

We were impressed by what we saw of the Portuguese depenalised system. It had clearly reduced public concern about drug use in that country, and was supported by all political parties and the police. The current political debate in Portugal is about how treatment is funded and its governance structures, not about depenalisation itself. Although it is not certain that the Portuguese experience could be replicated in the UK, given societal differences, we believe this is a model that merits significantly closer consideration.

Following the legalisation of marijuana in the states of Washington and Colorado and the proposed state monopoly of cannabis production and sale in Uruguay, we recommend that the Government fund a detailed research project to monitor the effects of each legalisation system to measure the effectiveness of each and the overall costs and benefits of cannabis legalisation.

Implications of discussing drugs policy - politics and the media

Drugs policy ought to be evidence-based as much as possible but we acknowledge that there is an absence of reliable data in some areas. We therefore recommend the Government allocated ring fenced funding to drugs policy research going forward. Such a funding stream would most appropriately sit with the Medical Health and Research Council so that the evidence base for prevention and recovery aims of the Drugs Strategy can be strengthened, although cross disciplinary applications in this area will be vital.

We recommend that the responsible minister from the Department of Health and the responsible minister from the Home Office together visit Portugal in order to examine its system of depenalisation and emphasis on treatment.

As our predecessor Committee supported in their 2002 report, we recommend that the Government initiate a discussion within the Commission on Narcotic Drugs of alternative ways—including the possibility of legalisation and regulation—to tackle the global drugs dilemma.

We welcome the Government's efforts to make clear its commitment to reducing drug misuse and tackling the consequences of drug misuse. We also recommend that the Government instigate a public debate on all of the alternatives to the current drugs policy, as part of the Royal Commission.

We have made a number of recommendations regarding the need for further evidence gathering. We believe that this would be most effective if it were co-ordinated through one body. The appropriate body to do this would, in our view, be the Advisory Council on the Misuse of Drugs, which is already tasked with advising the Home Secretary on classification decisions. It is logical that the body which is responsible for formulating scientific advice to ministers should also have a role to play in coordinating the gathering of scientific evidence on the subject.

Conclusions and recommendations

1. Chief Constables and other law enforcement agencies are failing to understand the impact of psychoactive substances. We are deeply concerned that there is not enough data collated by each local police area regarding the usage and effect of these types of substances. We recommend that police forces start a process of data collection immediately in order to have established, within 6 months, the challenges they face locally. This will enable them to develop an effective strategy in tackling the problems presented by psychoactive substances, both in pursuing those who are selling substances which may contain illegal drugs and also producing an appropriate education strategy for potential users. (Paragraph 7)

2. We conclude that there is currently an epidemic of psychoactive substances and it is highly likely that the creation of new psychoactive substances will continue to increase in the future unless immediate action is taken. (Paragraph 9)

3. We congratulate the work done by the Angelus Foundation on raising the profile of the problems associated with psychoactive substances and educating others about the risks. However, we believe that there should be more engagement between the Government and the Foundation and that either the Home Secretary or Norman Baker, the new Minister with responsibility for drugs, should meet with the organisation. Education of young people is crucial in order to prevent further deaths from psychoactive substances. We recommend that schools and colleges extend the current educational sessions they run on drugs policy with effective evidence-based sessions. (Paragraph 12)

4. It is clear that simply controlling new psychoactive substances under current legislation will not work. We welcome the Government's announcement that they are going to review other countries' systems and the Minister will be recalled to the Committee in 4 months time to give a full account on the potential costs and benefits of introducing these types of regulatory system within the UK. We believe that the burden of proof ought to be removed from enforcement authorities and placed on those who are selling the new psychoactive substance. The Home Office should introduce a new legislative model, taking into account the benefits of other systems in use abroad. The new model should shift the evidential responsibility, of proving the safety and the non-narcotic purpose of a substance, onto the seller for all new psychoactive substances. It should also be specifically related to the new psychoactive substances problem and not impinge on current legislation which controls illicit drugs. (Paragraph 14)

5. We welcome the use of alternative legislation to prosecute suppliers of new psychoactive substances and congratulate West Yorkshire Police and the Crown Prosecution Service on their use of the Intoxicating Substances (Supply) Act 1985 to secure convictions of two suppliers of new psychoactive substances—the innovative use of such legislation is to be commended. We also commend all of those involved in Operation Burdock and would highlight the cohesive nature of such an operation. Until the law has been amended we expect to see similar operations taking place as the benefits of such an approach are clear and we will be writing to every Police and

Crime Commissioner to highlight the work done on this case. We are concerned by the length of time it has take the Government to produce guidance on the use of alternative legislation. When new substances are emerging at a rate of more than one a week, taking twelve months to produce a five page note is an unacceptably slow reaction time. The use of alternative legislation, however, in order to cover this increasingly blurred legal area is insufficient. The Government's inability to establish an effective legislative response is indicative of its sluggish response to this problem. The issue of new psychoactive substances is unique and needs an immediate and tailored response. We recommend that any new legislation, brought in to address the problem of 'legal highs', is specific and focused. The law must ensure that the police and law enforcement agencies can take action comprehensively against those who sell new psychoactive substances and remove the reliance on existing legislation which is ill-suited to comprehensively tackling this problem. The legislation needs to allow sellers of new psychoactive substances to be prosecuted for an offence which is equivalent in sanction to that of the Misuse of Drugs Act 1971. (Paragraph 19)

6. We welcome the news that ACPO and Public Health England are already beginning to plan for the 2014 festival season. We recommend that, as well as raising awareness around the harms that new psychoactive substances can cause, police and trading standards officials also implement a joint operation, testing and monitoring the sale of substances at such events. We recommend that the police introduce quick turnaround mobile laboratory drug testing facilities at these types of event in order to facilitate the removal of potentially harmful or illegal substances from the site immediately. (Paragraph 21)

7. It is concerning that a year on from the publication of our previous report, which highlighted the lack of knowledge on this subject, there have been no improvements in the understanding or the collection of data around the issue of dependence on prescription drugs. We welcome the announcements that the British Medical Association and the Advisory Council on the Misuse of Drugs will shortly carry out work examining dependence on prescription drugs. The geographical spread and the scale of the problem must be definitively established. We recommend that the Royal College of General Practitioners produce guidance for GPs who are treating addiction to prescription drugs stating that all cases ought to be recorded on the National Drug Treatment Monitoring System in order to further clarify the prevalence of prescription drug misuse. (Paragraph 25)

8. We welcome the work of the All Party Parliamentary Group for Involuntary Tranquilliser Addiction and are deeply concerned by their estimate that there are currently 1.5 million people addicted to these type of drugs, a number which is far higher than those who are in treatment for addiction to controlled drugs. However, we recognise the lack of specific data on the misuse and supply of prescription drugs for non-medicinal purposes. We acknowledge the difficulties in collating this type of information due to the sensitivity of medical data, but immediate steps need to be taken to introduce a system whereby anonymous data can be collated to fully understand where the problem lies. When we visited America, as part of our previous inquiry into drugs, we were very worried that significantly more doctors and healthcare practitioners were able to be prosecuted for the illegal supply of prescription drugs there than in the UK. We are concerned that, despite the

differences in medical care structures between the two countries, healthcare professionals in the UK are able to supply prescription drugs illegally without fear of prosecution. We recommend that medical practices start an anonymous data collection of those patients who have been proven to be, or a medical professional has reasonable suspicion of being, addicted to prescription drugs and how they are being supplied. This is a first step in the collation of this type of data and we will be writing to medical professionals, such as the BMA, to understand how this best can be implemented and further used. (Paragraph 29)

9. We conclude that this practice must be formalised in order for it to continue with the structural changes in healthcare in UK. We recommend NHS England should issue guidance to local Clinical Commissioning Groups (CCGs), which will lead to them taking central responsibility for the collation of data on patients visiting multiple practices to request specific drugs. The administrative part of the CCG should be strengthened in order for them to facilitate sharing this information with all practices and thus informing all healthcare professionals in the area. (Paragraph 30)

10. There are fewer deaths and criminal acts associated with prescription medicine or new psychoactive substances than with drugs such as heroin or cocaine. There also appears to be a lack of involvement of organised crime groups in the diversion of prescription drugs or the supply of new psychoactive substances. However, we remain concerned that it is an area which is not being tackled. We recommend that the medical Royal Colleges establish a joint working group to assess the effectiveness of their consensus statement and examine whether local area health teams are effectively communicating concerns around individuals visiting multiple practices to request specific drugs following the introduction of the new health service structure. This working group should also be responsible for starting the collection and collation of data by local healthcare practices. Due to the urgency of this issue we will revisit this topic in 6 months time. (Paragraph 32)

Formal Minutes

Tuesday 17 December 2013

Members present:

Keith Vaz, in the Chair

Ian Austin	Paul Flynn
Mr James Clappison	Dr Julian Huppert
Mr Michael Ellis	Mr David Winnick

Draft Report (*Drugs: new psychoactive substances and prescription drugs*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 18 read and agreed to.

Paragraph 19 read, as follows:

We welcome the use of alternative legislation to prosecute suppliers of new psychoactive substances and congratulate West Yorkshire Police and the Crown Prosecution Service on their use of the Intoxicating Substances (Supply) Act 1985 to secure convictions of two suppliers of new psychoactive substances—the innovative use of such legislation is to be commended. We also commend all of those involved in Operation Burdock and would highlight the cohesive nature of such an operation. Until the law has been amended we expect to see similar operations taking place as the benefits of such an approach are clear and we will be writing to every Police and Crime Commissioner to highlight the work done on this case. We are concerned by the length of time it has take the Government to produce guidance on the use of alternative legislation. When new substances are emerging at a rate of more than one a week, taking twelve months to produce a five page note is an unacceptably slow reaction time. The use of alternative legislation, however, in order to cover this increasingly blurred legal area is insufficient. The Government's inability to establish an effective legislative response is indicative of its sluggish response to this problem. The issue of new psychoactive substances is unique and needs an immediate and tailored response. We recommend that any new legislation, brought in to address the problem of 'legal highs', is specific and focused. The law must ensure that the police and law enforcement agencies can take action comprehensively against those who sell new psychoactive substances and remove the reliance on existing legislation which is ill-suited to comprehensively tackling this problem. The legislation needs to allow sellers of new psychoactive substances to be prosecuted for an offence which is equivalent in sanction to that of the Misuse of Drugs Act 1971.

Amendment proposed, in line 14, to leave out from "focused" to the end of the paragraph.—(*Dr Julian Huppert.*)

The Committee divided.

Ayes, 2	Noes, 3
Paul Flynn	Ian Austin
Dr Julian Huppert	Mr James Clappison
	Mr Michael Ellis

Question accordingly negatived.

Paragraph agreed to.

Paragraphs 20 to 32 agreed to.

Annex and Key Facts agreed to.

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

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

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

[Adjourned till Tuesday 7 January at 2.30 pm

Witnesses

Tuesday 19 November 2013

Tuesday 26 November 2013

List of printed written evidence

List of Reports from the Committee during the current Parliament

Session 2013–14

First Report	Police and Crime Commissioners: Register of Interests	HC 69
Second Report	Child sexual exploitation and the response to localised grooming	HC 68
Third Report	Leadership and standards in the police	HC 67
Fourth Report	The work of the UK Border Agency (Oct–Dec 2012)	HC 486
Fifth Report	E-crime	HC 70
Sixth Report	Police and Crime Commissioners: power to remove Chief Constables	HC 487
Seventh Report	Asylum	HC 71
Eighth Report	The work of the UK Border Agency (Jan–March 2013)	HC 616
Ninth Report	Pre-Lisbon Treaty EU police and criminal justice measures: the UK's opt-in decision	HC 615
Tenth Report	Leadership and Standards in the Police: follow-up	HC 756
Eleventh Report	Khat	HC 869

Session 2012–13

First Report	Effectiveness of the Committee in 2010–12	HC 144
Second Report	Work of the Permanent Secretary (April–Dec 2011)	HC 145
Third Report	Pre-appointment Hearing for Her Majesty's Chief Inspector of Constabulary	HC 183
Fourth Report	Private Investigators	HC 100
Fifth Report	The work of the UK Border Agency (Dec 2011–Mar 2012)	HC 71
Sixth Report	The work of the Border Force	HC 523
Seventh Report	Olympics Security	HC 531
Eighth Report	The work of the UK Border Agency (April–June 2012)	HC 603
Ninth Report	Drugs: Breaking the Cycle	HC 184-I
Tenth Report	Powers to investigate the Hillsborough disaster: interim Report on the Independent Police Complaints Commission	HC 793
Eleventh Report	Independent Police Complaints Commission	HC 494
Twelfth Report	The draft Anti-social Behaviour Bill: pre-legislative scrutiny	HC 836
Thirteenth Report	Undercover Policing: Interim Report	HC 837
Fourteenth Report	The work of the UK Border Agency (July-Sept 2012)	HC 792

Session 2010–12

First Report	Immigration Cap	HC 361
Second Report	Policing: Police and Crime Commissioners	HC 511

Third Report	Firearms Control	HC 447
Fourth Report	The work of the UK Border Agency	HC 587
Fifth Report	Police use of Tasers	HC 646
Sixth Report	Police Finances	HC 695
Seventh Report	Student Visas	HC 773
Eighth Report	Forced marriage	HC 880
Ninth Report	The work of the UK Border Agency (November 2010-March 2011)	HC 929
Tenth Report	Implications for the Justice and Home Affairs area of the accession of Turkey to the European Union	HC 789
Eleventh Report	Student Visas – follow up	HC 1445
Twelfth Report	Home Office – Work of the Permanent Secretary	HC 928
Thirteenth Report	Unauthorised tapping into or hacking of mobile communications	HC 907
Fourteenth Report	New Landscape of Policing	HC 939
Fifteenth Report	The work of the UK Border Agency (April-July 2011)	HC 1497
Sixteenth Report	Policing large scale disorder	HC 1456
Seventeenth Report	UK Border Controls	HC 1647
Eighteenth Report	Rules governing enforced removals from the UK	HC 563
Nineteenth Report	Roots of violent radicalisation	HC 1446
Twentieth Report	Extradition	HC 644
Twenty-first Report	Work of the UK Border Agency (August-Dec 2011)	HC 1722

Oral evidence

Taken before the Home Affairs Committee

on Tuesday 19 November 2013

Members present:

Keith Vaz (Chair)

Nicola Blackwood	Lorraine Fullbrook
Mr James Clappison	Dr Julian Huppert
Michael Ellis	Mr David Winnick
Paul Flynn	

Examination of Witnesses

Witnesses: **Chief Constable Andy Bliss**, Lead on Drugs, Association of Chief Police Officers, and **Commander Simon Bray**, Lead on Psychoactive Substances, Association of Chief Police Officers, gave evidence.

Q1 Chair: Could I call the Committee to order and refer everyone present to the Register of Members' Interests where the interests of this Committee are noted? I invite our witnesses to take their seats.
This is a one-off session, a revisit of the Select Committee's inquiry into drugs that we published last year. We are delighted to see Chief Constable Andy Bliss and Commander Simon Bray who have come to give evidence today. Mr Bliss and Mr Bray, the Committee has decided not to revisit the whole of our recommendations. We are particularly interested in the issues of legal highs and prescription drugs, both of which we hope you will be able to assist us with. We will also be writing to the British Medical Association and taking limited written evidence.
Mr Bliss, you are the ACPO lead on drugs. As far as prescription drugs and their sale are concerned, the Committee visited the United States last year we were very concerned about the way in which prescription drugs had become so frequently sold by individuals—very much part of the criminal system. What is the position in the United Kingdom at the moment?
CC Bliss: We had a look at this last year, particularly focusing at that stage on the organised crime angle and whether organised crime was behind this. The committee at that stage were given some information from Northern Ireland indicating that this is a more significant issue in Northern Ireland and some suggestions around an organised crime element there, but we took soundings from forces round the country in England and Wales, and overall, while there was some evidence of this sort of behaviour around prescription drugs, there was not a significant indication it was of a great scale and certainly no indication that organised crime was involved.

Q2 Chair: Are we able to put a value or quantity on it? I have a figure that more than a million people are addicted to benzodiazepine.
CC Bliss: I can't put a value on it. The report that came back was pretty short. It is restricted but I would be very happy to share it with the Committee if it would help.
Chair: Please.
CC Bliss: What did emerge from forces around England and Wales was that diazepam was particularly prominent in the list of drugs, but I am very happy to share that with you. At that stage, bearing in mind that we have to prioritise and we now work to police and crime commissioners and the priorities they set, this was not coming across, particularly as far as organised crime goes, as a very significant issue at that stage.

Q3 Lorraine Fullbrook: When you got the evidence from Northern Ireland, where exactly were the organised criminals procuring their prescription drugs? Was it theft or some other way?
CC Bliss: I don't have that level of detail today but I am very happy to share the report with the Committee. It probably gives a little bit more detail and I can try to elucidate.
Lorraine Fullbrook: On our trip to the United States, it was mainly doctors who were prescribing prescription drugs in an illegal manner, so I would be interested.

Q4 Chair: Do you have evidence that anyone in the medical profession has been prosecuted in the same way as people in the United States have been prosecuted?
CC Bliss: No, I am afraid I don't have that detail.

Q5 Chair: If you could write to us, that would be very helpful.
CC Bliss: Yes, I will write to you on that.

Q6 Chair: Let us move on to legal highs, something that really does concern the Committee greatly. There was an 80% increase in deaths as a result of psychoactive substances between 2011 and last year—there were 52 such deaths last year. Adam Hunt was a young man who died in Southampton and last week the coroner said, "Anyone taking this kind of drug in any kind of quantity is potentially walking into the unknown, into disaster really", which was quite a serious thing for a coroner to say. Is this on the increase or are we now able to control the amount of psychoactive substances?

CC Bliss: Obviously they are of significant concern to us. I chair the committee overall and it may well be that I will add some points, but Mr Bray, who is with me, leads for us and if he may lead off.

Q7 Chair: Please, Mr Bray. Is it on the increase?
Cmdr Bray: There are different sorts of drugs coming into the country or being made available over the internet, but a large scale of the new psychoactive substances that we are having dealings with would be things like mephedrone, where there has been, according to the Crime Survey of England and Wales, a notable reduction, and likewise in other surveys as well. There has been an increase in numbers of seizures of mephedrone and other controlled NPSs—new psychoactive substances—but the issue is that we can't always tell what is in the substances until they are forensically examined.

Q8 Chair: Is it also correct that the substances and the tablets that are being produced are changing at the rate of one a week?
Cmdr Bray: There have been reports of new substances being found at quite a significant rate, particularly around Europe although not all those substances have been identified through our forensic early warning system. A lower number has been found in the UK.

Q9 Chair: What facts and statistics can you give this Committee today?
Cmdr Bray: In relation to the numbers? Most of the ones that are known through public sources anyway, and I will just get on to the forensic early warning system side of things. We are talking about 70-odd new substances in the last year. I believe it was 49 the previous year and 41 the year before that. However, the forensic early warning system has identified around 27, I believe, over that time as being relevant to the UK. Clearly there is a system for picking up on those that are causing concerns once they have been forensically identified and if they have any particular harms linked in with them. It is the job of ACMD to refer to Government as to whether they should become temporary class drugs.

Q10 Chair: In your evidence to the Select Committee last year you said, "Law enforcement agencies have well established methods for tackling criminality associated with conventional illicit drugs such as heroin, cocaine and cannabis, but these established approaches are not well geared to meet the challenges presented by legal highs". That was a year ago. Has there been any change in the way in which you meet these challenges?
Cmdr Bray: What has happened in that time, of course, is that a number of additional drugs have become controlled or temporary class drugs and fall within the remit of the Misuse of Drugs Act and therefore there is an opportunity to prosecute in those cases. Our testing regimes mean that we can now test for ketamine and mephedrone and some of those additional drugs. Once they are identified and forensically examined, we can do some more targeted work on them and deal with prosecutions or close down internet suppliers of those particular drugs. We work very closely with the National Crime Agency around internet suppliers.

Q11 Chair: The figures we were given showed where young people get these drugs from: 17% got them off the internet, 33% from what is called head shops that specialise in the sale of these substances, 36% acquired them in a party or a club, and 54% of those who used them were offered these substances by their friends. Are those figures still accurate?
Cmdr Bray: Those are different figures from the ones that I am aware of.

Q12 Chair: Would you tell us what the figures are?
Cmdr Bray: There are two sets of figures. One is that in new psychoactive substances generally, and that would include controlled ones, about 10% are obtained from the internet. However, I have also seen other surveys in relation to research chemicals as they are described—the non-illegal ones, the non-controlled ones—which show about half of people getting them from the internet.

Q13 Chair: But what do you think? You are the ACPO lead. Presumably you are the ACPO lead because you know which of these facts are correct. What facts are you giving the Committee?
Cmdr Bray: I think it does depend on the type of substance that we are talking about.

Q14 Chair: Roughly how much comes from the internet, 10% or 50%?
Cmdr Bray: I think it depends on substance by substance. I can't tell you what I don't know but I can tell you that in relation to mephedrone, for example, we know that there are about 4,000 offences recorded per year currently. Class B drugs, mainly new psychoactives but now controlled new psychoactives, in many cases nowadays are obtained through friends and dealers, not head shops in those particular cases but through established networks of getting drugs in the way that other drugs are supplied.

Q15 Chair: In terms of people going into shops, is that still about a third or has that increased?
Cmdr Bray: I would say if you take somewhere between the different figures, then possibly about a third, but again it will depend from place to place. There is a particular problem in relation to head shops in places that are outside the remit of this Committee, I suppose, like Northern Ireland where they have a set of five head shops in the city centre of Belfast and where they have also been affected by the knock-on legislation in the Republic. We learned quite a lot from that Northern Ireland experience about how they deal with the antisocial behaviour and new methods of tackling head shops.

Q16 Chair: How many traders have been prosecuted in respect of selling any of these psychoactive substances when the persons who use them have subsequently died? Have there been any prosecutions?
Cmdr Bray: I can't give you any figures on prosecutions specifically around that sort of event.

You may be aware of the incident in Leeds where some market traders were prosecuted under the Intoxicating Substances (Supply) Act for supplying a substance that was then inhaled by a young person, but the restrictions in relation to that Act are that it has to be inhaled.

Q17 Chair: Do we have these figures?
Cmdr Bray: We don't collate those figures centrally in terms of prosecutions for—

Q18 Chair: Do you not think we ought to? Wouldn't it help you as the ACPO lead if you knew how many people had been prosecuted?
Cmdr Bray: It is rather difficult to draw up figures when you know that the substances, from packet to packet in some cases, as well as from place to place, are of different compositions. That is why the forensic early warning system is so useful to us and also the work that John Ramsey and TICTAC and various other organisations have done in sampling the range of substances that are out there. We know, for example, from the forensic early warning system that in many cases a nice shiny packet of material may contain three different substances, it may contain more, and it is as likely to contain controlled substances as well as uncontrolled. Having been down and seen John Ramsey at work, I know the complexity of equipment that you need in order to establish all the different types of material. It is certainly an eye opener going down and looking at his work.

Q19 Chair: So the sad death of Adam Hunt could well be repeated in other parts of the country, and we are hearing later from Hester's mother.
Cmdr Bray: We are learning all the time, quite clearly, as we come across new substances and get the intelligence. I have an ACPO working group, or it is a multi-agency working group in fact. It involves the Centre for Applied Technologies at St Albans—that does the forensic early warning system work—as well as the National Crime Agency, Trading Standards, the National Offender Management Service, Home Office, and so on. It brings together intelligence and we are constantly trying to find out from different parts of the UK and different organisations what the latest information is.

Q20 Nicola Blackwood: You have given us some stats about the use of psychoactive substances, but I wanted to take your mind back to maybe 2009–2010 when the concern about legal highs was really first raised to public awareness. What is your assessment of how popular legal highs are now among young people and those most vulnerable to the risks of legal highs?
Cmdr Bray: I think the experience of 2009 to 2010 in relation to mephedrone has heightened awareness quite clearly about legal highs but also the fact that mephedrone relatively quickly became a class B drug put a number people off. The trouble is that as new substances come through, are marketed in nice shiny packets and are quite accessible, whether it is through established head shops, pop-up shops, garages, cobblers, you name it, different sources, it is—

Q21 Nicola Blackwood: Would you say that legal highs are more popular, as popular, less popular?
Cmdr Bray: It is very difficult for me to say that. I think there is a lot of interest in new psychoactives now. I am trying to avoid using the term legal highs as well because, as I say—
Nicola Blackwood: Psychoactive substances. You are free to use that term.
Cmdr Bray: It doesn't really trip off the tongue but we have to recognise that the substances within them quite often are not legal, that they are controlled. There is a big role here for education about putting people off them in that sense.

Q22 Nicola Blackwood: I am trying to get an assessment of how much of a problem police on the streets are having to deal with and whether it has increased due to the number of substances on the streets since 2010, or whether you think it is decreasing.
Cmdr Bray: I don't think that there has been a massive increase. It is fairly stable in many respects. We know that 8% of young people in the UK have, in their lifetime, tried new psychoactive substances compared with 5% in the EU, so it is not massive in the sense that it is high percentage numbers. It is 8% have ever tried it. We also know that a large number of users of new psychoactives are those people who use controlled drugs too.

Q23 Nicola Blackwood: My next question was to follow up on some of the comments you made to the Chair. This is obviously a very dynamic field of criminal activity, with legal highs—psychoactive substances—continually mutating in order to avoid legal barriers. What is your assessment of both legal and legislative responsiveness to those drugs when we become aware of them but then also operational responsiveness? You have mentioned a number of ways in which you can respond operationally when you discover these substances, but also do you think that we are quick enough to respond legislatively when we find something that we think should be controlled?
CC Bliss: Shall I start on that one? This is a very complicated area. You have used the word "dynamic". It is fluid; there is an element of fashion around this, and if either of us give a view about what the situation is today, that can change within almost weeks, particularly during the summer, the festival season. We have not mentioned festivals but I think they play a big part in this. In terms of the legal framework, inevitably some of these substances, as Mr Bray has mentioned, are legal and some are not, and it is very difficult for the frontline officer, or indeed for the young person who may be intent on buying this stuff, because it may just be a white powder. That is one of the issues.
In terms of the law, while we do have the orders that can be made pretty quickly, and that is helpful, nonetheless inevitably we are always playing catch-up and that is one of the dilemmas that we are having to deal with. Mr Bray can certainly say more about that. In terms of the operational impacts, you may be

interested in talking about education later on. One of the areas of education—

Chair: We will come on to education later. Mr Clappison has specific questions.

CC Bliss: If I may just say in terms of education of police officers, I think we are already doing more and we intend to do even more to make sure that our frontline officers understand exactly what we are up against. I think to many frontline officers, when they look at these what appear to be condom-like packets, they look as though they are commercially produced, legitimate items when in fact, as we know, they are often not, so we have to do more about educating frontline officers, so that the operational response is as right as it can be.

Q24 Michael Ellis: Just following on from that, you have spoken of the orders that can now be made quite quickly that will in effect create an illegal substance or make it illegal if it was not before. Part of the difficulty has been that the legislative framework has struggled to keep up with the fact that illicit people working in labs somewhere are able to change one or two elements of a controlled drug and that actually under the law changes its status and makes it potentially legal. It is very easy to change one or two small parts of the chemical composition of a drug and therefore legalise it. Have the changes that have taken place in recent months and the last couple of years improved the situation? Is there any way that you can think of that would further improve it?

CC Bliss: I will lead off on that, but I think Mr Bray will come in on it. Inevitably, as I said, we are playing catch-up. The danger is that more and more substances become proscribed but you eventually legislate and there will be a whole host of substances. Is there another way to do this? It is a debate that we have had. For example, if Parliament legislates for a blanket ban on psychoactive substances in general, that would be very far reaching and that might be easier to enforce. The reality is, though, that frontline officers are equipped with powers and at the very front end at 3.00am when you stop someone and search them and find them in possession of a white powder, that could equally be cocaine. So we do have powers.

Q25 Michael Ellis: It could be, but frontline officers are not expected to have mobile labs with them at all times. So long as they are acting reasonably under a reasonable suspicion, if it turns out to be an innocuous or lawful substance those officers will not be in trouble.

CC Bliss: No, not at all, and I think that is the point I am making. We have got powers. This is more about what is prosecuted and what is not and the fact that the scientists are constantly looking to morph the substances very slightly, just to evade the law. That is the nub of the issue around prosecution.

Q26 Michael Ellis: Yes, which is the point that I am making. Just to finish that point, because this is the crux of it, it is so easy for the sham scientists, if you like, to change a little aspect of this and try to subvert the process. Mr Bray, did you want to say something about that?

Cmdr Bray: I was just going to come back to your original point there in terms of how responsive the system is. Under the current system, hundreds of new psychoactive substances are now controlled and most recently I think it took about five days turnaround from the ACMD reporting their recommendation for it to become law, so there is that quick turnaround. As you say, we are talking about white powders and, provided they are forensically examined and provided we then do follow up on it, then we can prosecute as necessary.

Q27 Lorraine Fullbrook: I would like to ask a supplementary before I ask my question. On that point, many of the new psychoactive substances contain legal substances like methadone or BZP. When the analysis is done, do you record the prosecutions on the illegal substance part of the psychoactive drug?

Cmdr Bray: Yes, we would. Sorry, I may have misheard you. The illegal part?

Lorraine Fullbrook: Yes, the illegal part.

Cmdr Bray: Yes.

Q28 Lorraine Fullbrook: The Government produced an action plan in 2012 for how to tackle this problem. What is your assessment of the effectiveness of the action plan that has been produced?

Cmdr Bray: We are working very much in sync with that action plan. The working group that I chair is focused on three elements of it: improving the understanding of the threat, the better use of the legislative framework and the strengthening of enforcement processes. That is why we try to take all the ideas from the different agencies like the National Crime Agency, which leads on certain aspects, trading standards and also police forces, not just from England and Wales but from Scotland and Northern Ireland too. As a result of following that plan in a shadow form, we have certainly learnt a lot and have spread good practice around. I think there is quite a lot more that we can do but I think it is all heading in the right direction.

The key bit about improving the understanding of the threat is having access to the FEWS, the forensic early warning system, and the drug early warning system, the DEWS, and all the work that we are doing with festivals. That has increased our knowledge of what types of substances are out there. We have been working with the regional intelligence units as well within individual forces to make sure that they are all aware of the different assessments and threats and there is much more linking together and that we are not as slow off the mark as perhaps we might have been a few years back.

Q29 Lorraine Fullbrook: On the early warning system, from the member state informing Europol and the European Monitoring Centre for Drugs and Drug Addiction, how quick is the turnaround from the member state identifying the psychoactive substance to the report being produced to the council, the EMA and the commission? How long does that take?

Cmdr Bray: I am afraid I do not know the detail of that. I am sorry I am not in a very good position to answer your question on that one but I can find out.
Lorraine Fullbrook: Thank you.
CC Bliss: Can I make a quick comment on the action plan, perhaps an update? There are three things I would mention. One is we are very keen to brief police and crime commissioners. We are working with Home Office officials to try to get in front of all the PCCs shortly to give them an update about what is happening in the drugs enforcement world, and this will definitely feature. I think that is an important point to make. Simon Bray has just mentioned festivals and, without going into operational detail here, we are planning pulses of activity over forthcoming months, including already starting to plan for festivals next year.

Q30 Mr Clappison: You began to tell us a few moments ago about your work in the field of education and prevention and you specifically mentioned police officers and how you are educating them. Could you tell us a bit more widely about the work that you are doing to educate people about the risks of these substances and hopefully prevent them from taking them?
CC Bliss: Absolutely. It is a very important aspect. I do think, as the policing lead for this area though, it is important that teachers, charities—obviously there is one here today—and health professionals play their part. In the past sometimes police officers have been going into schools and talking to young people about drugs and coming up with inappropriate messages. They have actually backfired on us. I think it is very important that we do what we know best and when we go into schools we talk particularly about choices and consequences, in other words explain what we really know best, which is policing and what the consequences may be if these substances are illegal, because that is very credible, and try to make sure that we only speak about issues around drugs that are within officers' experience. I think that is where the focus of policing activity in and around schools is.

Q31 Mr Clappison: What about older people? We know that there are some older people, sometimes somewhat unusual older people, who resort to drugs. Perhaps you would not expect to see them but—
CC Bliss: Absolutely. I think the same applies. I recently had a meeting, and I know Mr Bray has a meeting coming up, with one of the directors at Public Health England and they are very keen to work with us on this and to come out to—

Q32 Chair: Specifically on older people?
CC Bliss: Well, on the education of people in general. They are talking about coming out with us to festivals and having stands and getting very involved in education. Obviously that does apply to the over-18s as well.

Q33 Mr Clappison: Do you think the work you are doing is having an effect?
CC Bliss: I think where it is credible it can have an effect, yes.

Q34 Paul Flynn: Will the prohibition of khat drive a wedge of antagonism between the police and the already marginalised Somali and Yemeni communities?
CC Bliss: I lead on the khat issue personally and, in succinct answer, I very much hope not and we are doing an awful lot of work.

Q35 Paul Flynn: Could we go into this? You have given your answer. One of the likely effects of the prohibition of khat is that a drug that has been used legally for a long time, by the Somali communities particularly, will suddenly become illegal. What do you think they will do? Will they use it illegally, which puts them in the criminal market, or will they go on to far more harmful drugs, addictive drugs like alcohol?
CC Bliss: I think and I am hopeful that many will give up, in other words they will—

Q36 Paul Flynn: We can see you are as optimistic as your name, Mr Bliss. Could we look at what has happened? The experience of 44 years in Britain is that every prohibition of a drug has resulted in an increase in that drug's use, its harm and the black market profits. So if that happens with khat there will be more money made with khat, there will be a greater incentive for those that are in the khat business now to extend their markets beyond the Somali and Yemeni communities. Isn't this likely to happen?
CC Bliss: Let me qualify my answer. I think we will know very quickly because, as members of the Committee may know, khat is a plant substance and it degrades very quickly. The psychoactive effects degrade within about three or four days. When the volcano off Iceland erupted—and you may wonder why I am talking about the volcano—and flights were grounded for about a week, the khat supply in England and Wales dried up. We have spoken in great detail with local communities about this because we are very keyed into these communities and we do recognise the sensitivity in policing. The feedback was that quite a lot of members of Yemeni, East African communities gave up taking khat but if they turned to anything they turned to valium. That is what the community are telling us. So, there is a risk and—

Q37 Paul Flynn: Have you studied the effect of bans on khat in other countries and seen the results of that?
CC Bliss: We have looked at some of them. We sent an officer to Holland to look at the recent experience there. We have not picked up, in the work that we have done, a very significant displacement to other drugs, which is part of the reason I remain optimistic. But I do accept that there is that risk.

Q38 Paul Flynn: Just one final point in the legal highs. Have you studied the effects of the legislation in New Zealand on legal highs, which is about the only country in the world that is taking an intelligent approach to this?
Cmdr Bray: We have been keeping a weather eye, recognising that New Zealand is a new scheme that has been put in place and we have not had any feedback as to how well it has gone. We are aware that

there are other schemes in places like the Republic of Ireland and elsewhere. But we are focusing on making sure that we make the most of the situation in the UK and improve our knowledge of how things operate here and how best we can use the tools available to us.

Q39 Paul Flynn: The use of mephedrone increased threefold in Wales when it was banned and there is a report also suggesting it is still increasing and the ban, by publicising the drug itself, actually resulted in an increased use. You are on a hiding to nothing here, aren't you, by using the legal process in trying to stop it? New Zealand has a different idea by saying that if the makers of the legal highs can prove that they are low risk they are allowed to sell them. That puts the onus on the people who are making the money.
Cmdr Bray: It is very interesting to hear how other legislatures are putting their ideas into practice. However, in relation to our own and in relation to the mephedrone point that you made, I would just reiterate about the England and Wales survey that suggested that there is a significant reduction in usage although naturally, because mephedrone has become controlled, the police have more contact with it and therefore the police figures have increased. There is this difference.

Q40 Paul Flynn: So you are one-trick pony. You have one answer to everything, which is prohibition, which has proven again and again that it does not work. It increases drug harm and use.
Cmdr Bray: What I am trying to say is that we are policing to the law that we work within and trying to make the most of that current situation.

Q41 Chair: Just to be clear, Mr Bliss, you did not recommend the banning of khat? You did not recommend it as the ACPO lead. You were asked for views, presumably.
CC Bliss: It is not my place to recommend. I didn't recommend it, no.

Q42 Chair: Exactly. So you didn't recommend it, and you know the position of the advisory council, which is that it should not be banned?
CC Bliss: I do, yes.

Q43 Chair: I should declare an interest. I was born in Yemen and I chair the All-Party Yemeni Group and I have chewed khat. It had no effect on me, I have to tell you, but I have chewed it. You mentioned that when the volcano erupted that some members of the Yemeni community went on to valium.
CC Bliss: That is what we have been told.
Chair: Was that legal or illegal valium?
CC Bliss: I don't know but that was—

Q44 Chair: You don't know. Mr Flynn was obviously very probing, because he is very passionate about this issue, but it does seem to me that you seem to be reacting to what people are asking you to do and enforcing whatever is required of you rather than saying, "We think this is an important idea because it will stop criminality". Is that right?
CC Bliss: There is limited evidence that there is an association between khat and criminality. All I can speak of is the evidence that we have found and in our research we have discovered in England and Wales there is some low level antisocial behaviour linked with khat, including the littering from the bags it is contained in but also the spitting out of the cud.
Chair: Mr Flynn, I am sure Dr Huppert will continue with your line of questioning.

Q45 Dr Huppert: I think many of us are of similar views. You said that people moved to valium, and I think you are probably right that people transfer a drug rather than stop taking anything, certainly given that people do still consume cannabis and everything else. What assessment have you done of the harms of valium and how addictive that is?
CC Bliss: Just to be clear, that is anecdotal evidence from one community in London, I believe. We have not taken that further and looked at the displacement effect so I couldn't say any more about that.
Dr Huppert: You raised it as your solution to what would happen.
CC Bliss: I absolutely take your point about displacement and would it be displacing to a more harmful product.

Q46 Dr Huppert: Many of us think that the khat ban is a big mistake, for the reasons the Advisory Council on the Misuse of Drugs have set out. There is no evidence of harms and this will be debated in Parliament next Monday. To move on to the more general issue about transfer of drugs, you were talking about the need to educate people honestly. It must be a challenge when you know from any study of the evidence that a number of currently controlled drugs are less harmful than a number of perfectly legal substances. It must be slightly hard to explain to people that Parliament in its wisdom has made less harmful things punishable by many years in jail but more harmful things unpunishable. How do you get round that if you are trying to educate people?
CC Bliss: We are entering a complex area but I shall try to give a succinct answer. As I mentioned, clearly Parliament determines what is lawful and what is not lawful. I suppose my earlier answer to Mr Clappison was very much about the police sticking to the knitting. We stick to what we know best and talking about the law and choices and consequences that particularly young people, but older people too, make. It is for Parliament to decide. Frontline police officers exercise a degree of discretion, and at the more strategic level police and crime commissioners now set strategy and therefore can interpret to some degree Parliament's wishes and exercise some discretion, but I think ultimately it is a matter for Parliament.

Q47 Chair: Thank you. Three very quick final questions. First of all, we recommended in our last report the use of consumer protection laws and trading standards departments to be used in order to tackle the new psychoactive substances. Do you know whether this has happened?
Cmdr Bray: There have been a number of attempts and ongoing efforts to deal with issues using

consumer protection laws. Obviously trading standards experts would have greater knowledge and expertise and opinions than I would, but I am aware that there are a number of cases involving consumer protection from our Fair Trading Act and Enterprise Act approaches. They have not reached a conclusion yet, as far as I am aware.

Q48 Chair: No one has been prosecuted as far as you know?
Cmdr Bray: I am aware that there has been a prosecution in Norfolk under the General Product Safety Regulations. I think it was pushing at the boundaries of those regulations but that stuck. Likewise, you have heard about the Intoxicating Substances (Supply) Act. That has been put in place. However, I think the trading standards legislation is being stretched in order to meet the challenges.

Q49 Chair: It would need new legislation. It is not sufficient under current legislation?
Cmdr Bray: Without expertise but just looking at it from my perspective, I think it needs another look at because it is a new set of problems that have come along in relation to trading standards.

Q50 Chair: Very helpful. Mr Bliss, you meet Mike Barton on many occasions, I am sure, at ACPO meetings. Presumably you don't agree with his view that there should be legalisation of drugs?
CC Bliss: I do know Mike Barton very well. He is a good officer and a very distinguished officer, but he has expressed his views and contributed to the debate. Back to my earlier point, my personal view in policing is we are best sticking to the knitting. It is for Parliament to decide. We will get on with policing, always proportionate policing and with discretion, but they are Mr Barton's views not mine, I am afraid.

Q51 Chair: As you know, Uruguay today has decided to legalise cannabis and there is a couple of states in America where it is legal. Will you all be watching the results of what is happening there? I know you are keen on comparative research.
CC Bliss: Clearly in this area above all others—I am sure members of the Committee would agree with me—it is important always to look at the evidence. The international evidence is always interesting and informative. It does not always land the same here. So, yes, we will look with interest but at the minute cannabis is illegal. We are now seeing quite a lot of cannabis production in the UK, both farming on a large scale and in smaller scale premises, and there is quite a lot of violence and organised crime associated with that. There is quite a lot of enforcement work to do at the moment.

Q52 Chair: I think the Committee is concerned that you are still playing catch-up. You used that phrase a couple of times. It is no criticism of yourselves, but it is a very big worry when you look at cases like Adam Hunt, and indeed the Hester Stewart case. We are hearing from Mrs Stewart now. It is disappointing, isn't it, that we are still playing catch-up with what is going on? For whatever reason it is, we still don't seem to be in control of this.
CC Bliss: Chairman, we work, as do frontline officers, very hard to do our best around drugs enforcement. The biggest tragedy for me, and I am sure for members of the Committee, is that too many young people die through illegal drugs and that is what really matters to us.
Chair: Thank you both for coming at very short notice. It has been extremely informative. We intend to produce our report very quickly so if you could send us those documents, we will treat them in the manner in which you send them, on a restricted basis. Thank you very much for coming.

Examination of Witnesses

Witnesses: **Maryon Stewart**, Angelus Foundation, and **Jeremy Sare**, Angelus Foundation, gave evidence.

Q53 Chair: Mrs Stewart and Mr Sare, thank you very much for giving evidence to us again. Mrs Stewart, of course you have been before us 18 months ago and we, on this Committee, are full of admiration for the excellent work of the Angelus Foundation. We want to explore some of those issues with you today. We have just taken evidence from very senior police officers who do not seem particularly alarmed at the increase in psychoactive substances that are available. Do you feel that there is an increase? Is there reason for us to be more alarmed than we were when we saw you a year ago, Dr Stewart?
Maryon Stewart: Yes, I think there definitely is. If our mailbag, our emails and our telephone, is anything go by, we are seeing an increased number of reports of deaths and, even probably more importantly, harms, from families who have relatives, for example, who are either in a coma or have come out of their coma and they can't function any more, or they have been sectioned in a mental hospital, and nobody seems to be measuring the harms. I do find it alarming that, although it is encouraging that the police are now opening their eyes, probably more so than 18 months ago—they have to because young people are falling over at festivals and dying—I do not think they have even licked the surface really. As for education, I do not think that they have the measure of that at all.

Q54 Chair: We are coming on to that later. You were very passionate about the need to ban GBL because of the death of your daughter Hester. Was it a concern to you that on 7 July two men were admitted to Cardiff Hospital who were critically ill as a result of using GBL even though it had been banned?

Maryon Stewart: Yes. I think it is very sad and very concerning, but the fact is that just because you ban something, we all know that does not mean that people are not going to take it. As we know with mephedrone, there were probably about two-thirds of young people still taking it, even though it was double the price, after it was banned. When I started my campaign when Hester died, which is actually four and a half years ago now, I thought that banning GBL and a few other substances would help to save lives and I thought that that was the end of the story. I had no idea that there would be an epidemic, and indeed there were 73 new substances identified last year. I spoke to John Ramsey last week when we were filming and there have been 68 so far this year and it is showing no let-up. It is a very worrying situation. Some of the substances he was talking about, which are available in the high streets, actually contain substances that are like class A drugs, so it is not just class B drugs we are talking about. He said that in his wildest dreams he would not have thought 10 years ago that this would be possible and yet now these things are available, not just in the head shops but also in some garages, cobblers, ice cream vans.

Q55 Chair: The inquest into the death of Adam Hunt took place last week and the words of the coroner are pretty chilling, that all young people face the possibility of this happening. Do you feel that not enough is being done by the police, the Government, other agencies? What needs to be done? It is alarming to hear what you have to say.
Maryon Stewart: I have to say that we continue to be baffled and deeply disappointed that the advice that committees like the Home Affairs Committee and also the All-Party Group for Drug Reform and the ACMD are giving the Government seems to fall on deaf ears. We were talking to Jeremy Browne in January this year and he was about to go on a tour and we did get his all-party committee to have a special dedicated meeting about legal highs. We are now nearly at the end of the year and no action has been taken. They are considering what is going on in other countries and yet each weekend and each week more children are being harmed and dying. Also the Government have devolved the power to the regions so that regions are supposed to have the power to decide what happens, but how are on earth are they supposed to do that when they do not have any education?

Q56 Chair: Indeed. We will come on to engagement with Ministers in a moment. Is your assessment to this Committee, a year on since you gave evidence, that the problem of psychoactive substances is on the increase? It is not stable, it is actually going up?
Maryon Stewart: Yes, absolutely. We were at a meeting with 30 festival owners last week and one of them was telling us about 20 bodies being laid out on ice blocks.
Chair: This happened last week?
Maryon Stewart: No, they were recounting a story and other stories about people who died at festivals. There is a serious concern. This is such an unknown quantity now. Young people and anybody who takes these substances are playing Russian roulette with their lives. There is no question about that. It is deeply concerning and I share that coroner's view.

Q57 Mr Winnick: I join with the Chair in his opening remarks, Mrs Stewart. On the position that you have just made, which you have done previously in giving evidence to us, are you finding it a source of continued difficulties in meeting with the appropriate Ministers?
Maryon Stewart: Some Ministers have agreed to meet us, some have not. I find it difficult. I feel that the Home Secretary really should be taking more responsibility for this epidemic and there needs to be much more joined-up thinking and action, not just talk about what may happen. There is really very little action, at the end of day. We are now meeting with Public Health England and hoping that we can address the regions, but there needs to be central Government direction to the regions. This is not an ordinary situation. It is an epidemic. Young people's lives are continually at risk. Their parents have very little information about how to have a wise or informed conversation, and absolutely no one is addressing the situation[1].

Q58 Mr Winnick: You speak, of course, with personal and tragic experience. When was the last time you met with a Minister?
Maryon Stewart: I met Anna Soubry about two weeks before she was moved from her position.

Q59 Mr Winnick: Was there any difficulty in arranging a meeting with her?
Jeremy Sare: She refused to meet us first of all but Diana Johnson managed to facilitate a meeting eventually.

Q60 Mr Winnick: Presumably you will continue, insofar as it is possible, a dialogue with her successor?
Maryon Stewart: Yes. Obviously Jeremy Browne is no longer there and Norman Baker has taken over, so we have written to ask to meet him, but it just starts the process. Since Hester died I think there have been five different drug Ministers.

Q61 Mr Winnick: You wanted to meet the Home Secretary herself.
Maryon Stewart: Actually, since Hester died I think there have been 10 different drug Ministers, five since this Government began. I find it so unbelievable. If it was a corporation, you would not move the finance

[1] *Note by witnesses:* I [Jeremy Sare] would also like to clarify the issue of access to Ministers raised by Mr Winnick. It has not been altogether satisfactory. We were granted a good meeting with Jeremy Browne as HO Minister in January 2013. However we were refused a meeting with Public Health Minister Anna Soubry. Diana Johnson managed to facilitate a meeting with Ms Soubry eventually in September. We were not informed prior to the meeting that it would be a roundtable with other organisations. I would like to put on record extremely helpful Diana Johnson has been to our cause. We met Liz Truss Schools Minister at DfE in February. Again it was a roundtable with five organisations lasting only 30 minutes. Maryon was allowed to raise one issue, I myself [Jeremy Sare] was not able to contribute anything. We were refused a meeting with DPM but instead had useful discussions with two SpAds Tim Colbourne and this month Alex Dziedzan.

director to human resources and expect him to function, so I don't know how a Minister who is starting to get a grasp of the situation and get a feel for how they can bring about change, then just gets moved or sacked. I feel like we take 10 steps backwards.

Q62 Mr Winnick: As far as Ministers are concerned, have you asked to meet the Home Secretary?
Maryon Stewart: Yes.

Q63 Mr Winnick: And the answer—
Maryon Stewart: We have never been granted an audience with this Home Secretary. I have seen past Home Secretaries[2].

Q64 Mr Winnick: Can I turn for a moment to Mr Sare? You were in fact head of drug legislation at the Home Office. Would it be right to say, without putting words into your mouth for one moment, that you had some moment of conversion? The position that you have now is somewhat different, obviously, from when you were a senior civil servant at the Home Office.
Jeremy Sare: That is right. That was not the reason I left the Home Office. That was another matter, but I think it came to me when I was interviewing, as a journalist, Bob Ainsworth and realised that at the time when he was Minister and I was an official we were both arguing about a point that neither of us believed in.

Q65 Mr Winnick: You were at the Home Office at the time when cannabis was reclassified. You were secretary to the Advisory Council on the Misuse of Drugs. Is that correct?
Jeremy Sare: I was head of drug legislation at the point of January 2004 when the reclassification happened.

Q66 Mr Winnick: Was it your personal view that cannabis should be reclassified?
Jeremy Sare: Yes, I think it was commonly held among the drugs directorate that the two main stated reasons by the Home Secretary, David Blunkett, at the time of realigning police resources towards class A and preventing 60,000-odd young people having a permanent criminal record were strong and valid reasons for reclassification to class C.

Q67 Mr Winnick: Do you regret the fact it has been reclassified again?
Jeremy Sare: These are my personal opinions that are not that relevant to—
Mr Winnick: Yes, of course. That is what I am asking you. The answer is yes?
Jeremy Sare: Yes.

Q68 Chair: Is the problem that there has been so many drugs Ministers over the last three and half years? I think I have counted seven different Ministers responsible for drugs. If there was more continuity it would be—
Maryon Stewart: Yes. We worked with James Brokenshire for about 18 months just before the election and he did have a really good grasp of the situation and he helped enormously. At the time we all thought that banning would be helpful. We had no idea, we didn't have a crystal ball so we could not see what was about to happen. Then he agreed that banning was not and that raising awareness was the best way to travel. We had a good relationship with him and it looked like we were probably going to get other Ministers co-operating but then he got moved.
Chair: It is the turnover that concerns you.

Q69 Lorraine Fullbrook: I think you have answered some of this question already. Last year the Government published the action plan to tackle the new psychoactive substances and I would like to ask the same question I asked the two police officers. In your assessment, what is the effectiveness of the action plan?
Maryon Stewart: I don't think it is very effective, for a start. One of the things that they are planning on doing is using social media and Talk to Frank. They have practically no presence in terms of social media. I don't think they are making much impact on young people at all. I am not aware that their action plan includes educating even educators or going into schools or educating parents. I suppose my personal opinion is that they are just paying lip service to this whole situation.
Jeremy Sare: It is very much reliant upon the Misuse of Drugs Act, and the UN report showed that there are now more legal drugs, commonly known as legal highs, than there are illegal ones in the UN convention. I think we have reached that tipping point whereby everyone must ask whether the Misuse of Drugs Act can cope. Even though we have the temporary class orders, which are probably the fastest way of controlling drugs across the European Union, is that still sufficient to take action against the supply of these substances.

Q70 Lorraine Fullbrook: Do you think it is or is not?
Jeremy Sare: No, certainly it is not, because the numbers have grown inexorably. We expect this year's figure to be even higher than last year's, which was a record.

Q71 Lorraine Fullbrook: What additional would you like to see to the action plan?
Maryon Stewart: One of the things that we had at the end of last year was a pro bono campaign that was given to us by a communications agency, Leagas Delaney, because Tim Delaney's daughter had had her drink spiked so he was sympathetic. He gave us a pro bono campaign that was worth about £500,000 and we had posters around the country and in stations and fliers and things like that. There needs to be a national awareness campaign. This is an epidemic.

Q72 Lorraine Fullbrook: How long did the campaign last?

[2] *Note by Witnesses:* These were not formal written requests to the Home Secretary's office. The requests were raised personally with Drugs Minister Jeremy Browne and Home Affairs PS to PM Gus Jaspert but did not progress.

Maryon Stewart: Our campaign was only able to last for officially a month but some of the posters stayed up for two months. It was a spot in the ocean, so that campaign needs to be continued.

Q73 Lorraine Fullbrook: Do you think that would be the best way of doing it?
Maryon Stewart: I think that is one of the ways. Social media is very important and we need to find material. The point is that when we first start talking about mephedrone, for example—after GBL came mephedrone—I was asked to be the spokesperson for that and we found that when newspapers like the *Daily Mail* covered it, John Ramsey, our toxicologist, could not even buy it because it had sold out. We realised that we had to go back to the drawing board and we had to do focus groups and surveys to find out what would actually move young people to make a different decision. We found through our research that the things that they seemed to be most touched by were short films that had examples of young people who had died, how their families and friends had suffered. It seemed to touch them in their hearts and it made them feel that they did not want to be the next casualty and they would not want to lose their friends in that way. So we have been going into schools and talking to 14- to 18-year-olds and we are finding that it does move young people. In fact, over three-quarters of 14-to 18-year-olds that we have spoken to so far feel angry and misled and they feel that they should be being educated, and they are quite right, they should be.
There has only been one survey of parents done so far by Talk to Frank and that found that 86% of parents had no knowledge about legal highs. I don't think the other 14% really knew what they were being asked because I have yet to meet a parent that really does understand what they are. There is nobody providing education for parents, so how on earth can parents have wise conversations, and yet professors in our group say that approximately 70% of decisions young people make are determined by direction from their parents.
We believe, at Angelus, that there needs to be a coming together, not just of the Government but of the police and educators, medical profession, toxicologists and probably psychologists to look at how peer pressure influences young people, so that we can come up with some wise, incredible solution to this situation and set the way for the rest of the world, because it has become an epidemic in other countries around the world like America. It is not simple. I believe it is doable but it has to be done in a very informed and scientific way, and we have to measure outcomes every step of the way to make sure that we are succeeding.

Q74 Lorraine Fullbrook: Currently at the moment the Angelus Foundation are doing all of this on your own?
Maryon Stewart: Yes. Well, we are doing it in conjunction. We have published a handbook for parents called *Talking to your children about legal highs and club drugs*. We have done that in conjunction with the charity Adfam and the Club Drug Clinic. We do have other charity partnerships, but we are very small, we have very, very limited funding. It is very difficult and involves working very long hours.

Q75 Chair: On this question of where do young people get their drugs and legal highs from, we were given the figure of 10% from the internet, 36% from head shops and about a third were able to get it from nightclubs. Do you have any figures that would help the Committee as to where these psychoactive substances are coming from?
Maryon Stewart: I don't think we have any internet figures. We did get Amazon to stop selling them worldwide in the summer, with the help of the *Daily Mail*.

Q76 Chair: What happened? Did it work?
Maryon Stewart: Amazon wouldn't communicate with us but we got the *Daily Mail* to phone them. We had the front page and the inside cover of the *Daily Mail* and by teatime that day they had removed the legal highs from their websites, not just in the UK but in other countries.

Q77 Chair: How long did they do that for?
Maryon Stewart: It is permanent.

Q78 Chair: Permanently. Would you like to see that happen with others on the internet?
Maryon Stewart: Yes, absolutely. Google is a bigger fish, though, and it is going to require a lot more work to stop them taking sponsored adverts. But our attention at the moment is on trying to amend the Antisocial Behaviour, Crime and Policing Bill so that we can prohibit the sales of legal highs through retail outlets. We strongly believe that the onus should be put on the manufacturers to prove that these substances are safe for human consumption, as a pharmaceutical company would have to do if they were bringing a drug to market.

Q79 Chair: As does the Committee in our previous report. Is 54% of legal highs being offered by the friends a correct figure?
Maryon Stewart: I have absolutely no idea. I don't think there is any evidence to support that, to be perfectly honest.

Q80 Paul Flynn: We are all very sympathetic to your situation and hope your campaign is successful. I watch your website. Can I gently suggest to you that there is no record of education working? I don't know if you remember a campaign called Operation Charlie in 1997. Charlie stood for Chemical Harm Reduction Lies in Education. They chose the title of the trial before they actually started and they reached the conclusion that it did not work. There have been trials over 25 years in other countries where they have tried education. Isn't it in the nature of young people to believe that they are immortal, that they court danger and that they will be attracted by the true scary stories that we present to them, and in fact by having a campaign of education we could increase and give them a further incentive to use the drugs?

Maryon Stewart: Yes, I think we have to be mindful of that. There are some studies I am aware of that have had positive outcomes. There are Canadian, Australian and American studies that have actually shown a reduction, not necessarily in legal highs but in alcohol and conventional drugs. That is why we went back to the drawing board to do our research very thoroughly so that we could only choose things that would move young people. We are at the beginning of a journey and we are working with the first master at Eton and some researchers at Cambridge to get our research published so that it can become part of a schools programme.

I agree that some young people display risky behaviour. Some of the studies show that 40% do. Other young people will not try anything because they just won't. Then you have a huge group in the middle who are very much peer-led and will probably be persuaded to use something if they think it is legal and safe. They are low-hanging fruit as far as we are concerned because we believe, from the research that we have done and the focus groups we have done so far, that we can actually change their viewpoints just by giving them information, because they don't want to be duped, they are wise and they don't want to risk their lives. They just want to have fun.

Q81 Paul Flynn: Are you attracted by what New Zealand is doing by giving those who profit from the sale of these drugs an interest in reducing the risks?

Maryon Stewart: Sorry, I am not sure I understand.

Q82 Paul Flynn: In New Zealand they are suggesting that some of the legal highs should be allowed to be sold legally as long as the manufacturers can prove that they are low risk.

Maryon Stewart: Absolutely. Young people have always wanted to experiment. If we could find the utopia that they can experiment with and it is not going to cause any harm, then I would say that we can't stop them and why would we want to. The point is we don't want them out playing Russian roulette with their lives and their wellbeing and we don't want them being misled thinking that they are not.

Q83 Paul Flynn: I understand precisely your motivation as a bereaved parent, but wouldn't you agree that more young people and more adults are killed by paracetamol and by illegal drugs and isn't this a matter of equally great concern?

Maryon Stewart: If you take paracetamol for a headache you are not going to be killed by it. If you have one or two glasses of alcohol, there are medical studies to show that it has a therapeutic effect. We are talking about chemicals that are available in the high street and on the internet that are being called legal, so young people are being misled to think they are safe, and they can have damning consequences to ruin their lives or even kill them. That is a different animal altogether.

Q84 Dr Huppert: The idea that we should be giving people information that is credible and accurate is fantastic and I wish more people took that approach in this space. You are absolutely right, there is some very bizarre behaviour. When we looked at this before, we had a look at the Guardian/Mixmag survey, which I am sure you have seen. It found that 15% of respondents said they had taken an unknown white powder in the last 12 months, so not even knowing what it was supposed to be, and a third of it was supplied by somebody they did not trust. That ought to be the easiest thing to persuade people not to do. Thank you very much for what you have been doing. I have two questions, one short, I suspect, and then a slightly longer one. The short one is that we were talking earlier about khat and the proposals to make that illegal. Is it something that has crossed your radar in any way? It is technically a legal high at the moment. Is it a completely separate issue from the sort of things that you have been dealing with?

Maryon Stewart: Yes. We don't really concentrate on that.

Dr Huppert: It has not been coming up in your postbag?

Maryon Stewart: No.

Q85 Dr Huppert: I thought that might be a brief question. To come back to something that, Mr Sare, you said earlier about the Misuse of Drugs Act and whether it is now fit for purpose, I wanted to make sure I understood. Our predecessor committee, which included the Prime Minister, in 2002 said there should be an independent assessment of the Misuse of Drugs Act. We called last year for a royal commission to look at ways forward, including looking at the Misuse of Drugs Act. You said you would have to question whether it is fit for purpose. What do you think is the best way forward? Is it something like a royal commission, broadly speaking, or is it something else?

Jeremy Sare: We don't take a very strong sort of political view on what model is ideal for controlling drugs and setting penalties for supply and possession and so on. Our advisory board are mainly clinicians and so on. We are of the general view that we would support a review of the Act, and I think a survey in the *Sun*, of all places, showed that the public agree with that and privately I am sure MPs would mostly agree with that too. That is not a terribly controversial view. Whether it comes to a royal commission, that would be something where, given that the Misuse of Drugs Act is so overdue for a review, I am not sure we would quibble about what form it took.

Maryon Stewart: I would like to add something to that. One thing I would really like to emphasise is that all too often people say, "Oh yes, we need to review the Drugs Act" and they lump legal highs—I know that is an awful term and we hope that one day we will not call them that but that is the reality of what they are called at the moment—into the Drugs Act. I fear that that is going to take quite some time to come about and that we need to take some radical and fast action to protect young people and their families. I don't think we can afford to wait for reviews of major Acts. I just want to stress the fact that these substances that are not technically drugs, although many of them contain drugs, are legally available on the market and we need to take some urgent action to curtail the supply as well as the demand.

Chair: Thank you very much for giving evidence. We are most grateful. If there is anything that you have missed out in the evidence session please write to us. We are going to turn around our report very quickly. What we decided to do is not just publish the report on drugs last year but to revisit it to see whether any of our recommendations have been met. Otherwise all we do as select committees is have good ideas and make recommendations and nothing happens. We don't want that to be the case. We are most grateful to both of you and we wish you well in the work that you are doing.

Examination of Witness

Witness: **Dan Reed**, Director, Legally High: True Stories, gave evidence.

Q86 Chair: Thank you very much for coming in. Mr Reed, you are the director of *Legally High: True Stories*, a documentary that looked at this area very carefully. We know some of the evidence that you give to us today will be from another party who is not here, but we are keen to know what you found, which we think is relevant to the inquiry that we are conducting into this issue. From what you saw and what you experienced with these young people, do you think that the use of psychoactive substances is on the increase?
Dan Reed: The young people that we spent time with and got to know quite well were in different parts of the country and I think there are different patterns in different parts of the country. It is hard to generalise, but certainly, anecdotally and statistically, in the last five years the use of legal highs has increased hugely.

Q87 Chair: I understand that they took these legal highs in front of you and you filmed what was going on.
Dan Reed: Correct.
Chair: I have admitted earlier on today to chewing khat. Did you try any of these? Obviously it is perfectly legal to do so, but before they were taken by these young people, did you try them?
Dan Reed: No, absolutely not.

Q88 Chair: But you saw them try these drugs?
Dan Reed: Yes.
Chair: What was the effect that you saw on them?
Dan Reed: The effect of the drugs that we saw them take orally and by injection and by snorting ranged from very powerful, rendering them almost comatose, incoherent, completely incapable of functioning—very, very high in other words—to what you would describe as a mild buzz. There is a spectrum according to the different drugs that they took.

Q89 Chair: Of course these were perfectly legal because they had not been banned, but were the young people aware when they took these substances that they were going to have the effect that they had on them? Someone being comatose sounds pretty dreadful.
Dan Reed: Yes, they were. Injecting legal highs is not common behaviour; I would describe as being quite specialised behaviour by more experienced drug users. Certainly Baxter, the name of the protagonist in my film, was aware that the drugs would have that effect on him, yes. He has experimented with them before, similar types of drugs, and he knew what he was in for.

Q90 Chair: Hopefully we are going to see your documentary when it is available.
Dan Reed: It is on already.
Chair: It is available? I have not seen it yet, but were there any bits of it that were too shocking to put into your documentary? Did you leave anything out or what you showed the public is very clearly what is in there?
Dan Reed: I think what we showed the public gave a very good indication of the kinds of things that happen. There were perhaps extremes of behaviour that we did not show, but they do not augment the picture that the documentary presents. Baxter at one point is completely overcome by the 2-MeO-ketamine, the drug that he injects.

Q91 Chair: Do you think your documentary perhaps glamorised the use of psychoactive substances and, as a result of people seeing what was going on, they will say, "Well, this is perfectly legal. We would like a bit of that, please"?
Dan Reed: That is a very interesting question. I have three children and I live in a community with a lot of children around and I meet a lot of mums. Many of the mums watched my film and I distinctly remember one of them saying to me, "I'm going to show your film to my teenage daughter because it will put her off drugs for the rest of her life". We have had that kind of reaction quite a bit. The behaviour that people see on screen is interpreted as discouraging and the opposite of glamorising. No doubt there are people who already take drugs who might watch the film and say, "Well, that is pretty strong stuff. Maybe I will get some, too". That obviously was not the intention of our film and I think there is a very strong argument for saying the film de-glamorises or debunks some of the glamour that can be associated with drug taking. It is a sad spectacle, I think.

Q92 Chair: You seem too young to have a teenage child. Perhaps I am wrong.
Dan Reed: I am 48.
Chair: Well, you are old enough to have a teenage child. Would you allow one of your children to take legal highs or even get involved in this programme?
Dan Reed: No, I would not.

Q93 Michael Ellis: Mr Reed, how do you find these people when you are beginning your television programme research? Where do you go to look for these people? I am interested, because it could be said by sceptics that television producers will often go in a particular direction, whatever the sample subject is,

and find those people that are easiest to find and, therefore, get the same results. How do you go about finding people who are taking these substances but also are prepared to go on television about them?
Dan Reed: Specifically in the case of Baxter and company and with the other people we found—we had a group of lads and girls in Redcar in the north-east and then we had what you might describe as a middle-class couple from Hertfordshire and others. Quite often we deal with subjects that are controversial or subject to different social interpretations. Are drugs good? Are drugs evil? Should the taking of drugs be banned? People line up on both sides of the argument and some people feel evangelical about it.

Q94 Michael Ellis: What I am saying is, do you advertise for these people?
Dan Reed: If you let me finish I will answer your question.
Michael Ellis: Go on.
Dan Reed: Therefore, we do sometimes find people who take these drugs who do believe it is important to show what effects they have, it is important to show how it happens and important to show that has dangers or that it can be done safely, according to them. Most people would not agree to appear in a documentary taking drugs. That is clear. I am satisfied that the types of people in my documentary are representative of certain niches, certain pockets of—

Q95 Michael Ellis: Yes, but you are not answering the question so far. How do you find these people? Are you advertising for these people?
Dan Reed: No, no, no.
Michael Ellis: You say you are satisfied, but I want to see if others might be satisfied. Are they representative of what is going on outside in this country?
Dan Reed: As far as we can ascertain, yes. For instance, the reason we found most of the people who have been in the film taking drugs was through online chat forums. These are places where people who do take these drugs congregate and exchange notes and exchange trip reports and so on.

Q96 Michael Ellis: Having met with them subsequently, especially the young people—you talked about a group of lads in Redcar, was it?
Dan Reed: Yes.
Michael Ellis: Can you say anything to this Committee about what your impression is of what it was that attracted these people to these drugs? What was their motivation?
Dan Reed: There is obviously the more general question of why do young people want to take drugs, and I will put that aside for the minute. Why were these people specifically taking legal highs? I think that is what you are interested in. There are a number of different reasons. First, the availability of good conventional drugs was not as good in Redcar as elsewhere. It is harder outside the metropolitan areas to come by good conventional drugs. That is one reason. The second reason is that you can order these drugs online and if you are caught with them you will not get arrested.

Q97 Chair: It is ease of access?
Dan Reed: Ease of access is a big factor. The other factor is that if you are part of a self-selecting little cultural group—emos or the more sophisticated kids perhaps, as these were in Redcar—you might pride yourself on your exploration of the world of new psychoactive substances. The exotic chemical names are quite impressive.

Q98 Michael Ellis: It is a way of being cool?
Dan Reed: It is a way of being cool and it is a way of getting drugs cheaply as well. These drugs are often cheaper and they can be purer. There are two types of legal highs. There are branded legal highs that are blends and mixtures and you often do not know what you have, and then there are the so-called research chemicals that are pure.

Q99 Michael Ellis: Finally from me, what do you think, if you have an opinion on this, having spoken and worked with these young people, would be the most effective way of stopping their use of them? Do you think it would be somehow making it uncool? In some jurisdictions, for example, they use celebrities to promote messages—celebrities that the users of these drugs might be influenced by as opposed to politicians or police chiefs—and to say how uncool it is or how dangerous it is. Do you think that might work with these people or do you think something else might work?
Dan Reed: No, I don't think grownups saying something is uncool is going to convince anyone. This is a very big question, obviously. How do you stop people taking drugs, let alone legal highs? I think what is important is to primarily stop people taking drugs in a dangerous way. When you ban a substance like mephedrone or any of the other drugs that we examined in the film they are driven underground and, therefore, purity is tampered with. There is an incentive then to adulterate it, to make it into something that might not be mephedrone and that you can then overdose with. At the risk of sounding bland, I think people need to be educated and people need to know what they are dealing with and what they are taking and that is very important.

Q100 Mr Winnick: The fewer people that use drugs the better, whether they are illegal or legal, except obviously those who use them as a result of a medical prescription in the way that we know. Be that as it may, in your film one of the subjects—I think it was only one—stated that he was moving from these new substances, which we are now discussing, to using heroin. Was it just one person on the programme?
Dan Reed: Yes. If you are asking, are legal highs a gateway to serious opiates—

Q101 Mr Winnick: Basically, yes.
Dan Reed: No, I don't think so.

Q102 Mr Winnick: Being a media person, clearly you anticipate politicians' questions.

Dan Reed: No, I don't see any particular connection. What you have in Stephen Baxter is someone who has experimented with a lot of drugs, who had used heroin apparently even before he came into contact with legal highs, I think, or around the same time. Heroin was just one in a spectrum of drugs including legal highs that he used.

Q103 Mr Winnick: What you are saying, if I understood, Mr Reed, is that using these substances is in no way, necessarily, an avenue or gateway, whatever expression one uses, to the drugs that we know about?
Dan Reed: Not at all, no.

Q104 Dr Huppert: Did you at any point come across people who were using khat or was that any part of what you looked at?
Dan Reed: Using khat?
Dr Huppert: Yes.
Dan Reed: No. You are aware that mephedrone is a derivative of khat?
Dr Huppert: Chemically, yes.
Dan Reed: Not chewing leaves, no.

Q105 Dr Huppert: Thank you, that is helpful. The other question, following on from the question from my colleague David Winnick, there is an issue at the moment that some of these legal substances are more harmful than some of the illegal substances. Do you think, because of the legal or illegal nature, people are choosing take things that are more dangerous?
Dan Reed: I think the big danger with legal highs is dosage. People do not understand the active dose and a lot of the deaths that have occurred have occurred either as a result of multi-drug use—combining legal highs with other stuff, you never know how drugs will interact—and also taking the wrong amount. With conventional drugs, because people have been taking them for 20, 30 or 50 years, there is a rule of thumb. If you have a sense of whether your heroin or your cocaine, or whatever it is, is reasonably pure you know roughly how much to take. There is an anecdotal rule of thumb. With legal highs, because they are so new, nobody knows what 5-MeO DALT does to you apart from the aficionados and that is why there are these online forums. If people are making the effort to get informed then they are usually okay. If kids take it the way they would any other Saturday white powder it can be very dangerous because people just have no idea what they are taking.

Q106 Dr Huppert: You are right that with many of these new substances we have no idea how they work, how they would interact with alcohol or all sorts of other things, but I did not quite get an answer to the question. Maybe I did not quite express it clearly. Because of the legal structure we have where some things are classified and some things are not, is that changing people's behaviour in a way that means they are taking things that are potentially more dangerous for them?
Dan Reed: Yes, it is changing some people's behaviour because they have access to chemical compounds that they do not understand the effects of.

Q107 Chair: The cheapest legal high that you could find on the market was how much?
Dan Reed: £10 a gram, ethylphenidate. That is the cheapest snort. There are probably cheaper cannabinoid compounds, very cheap.
Chair: I think Dr Huppert has found one that is cheaper.
Dr Huppert: No. I do not have a useful handle on how much a gram is.

Q108 Chair: What is a gram?

Q109 Dr Huppert: What is the cheapest per high or per dose?
Dan Reed: Per high, yes. Something like ethylphenidate, which was the one Cane that was snorted in the film.

Q110 Chair: We remember Smarties.
Dan Reed: I am sorry?
Chair: In relation to a Smartie in a Smartie packet, is that a gram?
Dan Reed: Smartie packet. Well, a gram would be slightly more. Do you mean a Smartie tube?
Chair: Yes.
Dan Reed: Yes, that is lots. That is far too much. A gram is a tiny amount. If you imagine a small baggie, do you know what I mean?
Chair: Yes. It is that size.

Q111 Dr Huppert: A dose is in the order of gram or—
Dan Reed: A dose might be anything from a tenth of a gram to a 100th of a gram.
Chair: We should have asked you to bring them in with you.
Dan Reed: Yes. I am not being evasive. There is a huge range and a huge variation in this stuff.

Q112 Chair: Basically a teaspoon is five grams?
Dan Reed: A teaspoon is around five grams, yes. Three to five grams, depending on the compound.

Q113 Chair: So it is about £50?
Dan Reed: Yes.

Q114 Lorraine Fullbrook: In the Netherlands there is a drug-testing service that allows the chemical composition of drugs to be identified.
Dan Reed: There is one here, too.

Q115 Chair: Is there? Where is it?
Dan Reed: It is called TICTAC and it is at St George's Hospital.

Q116 Lorraine Fullbrook: Would that type of service be useful to the users that you had on film?
Dan Reed: I am sorry. You are talking about a consumer service?
Lorraine Fullbrook: Yes.
Dan Reed: I don't think so. There are a tiny number, and there is one in my film, of people who take the drugs almost scientifically, with a real method. They allergy test and then they take a full dose and then they proceed with great caution. Those people are

okay. They are not going to come to much harm anyway because they are doing it very advisedly. They are taking the drugs in a very structured way. The people we need to look out for are young people who are just given a powder or given a pill in a bar or at a party. They will never go and test what they are given because they need to take it straight away.

Q117 Lorraine Fullbrook: You do not think if a consumer-testing service was available in the UK it would be—
Dan Reed: For legal highs?
Lorraine Fullbrook: Yes.
Dan Reed: I don't think it would be used much.

Q118 Lorraine Fullbrook: You don't think it would make any difference to the users in the UK?
Dan Reed: I am afraid not, no. I don't think so. I think a few people might use it, but I do not think it is going to address the big issue, which is how do we stop people coming to harm by taking these drugs.

Q119 Chair: You do not think that responsibilities on the manufacturers to say what is in their product is going to be helpful?
Dan Reed: If so-called legal highs were placed in a regulatory framework where the onus was on the manufacturer, the producer, to guarantee the purity of the product, I think that would be an interesting move. If people were misguided enough to take drugs, then perhaps they would come to less harm because they would know what it is they are taking. If you buy a bottle of Jack Daniels you don't expect to be drinking moonshine that makes you blind or methylated spirits. In the same way, it would be nice for people to be able to purchase their drug of choice, whatever it might be, and not come to harm.

Q120 Chair: If it turns out that obviously it is not non-harmful then the manufacturers can be prosecuted.
Dan Reed: If the manufacturers produce something that is showing signs that it could be harmful then, yes, they should be prosecuted. You could envisage a safety-testing framework that tests drugs along the line of current clinical drugs where you have stage one clinical testing and stage two with pigs, dogs, rats and so on. Once it has gone through there, I think it is quite unlikely that the drug by itself would prove to be harmful.

Q121 Chair: Dr Zee is on record as saying that he tests all his legal highs before they are sent out. He does not want people to be used as guinea pigs. Very few other people have come up and said that. Is that right?
Dan Reed: Yes. To be precise, I think Dr Zee's latest product or the product before the latest one has been tested. The money that he needs to put drugs through a proper testing regime has only been available recently. The drugs he produced before then have not.

Q122 Paul Flynn: The *Journal of Substance Abuse* has recently reported that mephedrone is much more popular since it was banned. Its price has increased from approximately £10 a dose to £25 and it is less pure. It very much follows the lines you are taking, that ban increases the danger. Is that you view?
Dan Reed: It is my view, yes. What is sold now as mephedrone is not necessarily 4-methoxymethcathinone, which is the original mephedrone. What is sold now is any number. It could be 4-MEC or 3-MMC. It could be any number of compounds. These compounds might be pure or they might be adulterated with other stuff. The answer is, yes, since it was banned, mephedrone has become something different, often something less pure, often something more expensive. It has been combined with other drugs. It has basically gone dark. We do not know what is happening to it, but anecdotally, in various tests at urinals in big cities, it seems to be very widely consumed now. It is apparently the fourth most commonly consumed psychoactive substance in the UK.

Q123 Paul Flynn: You significantly mentioned moonshine, and the experience of prohibition in America is that the great number of deaths that took place was because of spirit that had not been properly manufactured. It was not controlled in its strength or its purity. Are you attracted by the New Zealand approach to this of putting the onus for purity and risk on those who make the profit from it?
Dan Reed: I am. I do not see any other rational way to control the drugs that our young people might choose to take.

Q124 Paul Flynn: We can see the present view of going on from prohibition of one drug to prohibition of another drug is utterly futile and likely to do more harm. Do you agree?
Dan Reed: I think so, yes. I am always interested at comparisons with America where they have these very sweeping drug laws and if you produce drugs you never quite know whether you have committed a crime or not because the legislation can be applied, I think, retrospectively. That seems to put the fear of god certainly into the manufacturers of legal highs that I know. They will not export to America.
Paul Flynn: Thank you very much for your film. It was very educational.

Q125 Lorraine Fullbrook: When you were doing the research for your documentary did you find any evidence of criminal activity or organised crime behind so-called legal highs or psychoactive substances?
Dan Reed: I didn't come across any evidence of organised crime being involved in the UK, no, but I did hear of organised crime being involved in other countries, especially as the drugs become illegal and move around.
Chair: Mr Reed, you have been extremely helpful. I will go off and—
Dan Reed: Watch the film.
Chair:—watch the film, indeed. Thank you very much.

Examination of Witnesses

Witnesses: **Mahamud Ahmed Mohammed,** and **Paul Garlick QC**, Furnival Chambers, gave evidence.

Q126 Chair: Good afternoon. Thank you very much for coming to give evidence to this Committee about the issue of khat in particular. We are not going to talk to you about psychoactive substances or other issues of that kind. We are particularly interested in khat. I have to declare my interest, having been born in Yemen and having—not at the age of nine but since I returned to Yemen over the years—chewed khat in Yemen, though not in the United Kingdom as yet. Have you had any khat, Mr Mahamud Ahmed Mohammed? Have you chewed khat?
Mahamud Ahmed Mohammed: Yes.
Chair: What kind of effect does it have on you?
Mahamud Ahmed Mohammed: I don't see it affecting me when I am chewing

Q127 Chair: Is it readily available within the Yemeni and Somali community? I have a few Yemenis in Leicester. Mr Flynn has quite a number of Somalis. I have a number of Somalis in my constituency. How important is this pastime of chewing khat to the community?
Mahamud Ahmed Mohammed: It has been used when we are introducing for marriage, in case we want to get—
Chair: Sorry, you will need to speak up a little. I know it is difficult for you because it is your first appearance before the Select Committee.
Mahamud Ahmed Mohammed: We have been using it as a tradition whereby, when we go to give a dowry when you are getting married or something like that, we normally give a box of khat. Also, it is for pleasure. We chew it after work. It is like somebody going to the pub drinking. That is the normal use.
Chair: Mr Garlick, you are obviously representing those that are challenging the Government on this.
Paul Garlick: Yes.

Q128 Chair: Have you come across criminality in respect of the use of khat by the various communities?
Paul Garlick: I must say straight away that my knowledge of this particular subject is entirely derivative from the materials I have read.
Chair: Of course, yes.
Paul Garlick: I have never been involved in a criminal prosecution or defence case involving khat because, of course, it is not yet prohibited.

Q129 Mr Winnick: You have not chewed it?
Paul Garlick: I haven't, no. All the evidence that I have seen in preparing the application for judicial review, and particularly the advisory council's report, points to the clear indication that there is, at the moment, no criminal activity involved in the importation or the distribution of khat, which would automatically follow. I spent five years as standing counsel for Customs & Excise before I took silk and I can remember in those days, when cannabis importations were rife and in huge quantities, some of the cases involved very highly organised and very serious criminal activity.
There has been no evidence of that at all in relation to khat, primarily because it is not prohibited and, therefore, you have legitimate businessmen such as Mr Mohammed who are importing and also because the evidence tends to show that the profit involved in importation is very small, so serious crime are not interested in it. Of course, as soon as a prohibition comes into effect then, as one sees, there is a very substantial difference between the prices involved in the United Kingdom, where I understand it could be as little £3 to £4 a kilo, whereas in the United States it could be $500 per kilo. That is where organised crime becomes very interested in the activity.

Q130 Chair: The information we have received is that at the moment those who import, like Mr Mohammed, and those who pay for the khat pay taxes of about £2.8 million. Do you have any figures that you can give this Committee about importation or taxation? At the moment it is taxed, of course.
Paul Garlick: Yes, it is. VAT is taxed and I understand, and this information comes from the advisory council's report, that the amount of VAT recoverable on importation has fallen since 2005, which indicates that the amount of khat being imported—and it is all imported legitimately because I understand there are only two agents who operate at Heathrow, Mr Mohammed is one another person, who import the substance.

Q131 Chair: Mr Mohammed, if they cannot buy it from you across the counter in your shop—I don't know where your shop is. Where is it?
Mahamud Ahmed Mohammed: In Southall.

Q132 Chair: In Southall. We have heard evidence from the police today. I don't think you were here. There is evidence to suggest that if you take the community off khat in one particular case they went on to take valium instead of khat. If they can't go along there and buy their khat and they want to continue with it, what would they do? What would the Somali and Yemeni community do when they can't come along to your shop and buy a pound of khat off you? Where would they go and get it? Do you think people will just stop using it?
Mahamud Ahmed Mohammed: No, they will keep on digging looking for khat. They won't stop.

Q133 Chair: Where would they get it from? Presumably it would be illegal, wouldn't it?
Mahamud Ahmed Mohammed: I can't tell that one.
Chair: No, I don't want to know today. I don't mean today specific shops or streets. I am trying to ask you if they can't get it from you would they try to get it or would they just suddenly give up this habit of a lifetime and go on to valium, which is what has been suggested?
Mahamud Ahmed Mohammed: They have been using it for quite a long time and they will not leave it because it is in their blood. It has been traditional, so they will keep on using it.
Chair: Indeed. I understand from my Yemeni past, from the times of the Queen of Sheba. From that we go on to Mr Ellis.

Q134 Michael Ellis: That was a very good segue, Mr Chairman. I noticed that. Mr Mohammed, you made reference to it being traditional in some communities, but is it not correct to say that once upon a time it was traditional to smoke opium in some communities? That does not mean that the tradition should always be permitted to persist. There have been traditions in many cultures that no longer are in line with the social norms and mores that we have today. Do you accept that traditions can change and sometimes should change? Do you accept that, Mr Mohammed?
Chair: Perhaps Mr Garlick could assist.
Michael Ellis: Mr Garlick, perhaps you could answer?
Paul Garlick: Certainly, I would be pleased to answer that. To compare what I would not describe as acceptable but something that was not illegal, the use of opium perhaps in London in the early 19th century, and the use of khat is perhaps not helpful. I mean this with the greatest of respect. It is perhaps not a helpful analogy because they are disproportionately deleterious. The evidence from the council points to the fact that those who are using khat in the United Kingdom tend to come from disadvantaged groups, diaspora from abroad who are socially disadvantaged, and khat to them has a greater significance than it would to non-members of that diaspora. To take what they regard as a legitimate cultural experience away from them would have a disproportionate effect on that small number in the community.

Q135 Michael Ellis: You say that but, of course, the point that you have already made in answer to earlier questions is based on a profit motive, isn't it, on the part of your client? That is the logic of your argument in that effectively it is about profit and loss and it is about the fact that it would become much more expensive and it would put legitimate business supplying khat out of business and it would become more expensive for those to purchase it, but there is a wider argument to that argument, isn't there? The issue is one of social harm and that is the motivation behind those who are interested in prohibiting the use of this substance.
Paul Garlick: I do not accept that, I am afraid. I do not accept that for a moment. I should say that, although one of my clients is Mr Mohammed, we act generally for a great number of people, including those in Kenya who are farmers and whose lives depend upon this. In fact we are receiving a great deal of support, both evidentially and financially, from people in Kenya as well, so our interests are broader than that.
I don't think it would be correct to say that the decision by the present Government to make khat a prohibited substance is entirely revolving around the question of social acceptability. There is no evidence at all from the council to show that there is any social adverse effect. The amount of use is very small compared to the misuse of other substances.

Q136 Michael Ellis: Personal harm?
Paul Garlick: And social harm. There is very little evidence to show there is any social harm whatsoever. In other countries, such as the Netherlands for example, the prohibition was brought into effect with very little research before it was done and it seems that their major concerns were litter and people chewing the leaf and spitting it out in the street. I have seen no positive evidence, and certainly the council saw no positive evidence, that there is any real social harm.
Chair: I am going to have to end for the moment. We are coming back because we have more questions. You will just have to wait for another 15 minutes or so. We will return.
Sitting suspended for a Division in the House.
On resuming—

Q137 Mr Winnick: Mr Garlick, my questions are in no way to be misunderstood. You are a distinguished lawyer. You have acted as a judge for the War Crimes Court of Bosnia and so on. I preface my remarks so there should be no misunderstanding. What I am coming to is basically is, you are acting for Mr Mohammed in a professional capacity. Is that correct?
Paul Garlick: It is correct, sir. I am acting for Mr Mohammed because he is the claimant in the judicial review action.

Q138 Mr Winnick: Yes, perfectly legitimate.
Paul Garlick: I mention that merely because our clients are not limited to Mr Mohammed. We have instructions to act on behalf of the Kenyan Government and a great number of people who are in employment in Kenya, some 500,000 people. The Meru county in Kenya depend upon khat for their livelihood and they have all clubbed together and this action is brought. It is not a group action because judicial review does not permit group actions, but Mr Mohammed is our claimant in the action.

Q139 Mr Winnick: All perfectly in order and if it was not in order you would have not have been seated where you are, but I just want to press this further. You act in a professional capacity. You have referred to the large number of people in Kenya who would be placed at a great economic disadvantage if the ban went ahead, and that I understand perfectly, but your own personal views do not come into this, do they, Mr Garlick? If I could put it this way, if the British Government has asked you to put their case then obviously in a professional capacity you would act likewise. Would that be a fair summary?
Paul Garlick: That would be an extremely fair summary. Any lawyer acts in the best interests of his clients. I am very happy to give my personal opinion as well because that may be important. So far as khat use in this particular country is concerned, I think I talk now as a lawyer generally rather than acting for Mr Mohammed and my experience over many years of dealing with questions of criminalisation, both in this country and Europe because I sit as an expert on the European Criminal Policy Committee at the EU Commission. One of the matters that we are always very concerned about is the harmonisation of criminal matters throughout the member states, which is something that this Government—and I do not say this in any way pejoratively—seems to have been over

concerned about, that the United Kingdom should not be at odds with other member states of the EU.
My personal, professional concern in relation to this matter, my opinion if you like, is that to prohibit the use of khat, which may not be culturally acceptable in terms of Mr Ellis' questions to me before but there is no evidence that it causes any real social harm—and I found a reference during the Division, it is paragraph 235 of the council's report. The council received evidence particularly from the Yemeni community who positively stated to them that any prohibition of khat would have a disproportionate effect on the Yemeni population because they are already marginalised and this cultural significance for them is very important to them. We may not fully appreciate that, but if you are a member of a diaspora like this and you are economically marginalised already, to criminalise an activity that has previously not been criminal will have a very disproportionate effect on such people.

Q140 Mr Winnick: I am not out of sympathy, it so happens, in my own personal view about this. I have a good deal of sympathy for the argument you have put forward, but, as far as the Home Secretary is concerned, presumably she has considered the various options and come to the decision that she has, which you are challenging by way of judicial review. Do you think the Home Secretary came to this decision because she considered this was dangerous drug in the same way as others that have been so classified?
Paul Garlick: If it was the case that the Home Secretary considered this so dangerous that it should be classified then that is irrational, because all the evidence points quite to the opposite. I would like to think of the Home Secretary that she would not rationally reach that decision.

Q141 Mr Winnick: Why do you think she made her decision?
Paul Garlick: I think there are at least two reasons. The first is political expediency, because she feels that we will stick out as a sore thumb in the European community and the members of the EU, because we are now the only member state that has not prohibited the substance. Secondly, I think that she failed to consider the question of proportionality and failed to consider any alternatives. Our case on judicial review will be on a number of points. First, that there was insufficient consultation, and the advisory council has made that quite clear. They had not been consulted properly, which, to put it generously, is unfortunate.
In this particular case, given that there is no evidence of any real social harm, the prohibition and to make it a criminal act to use this substance is disproportionate. There are other less coercive measures that could have been taken. Regulation would have been perfectly acceptable.

Q142 Mr Winnick: Would your clients be satisfied with regulation?
Paul Garlick: Certainly. In fact I know that Mr Mohammed would welcome it. If you had a licensing system and a regulation system it would protect them in a sense. Now it is legitimate. It is not unlawful, but certainly they have no objection to regulation.

Q143 Lorraine Fullbrook: I would like to ask a supplementary question to that. Do you not think that one of the reasons why this prohibition is being put in place is that, being out of sync with the majority of other member states, the United Kingdom would become a trading post for a prohibited substance?
Paul Garlick: Madam, I don't. There are two parts to that question. First of all, this matter had a debate in the European Commission and the Director General of the European Commission pointed out that when you are dealing with matters of classification of substances subsidiarity is very important and each member state has to reach its own conclusions based on the social needs in each particular member state. I think it is very important that the United Kingdom should not blindly follow the decision of other member states because there may be very different considerations here. In the Greater London area there certainly are. The Somali communities and the Yemeni communities will all fall foul of the criminal law for the first time for continuing in a cultural exercise that has been going on for decades.
To your perhaps more important point, I quite understand the concern that the United Kingdom should become a hub. We do not believe that is the case, nor does the advisory council believe that. In fact quite the contrary. The previous witness, Mr Reed, adverted to this. As soon as you prohibit a substance and you criminalise it then automatically the value of the substance increases by a factor of probably 100, as we have seen between this country and the United States. That immediately causes serious criminal organisations to become involved.
If the Government was to adopt a less coercive measure, namely licensing and regulation, it would have this effect. At the moment you have legitimate businesses, principally two in London, Mr Mohammed and another agent, who are importing this. They are legitimate. They pay their income tax. They pay VAT to the Revenue. They act in a lawful way. If you criminalise their activities they will desist. They certainly will not continue. Who will fill the void? The demand will still be there and the supply will have to be met and, undoubtedly, organised crime will step in. As soon as you bring in organised crime you bring in a whole raft of highly undesirable factors. However, if you regulate it and someone such as Mr Mohammed or other people are licensed they will not only be continuing to pay their VAT, they will also be under a licence. They will have every incentive to co-operate with the authorities to ensure that if someone tries to come to them to buy large quantities of khat for onward distribution they will blow the whistle on them because they certainly would not want to get involved in unlawful activities. It just would not be in their interests. In fact, when one looks at the effect of prohibition, it could cause organised crime to step in, fill the void, and could be an organised criminal hub rather than a regulated legitimate hub.

Q144 Lorraine Fullbrook: Thank you. I would just like to go back to your point about the Kenya farmers.

Evidence suggests that increased khat farming has led to the reduction of farming food and has had an impact on food security. Given the shortage of food in areas of the world, is there not a moral case for banning khat?

Paul Garlick: The evidence that I have seen in relation to food insecurity is incomplete. Certainly so far as Kenya is concerned, statistically there has not been any dramatic reduction in the production of food. In certain counties such as Meru there is a very high proportion of farmers who are involved in the production of khat, something like 500,000, but that has been reasonably constant over the years. We know there is a huge quantity of food supplies coming from Kenya into the United Kingdom and elsewhere. The scale of khat use, certainly in the United Kingdom, is not going to cause any grave food insecurity in the world.

In addition, I know from my time in Afghanistan with the United Nations Drugs and Crime Organisation where I did an evaluation of their anti-drug policy and their anti-narcotic policies, as soon as you force farmers to do something they will fall foul of the criminal law. In Afghanistan we spent millions of pounds trying to persuade farmers to burn their opium and plant saffron. It worked for a year and then the following season the poppies were in the fields.

Q145 Chair: On the Kenyan point, we understand that 50% of the total production in Meru actually is khat production and that brings in about £4.9 million annually. There is no alternative to them. Would an alternative be, as Lorraine Fullbrook suggests, that they will then start making more food and using food production or do you think that they will continue to grow because they are subject to the law of our country and this will continue to be harvested and continue to be grown? There is no reason why they should stop because we decide to ban it, is there?

Paul Garlick: No. There will always be a very high domestic demand.

Q146 Chair: There is a market in Yemen and Somalia.

Paul Garlick: Indeed, there is a market, but when you look at—

Q147 Chair: If you look at Africa, has any country banned it as far as you are aware?

Paul Garlick: No.

Q148 Chair: That production will continue with a view that somehow they will all change and do something else. It will just come to Britain in a different way, presumably.

Paul Garlick: Yes, in an unlawful way rather than a lawful way.

Q149 Chair: Indeed. You mentioned the issue of other governments. Was there any consultation with the Government of Kenya, the Government of Yemen and the Government of Somalia?

Paul Garlick: No. In our application, one of our witnesses, Senator Murungi from Meru county, will be giving evidence. There was no consultation whatsoever. In fact, far from it. I understand—it is in his witness statement—the senator had dinner with the High Commissioner in Kenya weeks before the ban and there was no mention of it at all. It seems even our High Commissioner to Kenya did not realise the ban was going to be announced in July this year.

Q150 Dr Huppert: Thanks to both of you for coming to give evidence. There will be a debate in the Delegated Legislation Committee on Monday at 4.30pm to decide what happens next and we will have to see what the outcome is. I personally hope that there will not be support for the proposals, but we will see. I would be interested to understand a bit more about what the future prospects are for the judicial review and the timescales for that and how that will impact. It seems to me you have quite a strong case because the Advisory Council on the Misuse of Drugs says very clearly that, "The evidence of harms associated with the use of khat is insufficient to justify control and it would be inappropriate and disproportionate to classify khat under the Misuse of Drugs Act 1971", which seems about as clear-cut as you can get.

Even the Government's own impact assessment cites costs of £12.8 million in VAT per year. £4.1 million is their estimate of the profits. I do not know if that is correct, Mr Mohammed. They estimate a total net present value of £150 million out and no benefits at all that they can identify that are monetised. Do you think you have a strong case? I am sure you will say yes. What does the timescale mean and what would that mean about implementation of any ban?

Paul Garlick: This is a matter that has concerned us. There are two stages to judicial review, as I am sure you are all very aware. The first is the permission stage where you make an application to a single judge of the High Court for permission to bring judicial review proceedings. That application was lodged and we understand from the Crown Office of the Administrative Court that that application has now been put before a single High Court judge and he will consider the application and all the evidence that has been submitted in support of that application. We have a bundle of both the grounds and the evidence in support that we would be happy to make available to your Committee so that you can see the evidence and the witnesses.

We anticipate that the decision as to whether or not we will be given permission to proceed with the judicial review will be made during this legal term, so before Christmas. If we are granted permission to continue with the judicial review then that will go to a full court of three High Court judges. That will not be dealt with before the Christmas vacation. That is more likely to be dealt with next term, so that will probably be sometime in February. If we are refused permission by the single judge, then we have a right to renew our application to the full court and to ask the full court for permission, which we certainly will do if we are refused permission. Again, I doubt that could be dealt with this term, but could probably be in January of next year.

My personal opinion is that, at this stage in the judicial review, the test for being granted permission

for a judicial review proceeding is to show that there is an arguable case and certainly the grounds that we have put in, which extend to some 20 pages, and the evidence that we have, not only from people in this country but from people in Kenya and abroad, is sufficient for there clearly to be an arguable case. As Dr Huppert said, when one looks at the terms of the council's report itself and other professional witnesses, the decision seems to be quite contrary to the advice that was given. I think we have a more than reasonable chance of being granted permission and I would foresee that the full hearing will take place probably in February of next year.

Q151 Dr Huppert: Thank you for that and we will have to see how the two timescales fit. The report does say that there is no robust evidence to find a causal link between khat consumption and any of the social harms. Was there an assessment of the amount of social harm that would be reduced by banning khat versus the amount of social harm that would be created by banning khat by increasing the efforts for the criminal justice system or increasing the marginalisation of already marginalised communities? What is your assessment of the balance of social harms?
Paul Garlick: My assessment is that if it is criminalised those members of the Somali and Yemeni community, particularly in the Greater London area, will feel even more marginalised. There will be a great deal of social tension. They will not stop using it. If they don't stop using it, they will have to obtain it illegally. The cost will be much higher if it is illegal and if they are caught they will be prosecuted, which will inevitably increase tensions between that member of the community and the law enforcement agencies. In terms of community relations, it could have a very deleterious effect.

Q152 Dr Huppert: Thank you very much. As I say, it seems you have a strong case. It would be helpful, if you have materials that would be of benefit to us, either as a Committee or for the Delegated Legislation Committee on Monday, if you could send them through us to in time for the debate. I think that would be incredibly helpful and could make a difference.
Paul Garlick: We would be happy to do so.

Q153 Paul Flynn: In the 26 years that you, Chairman, and I have been members of this House, about every three or four years there is a call to ban khat and all the Governments in that time, 26 years, have looked at the evidence, examined the calls and rejected them and come to the conclusion on the basis of evidence that there would be more harm than good coming from it, for the reasons you mention: driving a wedge between the police and the Yemeni and Somali communities, criminalising a legal activity and possibly driving those communities into worse drugs, like alcohol, which are far more dangerous and addictive. Why do you think there has been a change now? There is no new evidence. It is an evidence-free policy, but one that I believe is probably prejudice-rich. What on earth do you think made this Government do what previous Conservative Governments and previous Labour Governments refuse to do?
Paul Garlick: I think that our present Home Secretary is a lady of independence and forthright opinions. I think, whereas previous Home Secretaries may have looked more carefully at the evidence that was put before them, I do not believe that in this case the Home Secretary has spent sufficient time considering the evidence. Other factors such as relationships with other EU member states and not wanting to give the impression of being out of step may have caused the decision to be made rather than a careful and critical look at the evidence.
As you rightly said, sir, nothing has changed. In 2005 the advisory council said, "No, it would be disproportionate". In 2013 they said the same. In the course of our litigation, my instructing solicitor and I visited the community in Southall. We went to a community centre there. We were amazed at the number of people who turned up just to know what we were doing and how we could help; not just people who were involved in the business but people who were involved in the community.

Q154 Paul Flynn: As someone who represents a city where there are substantial Somali and Yemeni communities and was born in Cardiff where there are even bigger communities, long-established, been there for a long time, I would wish you well in your cause and I hope you have a look at the previous weakness of the defence for this policy that came up in the earlier sessions of today's Committee.
Paul Garlick: I sit as a recorder in the Crown Court in Bristol and there are similar communities there, obviously. It is quite interesting. When you get outside London it seems that the local communities are quite able to deal with any of the criticisms—the litter problem, the chewing in the street. In places like Cardiff and Bristol, just by way of more gentle, less coercive measures, they seem to have solved the problem.

Q155 Dr Huppert: There is some controversy within the Kenyan and Somali populations and there are people within those communities who are in favour of a ban. Do either of you have a sense or know of any evidence, polls that have been done or whatever it might be, of what the balance is among the populations? There clearly are some in each camp, but is it 50:50? Is it more of one or more of the other?
Paul Garlick: I am afraid I am not able to help you on that. Mr Mohammed might be able to help you.

Q156 Dr Huppert: Do you have a sense of the balance?
Mahamud Ahmed Mohammed: 30% are against it and 70% are in favour.

Q157 Dr Huppert: That is your estimate or based on a proper analysis?
Mahamud Ahmed Mohammed: That is my estimate.

Q158 Chair: We have not touched on the issue of community relations, but presumably that will be affected in the sense that these two communities are

at the forefront, in some respects, of our fight against terrorism in Somalia and indeed in Kenya where we saw the recent outrage in Westgate. Do you think that the ban will have an effect on those relations?
Paul Garlick: I think certainly the relations between this country and Kenya will be very severely affected. We were at a meeting yesterday at the High Commission here in London. I understand you may well be communicating with a delegation that has come from Kenya to London and is here now, a very large delegation of all sorts of people, from senators to politicians to other people. The feeling in Kenya, certainly from the senator who I spoke to, is one of amazement that this could have been introduced without any consultation whatsoever and, in fact, without even the High Commissioner in Kenya being told. I understand he was extremely embarrassed to have to announce it to some of the senior politicians in Kenya.

Q159 Chair: I asked you this earlier, Mr Mohammed. Both you and I, of course, have chewed khat and I asked where you thought people would get it from. Just to re-emphasise, you don't think this will suddenly be given up as a social activity? There is a view that everyone will suddenly stop because it is banned, that they will give it up. You don't think that that is going to happen, do you?
Mahamud Ahmed Mohammed: It will not stop. They will keep on looking for it in other ways and the problem is going to affect our community whereby it will be criminalised in other ways. It will be a lot more expensive to buy it and, secondly, it will affect the elders to be arrested by the police. They have never been arrested before.

Q160 Chair: You mention a very important issue, which is generational change. The community that came here as first-generation immigrants perhaps used it and chewed in their countries of origin, whether it is in Sana'a or Somalia or Nairobi. The next generation is probably unlikely to be as interested in khat as the older generation because it was very much something to do with the old country. Do you think the fact that it is going to be banned will make it cool and people will want to know why it is being banned? I have looked at the figures and it seems to me khat use is going down.
Mahamud Ahmed Mohammed: No, it will make it worse.

Q161 Chair: It will make it worse if it is banned, do you mean?
Mahamud Ahmed Mohammed: If they ban it, it will create more criminals.

Q162 Chair: Sure, but at the moment do you find a generational change? Do you think the younger generation is as eager on khat as the older generation?
Mahamud Ahmed Mohammed: No.

Q163 Chair: You think they are less likely to use it anyway? What I am saying is the use is going down among the younger ones. Your customer profile, the people who come into your shop, are they more likely to be the elderly people or are the likely to be the teenagers or people of a younger age?
Mahamud Ahmed Mohammed: Most of them are underage.

Q164 Chair: They are underage?
Mahamud Ahmed Mohammed: Yes.

Q165 Chair: Which means how old?
Mahamud Ahmed Mohammed: 18, 17. Once they leave work they come and chill. It a situation where they come and chill and have conversation. Somebody will ask another person, "Do you have any vacancy in your place?" It is like a community where we normally sit down and discuss, sharing ideas.

Q166 Chair: And chew the khat, literally.
Mahamud Ahmed Mohammed: Yes.

Q167 Chair: Mr Garlick, a final question to you. Do you understand the point I am making, that this is very much a generational thing?
Paul Garlick: I do.

Q168 Chair: I am not saying no young Kenyan, Somalian or Yemeni is chewing khat. There are other things on the market that they are more keen on, but if you start banning something and telling young people they must not do something they are more likely to want to do it.
Paul Garlick: I have had a teenage daughter and I don't think she has chewed khat but, as we know with all teenagers, if you say to the teenager, "You can't do it," particularly if they are in a very small proportion of society where it is readily identifiable, they are more like to say, "Yes, we will". Once you criminalise that then there are difficulties.
I have just been handed a note that perhaps would be helpful. When we went to our meeting in Southall and we met a lot of the elders of the community in Southall it was made clear to us that it is mainly the older people who use it at the moment in that area.

Q169 Chair: Yes, as I thought. It is a generational issue, isn't it?
Paul Garlick: Yes. In your very first question to me you asked me about the amount. I have just turned to the council report. At paragraph 54 they have the comparative figures between 2005 and 2012 where the volume of tonnes imported and sold in 2005 was 280,000 tonnes and in 2011–2012 it was reduced slightly to 256,000 tonnes. In terms of importation, it has dropped a little. The community has increased in size but the quantities have dropped a little.
Chair: Excellent, thank you. Thank you both of your evidence and, on behalf of the Committee to those visiting members of the Kenyan and delegation, we pass on our sympathy for the recent atrocity that has occurred in Kenya. We were very concerned about them and I know that our Government is going a great deal working with the President of Kenya and others to try to find those who were responsible for this terrible crime. Thank you very much for coming in. You have been extremely helpful. As Dr Huppert has said, because the idea of this session was Dr

Huppert's, the parliamentary debate will be on Monday in one of the committee rooms and it may well be that Members may want to try to also get this on to the floor of the House next week. Thank you very much.

Tuesday 26 November 2013

Members present:

Keith Vaz (Chair)

Ian Austin	Lorraine Fullbrook
Nicola Blackwood	Dr Julian Huppert
Mr James Clappison	Yasmin Qureshi
Michael Ellis	Mark Reckless
Paul Flynn	Mr David Winnick

Examination of Witness

Witness: **Norman Baker**, MP, Minister of State for Crime Prevention, gave evidence.

Q170 Chair: May I welcome the Minister with an apology: I am extremely sorry that you have been kept waiting? There were two votes, each lasting 15 minutes, and I am afraid that delayed our proceedings, but we are delighted to see you here. Thank you very much for coming.

Norman Baker: If it is any consolation, my interest in punctuality has waned marginally since I have transferred from the Department for Transport.

Chair: You are now a Home Office Minister, you have been there for 50 days and have the passed 40 days burning bush test. Are you enjoying your new job?

Norman Baker: Yes, overall. It is very challenging. The Home Office is much more reactive than my previous post. I would liken it to the *Generation Game,* where you sit at the end and you see all these events coming past you; it is trying to remember them and what you need to do on each particular occasion. It is less friendly as a department, if I may say so, because of the sheer size largely, rather than any other reason. It is less homely that the Department for Transport, but it is obviously a key department for Government and I am very pleased to be there.

Q171 Chair: You said on 9 October, admittedly to the *Daily Mail,* "Theresa and I come from different places, but we work together, we work together".

Norman Baker: Yes.

Chair: There was some suggestion that because of your past history and involvement in civil rights issues that you would not be shown certain documents and papers in the Home Office. Can you reassure the Committee that you are able to access whatever information, whatever papers you need as a Home Office Minister?

Norman Baker: I think the Home Secretary answered that question when she came to give evidence before you. I am able to access any papers as any other Minister would, barring those that by statute are restricted to the Home Secretary—for example, information on intercept warrants and so on, which no other Minister sees.

Q172 Chair: Before we turn on to your portfolio, I want to ask you a question that is relevant to our session next week, when we have the editor of the *Guardian* come before us. Do you think the *Guardian* was right to publish the information it did when it received that information from Mr Snowden?

Norman Baker: The information the *Guardian* has published appears to me to be in the public interest, in the sense that there is a legitimate debate to be had about the nature of the role of our security services and the nature of the relationship between the state and the individual. I think those are legitimate matters for a newspaper to pursue. I have seen no evidence that what they published was damaging to national security. I know that has been alleged. I am having conversations in my wider role as a Lib Dem in the Department about such matters.

That is separate, I should say, from the activities of Mr Miranda, who was carrying what appears to be highly-sensitive material around the world, which is completely irresponsible, in my view.

Q173 Chair: So you disagree with the heads of our services, MI5, MI6 and GCHQ, when they told our sister committee that enemies of Britain would be rubbing their hands in glee because of what had been published by the *Guardian?*

Norman Baker: What I have read in the *Guardian* appears to be a responsible approach to be taken about events that are in the public interest. I suggest, as I did on *Any Questions?* a couple of weeks ago, that it is legitimate to have a public debate about where we are. We have new technology that has changed the landscape. We are no longer talking about simply intercepting letters or telephone calls. The situation has changed by the technology available, and I think it is legitimate then to have a debate about that.

Q174 Chair: You do not think that the editor should be prosecuted?

Norman Baker: That is a matter for the police to decide, whether there is evidence to prosecute, but I have personally seen no evidence that would justify that conclusion. I do think it is important, however, that we strike a correct balance between liberty and security. I think there is a danger that if someone says, "Give me more of your liberty and I will give you more security" that is a dangerous equation. I also think that some aspects of this clearly are irresponsible, including what Mr Miranda appears to have done.

Q175 Chair: Thank you. Let us move on to your portfolio. Last week we heard evidence from a number of people involved in the legal importation of khat and we also met, Members of this Committee

and I, with a delegation from Kenyan Members of Parliament. Do you believe that this substance should be banned by the Government?

Norman Baker: This was a matter, as you know, Chair, that was dealt with before my arrival at the Home Office. It was subject to consideration by the Advisory Committee, as you would expect, and then by the Home Secretary personally. The evidence from the Advisory Committee you will probably have access to and will be aware of. The Home Secretary—as I say, this was decided before I was in the Department—took the view, I think, that she did not wish the UK to be a hub for khat.

Chair: What is your view, because—

Norman Baker: I have not had to reach a view because the decision was taken before I arrived in the Home Office. I am concentrating on future policy rather than—

Q176 Chair: So you support the decision to ban khat?

Norman Baker: I have not taken a view, because it is not a matter that I am handling. It was decided before I reached the Home Office—

Q177 Chair: But are you not the Minister responsible for drugs?

Norman Baker: I am the Minister responsible for drugs, but I am not—

Q178 Chair: Is khat not a substance that comes under the Misuse of Drugs Act?

Norman Baker: Khat is a matter that—

Chair: Not yet anyway. It is an issue that would come within your portfolio.

Norman Baker: Yes, but this is a matter of just pragmatism. When you arrive at a department, if a decision has been taken that relates to—

Q179 Chair: Even if you disagree with it?

Norman Baker: Look, the decision has been taken by the Home Secretary. It has been validated across Government and as a matter of fact, when the SI comes forward, it will be handled by the Security Minister.

Q180 Chair: That is very unusual, isn't it, an issue to do with drugs being handled by the Security Minister rather than you?

Norman Baker: There is an aspect—

Chair: Did you excuse yourself from doing the set-up—

Norman Baker: There is an aspect of international organised crime, in the view of the Home Secretary, that makes it logical for the Security Minister to deal with that particular issue. I think you perhaps are reading too much into this. Look, to give you a parallel, I am also now dealing with animal licensing, animal experimentation. Lord Taylor, who was a Minister, was handling that—

Q181 Chair: Yes, we will come on to animals in a minute. Just for the point of view of this Committee, because the Committee has agreed a report today that will be published later in this week, would it be helpful for the Government to look at this report and consider the evidence that has been given to us?

Norman Baker: I think the Government should always look at reports from your Committee, Chair, because they are valuable to look at and we should always be evidence-based, and if evidence comes forward on any issue, whatever it happens to be, of course we should look at it.

May I just make the point I was making, because it was relevant to this, which is that animal licensing has been handled by Lord Taylor. When the change in portfolios occurred, then that was transferred to me, but I agreed with Lord Taylor that it was sensible that he saw through a particular project for a period of weeks until I took over. Sometimes it makes sense for someone to complete something rather than someone to take over at the fag-end of something.

Chair: Of course. Excellent. We would not want you to deal with fag-ends, Mr Baker. We have a quick question from Mr Ellis, who has to go, and then Dr Huppert and Mr Austin.

Q182 Michael Ellis: Mr Chairman, thank you. Minister, as far as the *Guardian* is concerned, would you not agree that they are not qualified, as a newspaper, to make judgments about what is in the national interest as far as national security is concerned and therefore it was rash and inappropriate of them to do what they did, as they are not equipped with all of the facts, as are the heads of MI5, MI6 and GCHQ, and who have responsibility for their people, to know whether something is dangerous to national security or not?

Norman Baker: This is not within my portfolio and I have not been privy to the full details of what has occurred, but I do understand that there were discussions about what it was safe and not safe to publish between the *Guardian* and those who were in a position to answer that question. But the *Guardian* must answer for themselves. If they have committed an offence under the Official Secrets Act or any other piece of legislation, then doubtless legal action can follow. But I do think in a democracy it is legitimate for issues of security to be discussed in a careful way. The issue comes down to whether or not the *Guardian* has done so in a careful way. I have seen no evidence that it has not done, but clearly others take a different view.

Q183 Michael Ellis: As far as khat is concerned, would you agree with me that it is irrefutable that it has a damaging and negative effect on people who take it? [An hon. Member: "Like the Chairman."] It is irrefutable that they would accept that it has a narcotic-type effect, so the reality of the matter is that it is a substance that has an effect and therefore it would be appropriate to judge it accordingly.

Chair: Just before you answer, and this relates to the fact that last week I did declare I have had khat and so has Dr Huppert, I think.

Male Speaker: One can often tell.

Chair: Minister, a quick answer.

Norman Baker: The khat is out of the bag perhaps. The Advisory Committee's advice purely on the health issues was in fact that it should not be restricted

in that way, so that is the direct answer to your question. The Home Secretary has taken the view that because of the wider aspects of policy that need to be taken into account, the potential for the UK to be a hub and so on that that justified banning it. That is sequence of events that has occurred.

Q184 Dr Huppert: I will resist the temptation to talk about the *Guardian* issue, but could I just look at the more general issue about our reports previously on drugs systems around the world? We conducted a very detailed report published last year that made a whole series of recommendations about drugs policy, most of which the Home Secretary did not agree with, but one that was taken forward was the idea that your predecessor—and now you, I hope—would look at examples from around the world of different systems. I hope you are continuing that, and what is your assessment so far, and in particular when it comes to new psychoactive substances? Have you had a chance to have a look at the New Zealand model?

Norman Baker: Let me say first of all it is not entirely fair to the Home Secretary, because there are a large number of recommendations and I think the majority of them were taken forward, just for the record, by the Home Secretary. The international comparators is one of those that she took forward and I think it has been a useful exercise. I have not yet been able to analyse it in detail, though my officials are producing reports of each of the visits. Indeed, the visits are not complete, because I have two visits myself to the Czech Republic and Switzerland next week. I also want to undertake a number of video conference exchanges to follow up some of the work done by my predecessor, and indeed, I have been talking to him about the evidence that he accrued and his experiences. That work is important and it will inform future policy. We should never think that we always have all the answers. If others have answers that should inform our policy, we should take those on board.

The New Zealand example, in terms of new psychoactive substances, is, I should say, an issue that worries me considerably. It is an issue where there are a number of substances coming on the market, let me put it that way, which are untried, and we do not know what the health consequences might be for individuals. It appears to be the case that, as far as I think coroners' certificates are concerned, 52 people died last year, and in some way that has been a contributory factor to their death.

I should also say for the record that, as part of the action I am taking on this—and I want to send the message that the trade in legal highs is not acceptable—that I have initiated with colleagues a concerted programme of enforcement action this week. That will lead to a number of actions from law enforcement agencies. I cannot go into too much detail but I can say that there have been arrests.

Q185 Chair: On legal highs?

Norman Baker: On legal highs. On new psychoactive substances.

Q186 Chair: Before you read all that out, if they are legal how can you take enforcement action against them?

Norman Baker: They may not be legal because "legal highs" is the term that is used. It is often misleading because often the so-called legal highs contain substances that are in fact illegal. In 2011, 19% of substances that were tested actually contained controlled drugs. There are also other offences that can be committed, for example, by failing to label matters correctly or, indeed, by selling substances to minors in certain cases.

Chair: Very helpful. If you hang on one second and pause for a moment, I think Dr Huppert wants to take this point forward.

Q187 Dr Huppert: I think it is very clear, I mean we recommended in our report that the existing trading standards powers, for example, should be used on many of these substances. I presume that would be part of what you are looking at. Is that—

Norman Baker: Yes. We are asking the police, the Trading Standards' officers and others this week to help us with enforcement action. There have been arrests in Cumbria this week already, and there have been materials seized, for example, in Kent yesterday.

Q188 Dr Huppert: It is very helpful to see action and another of our recommendations being taken up. You are quite right to highlight the fact that the term "legal highs" is probably not a very helpful term, emphasising the legality. Many of these substances are of course harmful, though substances can be harmful whether or not they are legal or illegal to the extent that that means anything. Do you think, however, that because of the badging of them as legal highs people see them as approved or safe? There is a risk that we are pushing people from substances that are currently controlled under the Misuse of Drugs Act, which may be less harmful than the things that people are being pushed on to by the fact that some are illegal and some are legal.

Norman Baker: Yes, undoubtedly there is a problem with the terminology. That is why I prefer not to use the term "legal highs" other than for shorthand. That is perhaps more attractive than "new psychoactive substances" to use as a term. Clearly some people will believe that those substances are safe because they are thought to be legal, with the assumption perhaps that the state would have banned them had they been unsafe. Of course we have in fact banned over 200 of these substances, and we have a methodology in this country that enables us to deal with these more quickly than other countries do, through our early warning system and through temporary control notices. But the reality is that these are being created in laboratories—places like China and India—and they then appear. Sometimes the first we know about it is when there is a problem with one of these substances.

So there is a major change here to the landscape in terms of the drugs that are available. The landscape is changing and we have to change with it. That is why I am looking at options as to what we might do about new psychoactive substances in particular. You

mentioned the New Zealand example. Of course, my predecessor took evidence from New Zealand as part of his work on that. That is one option, the so-called full regulation option. There is also an option of quasi-regulation, which is a consumer protection-type approach. There is the option of a blanket ban on anything that is deemed to be intoxicating or will have a psychoactive effect. There is also an option of analogue legislation by controlling a substance if it is sufficiently similar to a banned drug. That is the approach that has been taken in the US, for example.
Chair: Yes. Thank you.

Q189 Dr Huppert: Very briefly, I hope you would rule out the idea of banning anything that is psychoactive because some of us like caffeine and various other substances.
Chair: Very helpful. Let us move on.

Q190 Ian Austin: Which Minister was dealing with khat before you were the Drugs Minister?
Norman Baker: It came up, and I think my predecessor looked at it but I think the Home Secretary took personal ownership of the issue.
Chair: You mean Jeremy Browne?
Norman Baker: Jeremy Browne, yes.

Q191 Ian Austin: So what you are saying is that Jeremy Browne was responsible for it. He is no longer the Drugs Minister. You become the Drugs Minister and you are having nothing to do with it. That is the truth, isn't it?
Norman Baker: No.
Ian Austin: Because you do not want to have anything to do with it it is handled by James Brokenshire.
Norman Baker: No, I am not saying that. What I am saying is that of course Jeremy had an initial look at it, but the Home Secretary took a personal interest in this because of what she regarded as the complicated nature of the issue. Because it was not simply about whether or not the substance itself—

Q192 Ian Austin: Was there ever any discussion of you dealing with the SI?
Norman Baker: Can I finish the point I was making, which is that because the Home Secretary took personal ownership because it was a complicated issue it related not simply to the damage or otherwise of the product but also the complicated nature of serious organised crime. It therefore crossed portfolios in a way that was unusual for consideration of these matters. She took personal ownership and, therefore, it made logical sense when I discussed it with her when I first took up office. I was presented in a sense that there was a decision already taken, which was this had been announced in fact, I think in July, that a ban was to be taken forward and therefore the simple matter was as to which Minister took it forward. The Security Minister had been involved in discussions because of the serious organised crime aspect of that and, therefore, it is entirely logical he should deal with the SI.

Q193 Ian Austin: I am sceptical about all this because I think it is incorrect. I am just surprised that we have a Drugs Minister who will not tell us what he thinks of this drug, and that is why I am asking whether you were asked at any point to do the SI and you did not want to do it. That is what I would like to know.
Norman Baker: I had a discussion with the Home Secretary about the best way to take this forward, and we both agreed that it was sensible for the Security Minister to take it forward, given how far down the road it was, that he had been involved in discussions and I had not.

Q194 Ian Austin: Can I ask whether your period at the Home Office, so far, has disabused you of the view that it is possible in this country for the police, the security services, the Civil Service and the Government of the day to organise a huge conspiracy to pervert the course of justice by claiming that someone who committed suicide was actually murdered?
Norman Baker: I think I would refer you to the events of 2003 and the fact that Parliament was misled, in my view, or allegedly misled by the Prime Minister of the day based on a series of false documents alleging weapons of mass destruction, which did not exist. I hardly think that the events of 2003 suggest that the forces of Government can necessarily always be trusted on these matters.

Q195 Ian Austin: The reason that I am asking this is that I would think it would be extraordinary to appoint someone as a Minister in the Home Office who did believe that that sort of thing could happen in Britain. So, what I am asking you is whether you still believe that that happened?
Norman Baker: My approach to politics throughout my life, in the Home Office and the Department for Transport, as a Back Bencher, as a council leader, has been to follow the evidence. That is what I tend to do with drugs policy as with the rest of my portfolio. Following the evidence is the only safe course of action. In 2003–2004, for example, I made it plain that I did not believe that weapons of mass destruction existed—

Q196 Ian Austin: I am not asking you about weapons of mass destruction.
Norman Baker: You are because—
Ian Austin: No, I am not. I am asking you whether you still believe that David Kelly was murdered and that the Government of the day, the police, the security services and the Civil Service mounted some huge conspiracy to hide that from the public's view. That is what I am asking you.
Norman Baker: I have never in fact alleged that in the way you describe it. What I have made plain is that I am prepared to follow the evidence. I raise questions. If you want to go back to the events of 2003, rather than the events of 2013, I would ask you whether or not you are happy with the situation where the Prime Minister of the day, and presumably the Cabinet, misled Parliament into a war on behalf of

this country based on a false prospectus, based on documents that were sexed up?
Chair: Unfortunately, Minister, although it is helpful—

Q197 Ian Austin: It is worth pointing out that the way it works in here is that we ask the questions and you answer them. I was not an MP at the time and my views on that are utterly irrelevant but I think it is not irrelevant to ask you whether, given in the Home Office you are responsible for some of these things—now, look, if you do not want to answer that is fine. That is a matter for you but it is not unreasonable for me to ask the question.
Norman Baker: No, it is not unreasonable for me to draw attention to the fact that Parliament was grotesquely misled in 2003. I have written a book on the matter. I wrote it in 2007 and the conclusions I reached at the time are said in there. As far as my appointment was concerned, it was validated by the Prime Minister and Deputy Prime Minister.

Q198 Mark Reckless: Do you still support the conclusions you reached at that time?
Norman Baker: I have not read my book and I have not looked at the matter again, largely, since 2007.

Q199 Chair: You have not read your book?
Norman Baker: No. Why would I?

Q200 Chair: I thought you said you wrote this book.
Norman Baker: I have not read it subsequently. I spent a year—

Q201 Chair: You have not refreshed your memory with the book, that is what you mean?
Norman Baker: I do not know whether you want to spend the entire time on the events of 2003, but—
Chair: No. Minister, can I just point out to you, it is obviously your first appearance before the Committee, and I think it is relevant when we have a new Minister to ask questions of this kind. I think I am pretty fair as a chair. If I feel it is going in the wrong direction I will stop it, but I think it is legitimate for Mr Austin and for Mr Reckless, if they have any further questions on this to put them, and then we will move on. Mr Reckless?

Q202 Mark Reckless: I have just been given a copy of your book. I have yet to read it. I am not saying it is either a bad or a good thing. I just wonder if you still hold now the conclusions you reached then or if you had any reason to reconsider what you thought at that time.
Norman Baker: I concluded my book in 2007, having spent a long time following the evidence and I set down my conclusions in 2007. What I find extraordinary, if I may say so, is that we can have a highly public death that, uniquely, is not followed by a coroner's inquest. I think that is extraordinary and I find it—

Q203 Chair: I have not read the book. Was that your conclusion?
Norman Baker: That was the central conclusion along with—
Chair: I think the Minister's answer is he does stick by that.

Q204 Mark Reckless: Yes, with respect, I am not criticising your book or in any sense saying that you were inappropriate to write anything in that. I was just asking that question. Would you encourage me to read that book? Do you think it is still something you—
Norman Baker: I would always encourage people to read what I have written.
Mark Reckless: I will do so.
Norman Baker: It is most educating.
Chair: Order. I know Christmas is coming, can I promote my book? Is this the final question, Ian? We really do need to move on.

Q205 Ian Austin: It is the final question. Your central conclusion in the book is that David Kelly was murdered. You described it in the book as a "wet job" whatever that means. That is what you said. That would mean, as I have said, that the police, the Civil Service, the Government of the day, and the security services were all engaged in some huge conspiracy. I am asking you whether you still believe that that sort of thing is possible to happen—
Norman Baker: I have said to you—
Ian Austin: It is a simple, "Yes" or "No" answer.
Norman Baker: No. I have said to you that the construction you have put on that is not the construction I put in my book.

Q206 Ian Austin: Okay. Do you still believe that David Kelly was murdered? That is what you said in the book. Do you still believe that?
Norman Baker: I concluded that when I wrote my book in 2007. I have not looked at the matter since.

Q207 Ian Austin: Do you still believe it, yes, or no?
Norman Baker: I cannot answer it any other way. I concluded that was the case in 2007. I have not looked at it since. I spent a year of my life devoted to that. I think it is a great pity that others did not also query the fact that there was no proper coroner's inquest. However, they did not. I am now doing other things in my life, including trying to deliver a good service as a Minister in the Home Office.
Chair: Excellent. I think we have now reached a conclusion. We will all go and buy this book for Christmas.
Mr Winnick: Not me.
Chair: Mr Flynn, could we go back to drugs?

Q208 Paul Flynn: Can I ask a question I asked one of your predecessors, the late Mo Mowlam?
Chair: On drugs?
Paul Flynn: Yes. To become Drugs Minister, do you have to undergo a lobotomy to remove from your brain all your previous views on drugs?
Norman Baker: Had I had a lobotomy I could not answer that question.
Chair: Many have when they have appeared before the Committee.

Q209 Paul Flynn: I am always very grateful to you for signing my EDMs and I signing yours, but your views were that the police were wasting their time chasing after people who were using drugs like cannabis and they should concentrate on chasing crimes of addiction and serious crime. I can give you a quote if you would like. Is that still your view?
Norman Baker: The Home Office drugs strategy has three objectives, which I—
Paul Flynn: Can I ask you—
Norman Baker: I am being asked a question.
Paul Flynn:—are you reading from a script at the moment?
Norman Baker: No, I am—

Q210 Paul Flynn: Is it your view or not? There are many things I want to raise with you. The Angelus Foundation, which is a group campaigning about legal highs, they saw the answer as raising awareness, the answer was education. Can you think of any educational project against drugs that actually reduced drug harm and drug use?
Norman Baker: Educational project?
Paul Flynn: Yes.
Norman Baker: Yes. The Home Office has a website, the FRANK website, which has been very useful.
Paul Flynn: Yes, I know it well.
Norman Baker: It has been very useful in education, a lot of hits. There was a campaign designed particularly towards 13 to 19-year-olds, which has been effective. So I think, yes, education is absolutely key in giving people information to enable them to make choices.

Q211 Paul Flynn: Do you remember celebrating in the world anti-drug education in America, when drugs were endemic in the large cities? They sent out groups of former hippies with long hair, all very beautiful people with guitars, who went to the bible belt and said, "Don't do drugs because they are wicked and they are dangerous, and you end up as we did, in degradation, in sexual orgies. It is a terrible thing". We were rather surprised that drug use followed the anti-drug campaign as surely as night follows day. Aren't you in danger, as it happened with the ecstasy campaign in this country, as it happened with the criminalisation of methadone, of increasing the interest in drugs and the attraction of drugs by the anti-drugs education campaign?
Norman Baker: That does not seem to be borne out by the figures because, according to Home Office figures, drug use is as low as it was in 1996.

Q212 Paul Flynn: Yes. That is because everyone is working on these things and on iPads and so on and people become addicted to other things.
If I can ask you another question on this. You say the justification for the action on khat, which is different to the lack of action on khat taken by the last 20 Home Secretaries, is to somehow harmonise ourselves with Europe. Inspired by this, is the Government going to harmonise our policies with the laws on Europe in Holland, Portugal, Switzerland and Czechoslovakia?
Norman Baker: The reality is that the position in Europe—as I discovered from the study that my predecessor began—is very varied indeed. For example, in Denmark they have a three year trial to legalise the sale of cannabis. In Sweden, which is not very far away after all, they have a zero tolerance approach where imprisonment is a sanction available for minor offences. So it is impossible to harmonise because every country is different.

Q213 Paul Flynn: Okay. Well, do you still believe in legalising cannabis which you once did?
Norman Baker: I think it needs to be considered along with anything else, but that is not my prime objective and I am not advocating it at this particular moment. What I am saying is that there is an international comparison study going on, which is designed to look at all aspects of drug policy across various countries and we should be prepared to follow the evidence—to use that phrase again—and see where it takes us.
Can I come back to the three strands of Home Office policy? That is to reduce the demand for drugs, to restrict the supply of drugs and to support individuals recovering from dependence. I fully support those three objectives. The question is how we get to those three objectives. How we maximise the return.

Q214 Paul Flynn: Recalling your answer to the first question you gave, we could remind you that you are among friends now and anything you say here will not go any further. It is clear from your body language, and everything else, that you do not agree with this policy on criminalising khat, why not say so? It is a nonsense. It is a lot more with trying to boost the Tory vote in the next election by appearing to be tough on drugs, when they know there is no votes in being an intelligent on drugs.
Norman Baker: I do not want to get into that particular argument about different parties and drugs policies.
Paul Flynn: Oh come on.
Norman Baker: What I would say is that I am determined—as I always have been in my political life—to follow the evidence. Sometimes that is easy. Sometimes it takes you to difficult places.

Q215 Paul Flynn: The evidence on khat is it bad to—
Norman Baker: The evidence on khat I have not looked at in a great deal for the reasons that I have just given to you.

Q216 Paul Flynn: Are you the Drugs Minister or not? You blamed it on your predecessor. It is clear. I think anyone watching your demeanour, your body language, knows that you do not believe a word of it, do you?
Norman Baker: Look, I do not know whether you think the best use of my time as Drugs Minister is to revisit decisions already taken, whenever those have been considered by the Home Secretary and decision has been reached by Government, or whether it is best looking at new problems such as new psychoactive substances. I think my time is better spent on the future rather than the past.

Q217 Paul Flynn: I have great hope in your future career and as a pioneering Drug Minister, so if you cannot do that, what will you do?
Norman Baker: What I will do is complete the international study, which I think is very useful, which your Committee recommended, and which is throwing up some interesting positions taken by different countries. I am particularly keen that we look at the options for new psychoactive substances because it is not sufficient. What we have at the moment, frankly, is not going to do the trick and I am keen to learn from other countries in that regard as well.

Q218 Chair: Thank you. We also recommended very strongly that there ought to be a royal commission, given the evidence that we have received. Do you think that that would be helpful, given the statements that have been made by the Presidents of Colombia and Brazil, Kofi Annan and others who have given evidence to this Committee, that the best way to look at drugs policy is to have a really good royal commission to look at this whole policy?
Norman Baker: I think a royal commission is a superficially attractive idea but I think it potentially takes a very long time; it could be quite expensive and I think it is something that people can sometimes say, "Let's have a royal commission because it sounds like a good idea". We are in fact looking at aspects of policy already through this national comparator study. We have an existing strategy that is delivering a reduction in drug use as it is, and I am looking at new psychoactive substances. I would like to see how far we get with that rather than starting up a brand new process.
Chair: Indeed.

Q219 Mr Winnick: Is it not a fact of parliamentary life, Minister, that either a Minister agrees to go with a collective decision of a Government—some of the questions today, the guarding of drugs or what have you—or resigns. It is not a job for the Minister to give his own personal view, whether it is a Labour, Liberal or Coalition Government or Labour Government. What I am saying to you is it is a decision that you must make, but if you disagree with Government policy you obviously resign. You accept that is always the position, not just for you but for any Minister in any Government?
Norman Baker: I accept there is collective responsibility, if that is what you mean, Mr Winnick. What I would also say is a moment ago I was being asked not to read out material, but to answer the question, give my own views on matters, and now you are asking me to give a Government view or resign so I am slightly confused.
Chair: I think Mr Winnick was just mentioning the constitutional issue about having personal views as against the view of the Government, rather than asking you to resign. We would rather you did not.

Q220 Mr Winnick: I was not asking you to resign. I was asking—and I am glad the Chair has clarified—do you accept that that is the position for any Minister, not just yourself, obviously, junior or senior, that you put forward the collective line or if you strongly disagree one has to resign? We agree on that?
Norman Baker: Of course that is the case. For example, I would have resigned in 2003 had I been asked to vote for the Iraq war.
Chair: Please do not resign now because we have not finished yet. Mark Reckless, and then we have just a couple more then we will close.

Q221 Mark Reckless: Yes, Minister, I want to ask whether the position of the European Union was a consideration in the Home Secretary's deliberations with regards to khat?
Norman Baker: I think she was certainly cognisant of other European countries. I am not quite sure if the European Union, per se, as a concept was a relevant factor but certainly there is an international trade and she was taking into account, as I understand it, the potential for diversion into the UK if other countries have taken steps to ban khat.

Q222 Mark Reckless: We being the only country not to have banned khat when all other European Union countries have?
Norman Baker: I am not sure about all others. I indicated before that this was largely sorted before I arrived in office, but my understanding is a large number of other countries have banned it in Europe.

Q223 Mark Reckless: In practice, do you think it is a good thing for us to be in line with Europe on this?
Norman Baker: I think it is perfectly sensible for the Home Secretary to want to take into account other issues other than simply the toxicity of the substance.

Q224 Mark Reckless: Will you take into account the policy in Portugal as the Committee recommended previously?
Norman Baker: I will take into account the policy in Portugal, as I will the policy in Denmark, Sweden, New Zealand, South Korea, Japan, Canada, USA, Czech Republic, Switzerland, the Netherlands and Brazil.
Mark Reckless: Yes. I am glad to hear you will be keeping busy.

Q225 Chair: Is that your travel plans?
We were very concerned in our report—I am sure you do not spend all your time reading our last report—about prescription drugs. We had been to America and we had seen the growth of prescription drugs. You have set out very clearly, and I am very grateful for what you said, about what you are doing about psychoactive substances. We would like to know the results of the enforcement action you are proposing to take. If you could write to us about that?
Norman Baker: Yes, happily.

Q226 Chair: As far as prescription drugs is concerned, both outside prison, inside prison and generally, is there any new initiative to deal with that?
Norman Baker: There are two issues with prescription drugs. There is the issue as to whether or not addiction is created as a consequence of legalised prescription of those drugs. That is a matter that the

Department for Health is looking at now. Then there is a secondary issue, which is whether or not prescription drugs are being misused or redirected into the legal market for improper use. That is a matter that our advisory committee on misuse of drugs will be looking into.

Q227 Dr Huppert: Minister, we spent a lot of time on one specific aspect of your portfolio and I think on a lot of things that are not part of your portfolio. Can I just ask you about something else that is very much in your portfolio? Yesterday was the International Day for the Elimination of Violence against Women and Girls. I think that falls under the long list of things that you cover. What are you doing in that respect? This is something we will be looking at as a committee later.

Norman Baker: This is a very important issue, and I have to say that the more I look into it, the more concerned I am. I think attitudes that I had hoped to become more liberated, in terms of the relationship between men and women and how men regard women, have not in fact improve as much as I would like. The evidence in the papers today suggests there is a particular problem with boys in certain gang cultures, in particular, which I think is very worrying indeed.

I think what we are doing is the right thing and it is where the Home Secretary and I, which you picked up last week, were visiting a refuge in Wiltshire. We are at one on these issues to make sure that we do what we can to protect women. We launched the Domestic Violence Disclosure Scheme yesterday across the whole country, having had four successful pilots, which will enable women of course to gain access to information about potentially violent partners. I think that is absolutely right that that is available.

Secondly, the domestic violence protection orders that, when an incident occurs in a house, for the police to require the perpetrator to leave that house at that point, thereby leaving the victim some space and some safety to consider the position. Whereas before of course it was often the case that the woman—it was normally a woman, not always but nearly always a woman—was in fact often the one who left the house because she was frightened. So I think we are taking good steps on that.

The evidence, such as it is, is that the situation is, sad to say, far worse than I had certainly thought and that is why I am very pleased that the Prime Minister, for example, took a strong view of online child abuse images. We are taking steps as a Government to try to deal with that through contact with internet service providers in other friendly countries.

Q228 Chair: Yes. The Committee has launched an inquiry into female genital mutilation, which we will commence shortly. Obviously at the end of that inquiry we will ask you to come back as the Minister responsible, but initially are you concerned that there have been no prosecutions since this offence was brought in and can you offer an explanation as to why this is the case? We find it astonishing that nobody has been prosecuted but there are so many victims.

Norman Baker: There are potentially tens of thousands of victims in this country who have been subject to that appalling and abhorrent practice. It is deep and depressing for me that since I think 1985, when the Act first came in, that there has been no successful prosecutions. I can only speculate that sometimes people are reluctant to give evidence against members of their own family because it is often an interfamily thing. I have indicated to the law enforcement agencies that I would like to see more effort going into this area. I am hopeful there will be some successful prosecutions in the not too distant future. It may well be—

Q229 Chair: Is it because the communities are not coming forward with evidence that could be helpful to the police? Is it because they are too frightened to do so? Is it because these are young girls who perhaps do not want to report and cannot report an offence against their own parents?

Norman Baker: I think it is perhaps all of those to a degree, and perhaps the latter one in particular is the reason. In my view we have to look at whether or not evidence can be accrued in different ways that may not require the victim to have to testify. That is a sort of speculative thought in my head, but I am very keen to get to the stage where we do get some prosecutions on what is an appalling practice, which is out of date—it never was in date—and as inappropriate as foot binding was in Imperial China.

Q230 Chair: Let us go back finally to drugs. When Kenneth Clarke gave evidence to this Committee he said that we were in danger of losing the war on drugs. You are the new Drugs Minister. You have people like the Chief Constable of Durham suggesting to some extent decriminalisation, "Let's take away the revenue streams from the villains". How blue skies is going to be your thinking? Are you going to be able as Drugs Minister to be able to put forward radical proposals to try to deal with what is a situation that seems to be overwhelming this country and our police service? In countries like Colombia, which the Committee has visited, we were very moved to see the tragedy that has been befalling people there. As for the import of so much cocaine into this country, what are we going to do about this? What is the radical approach?

Norman Baker: Let us not overstate the problem. Drug use is at its lowest since 1996 when records began. It is 11% down from that date. We are also seeing low purity levels and high wholesale prices for both cocaine and heroin, which suggests that the strategy may be working to a degree. The question is can we do any more to achieve the three objectives that the Home Office set, which I entirely support. That is what the international comparator study is about, and I think if there are suggestions from other countries that clearly are working then we ought to be prepared to take them on.

Chair: Minister, thank you very much for coming today. We are most grateful.

Written evidence

Written evidence submitted by Public Health England [DFU 01]

LETTER FROM THE COMMITTEE SPECIALIST TO DUNCAN SELBIE, CHIEF EXECUTIVE, PUBLIC HEALTH ENGLAND, 13 NOVEMBER 2013

I am writing to you regarding an evidence session that the Home Affairs Committee is holding on New Psychoactive Substances and Khat. Please could you inform us as to:

1. The number of people who have approached treatment services regarding an addiction to either a NPS or Khat in a)2010 b)2011 and c)2012?
2. The estimated cost of treating those with an addiction to either an NPS or Khat?
3. The different aspects of work which Public Health England does regarding NPS'?
4. The different aspects of work which Public Health England does regarding Khat?

It would be helpful to have a response to this letter by Wednesday 20 November.

Committee Specialist

13 November 2013

LETTER FROM ROSANNA O'CONNOR, DIRECTOR OF ALCOHOL & DRUGS, PUBLIC HEALTH ENGLAND, TO THE COMMITTEE SPECIALIST, 20 NOVEMBER 2013

RE: NEW PSYCHOACTIVE SUBSTANCES (NPS)[1] AND KHAT

Thank you for your letter of 13 November 2013 asking for information from Public Health England (PHE) on the new psychoactive substances (NPS) and khat. Please see below our answers to the questions that you have raised.

1. *The number of people who have approached treatment services regarding an addiction to either an NPS or khat in a) 2010 b) 2011 and c) 2012?*

Number of new treatment presentations to adult treatment services for problems with either mephedrone and khat (2010–11–2012–13)

	2010–11	*2011–12*	*2012–13*
Mephedrone	839	900	1630
Khat	112	135	75

Notes

- All figures are for adults (18 and over)

- The figures show the numbers citing any use of mephedrone and khat among new adult presentations to treatment per year

- A code for mephedrone was added to the National Drug Treatment Monitoring System (NDTMS) Core Data Set in 2010–11.

- NPS are emerging at an unprecedented rate, and surveillance data takes time to catch up. The NDTMS data set was updated in April 2013 to capture treatment presentations for NPS not previously recorded. This data is not yet reportable.

Number of new treatment presentations to young people's services for problems with either mephedrone and khat (2010–11–2012–13)

	2010–11	*2011–12*	*2012–13*
Mephedrone	893	818	N/A
Khat	10	6	N/A

Notes

- All figures are for young people (18 and under)

- The figures show the numbers citing any use of mephedrone and khat among new presentations to young people's treatment per year

- A code for mephedrone was added to the NDTMS Core Data Set in 2010–11

- The 2012–13 young people's treatment data is due out 4 December 2013, so we are not able to release 2012–13 figures until after this date

[1] "New psychoactive substances" (NPS, often colloquially termed "legal highs") are psychoactive drugs that are either "new" or ones that until recently were little used in the UK.

2. *The estimated cost of treating those with an addiction to either an NPS or khat?*

Treating NPS or khat requires a therapeutic process tailored to each individual's needs. Treatment typically involves psychosocial interventions (talking therapies designed to encourage positive behaviour change). PHE is unable to provide a breakdown for the cost of treating NPS or khat alone. This is because treatment typically involves a range of interventions, and it is not possible to isolate each individual component costs, how they are combined and for how long they last for each individual treated. Decisions about what to spend on drug treatment and what services to provide are the responsibility of each local area.

3. *The different aspects of work which Public Health England does regarding NPS?*

PHE's current action on NPS falls into three broad categories: prevention, surveillance and supporting better treatment.

Prevention

PHE is responsible for the FRANK service which provides credible information and advice about all drugs including NPS and is highly trusted by its young audience. The service is accessible 24 hours a day, seven days a week in the following channels: talktofrank.com, a helpline, web chat, email and SMS. The website highlights the dangers of NPS in a number of ways from dedicated A-Z pages which explain the risks of specific substances, to news articles which provide the facts behind the NPSs that make the media headlines. In addition there is information for young people to help them resist pressure and say no to drugs.

PHE worked with the Home Office on a NPS campaign, between July—Oct 2013, which signposted people to further information on FRANK. This national work compliments targeted prevention campaigns being run by a number of local areas.

Surveillance

PHE's Centre for Infectious Disease Surveillance and Control (CIDSC) has revised a number of systems covering drug use and sexual activity to capture the potential impact of NPS use, including efforts to assess levels of use and associated infections risk among men who have sex with men.

The NDTMS changed its data set in April 2013 to capture treatment presentations for NPS not previously recorded.

PHE has developed a National Intelligence Network on Health Harms[2] associated with drug use, including NPS and provides intelligence for the Home Office led Drugs

Early Warning System (DEWs). The UK Focal Point[3] hosted within the PHE Alcohol and Drugs team feeds intelligence into the European-wide early warning system for NPS. PHE is also looking at amending existing mortality datasets in order to better capture NPS information. Finally, there has also been local action, supported by PHE regional centres, to map local profiles of NPS use.

Supporting better treatment

PHE's Alcohol and Drugs Team is supporting, and contributing clinical expertise to, the development of the first set of clinical guidance on the acute management and treatment of NPS called project NEPTUNE, developed by the Central and North West London NHS Foundation TRUST (CNWL). We have also included information on best practice, innovative responses and relevant data on NPS in relevant commissioning support resources, including Joint Strategic Needs Assessment materials for this year's local authority planning round.

Local PHE staff are supporting local areas to develop responses relevant to their areas, including scoping need for specialist commissioning which will inform 2014–15 plans for treatment. This work follows on from the National Treatment Agency for Substance Misuse (NTA) report "*Club drugs: emerging trends and risks"* (published November 2012), which called on services to adapt current treatment approaches and to make appropriate links to specialist medical treatment in order to better respond to NPS-related harms.

PHE's local intelligence demonstrates that local substance misuse treatment systems are beginning to respond to NPS. There is evidence of an increased commissioning focus in several parts of the country, with some areas doing specific needs assessments. Several specialist services have been developed, including in London, Leeds, and Manchester. Service providers and local PHE staff are actively collaborating to share best practice on what works and some local PHE teams have hosted national and local experts to present to networks of service providers and commissioners.

Finally, PHE Alcohol and Drugs are promoting better awareness and closer working links between sexual health and drug treatment services. This work was initiated by a roundtable meeting of relevant stakeholders which agreed to:

[2] The network includes representatives from the largest drug treatment providers in the country and national professional and membership bodies.

[3] Based at Public Health England, the UK Focal Point collates data and information on drug misuse in the UK and reports it to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

— Support improvements in service provision by sharing good practice examples.
— Providing advice and guidance for commissioners.
— Collating and disseminating evidence of effective interventions with particular groups.

4. *The different aspects of work which Public Health England does regarding khat?*

PHE's current action on khat falls into four broad categories: prevention, raising awareness, collecting khat treatment data and helping local commissioners meet khat-related need.

Prevention

The FRANK website and helpline (see information above) provides credible information and advice about khat. The website highlights the dangers of khat in a number of ways from dedicated A-Z pages which explain the risks of specific substances, to a news article which explained the recent change in the law. PHE's support for local areas will further highlight the need to tailor drug prevention initiatives to include khat as appropriate.

Raising awareness

PHE will lead on identifying opportunities to raise awareness of the potential harms of khat and associated community needs at a local level. We will also provide additional advice to local areas where khat is used, which will cover a range of issues highlighted by the Advisory Committee on the Misuse of Drugs (ACMD), including the need to:

— Ensure that treatment providers are competent to support people whose khat use is problematic;
— Alert clinicians in mental health services to the scope for khat to complicate treatment of existing mental health problems; and
— Alert midwives and health visitors to the risk of potential harm to children from khat use in pregnant women or breast-feeding mothers.

Collecting data on treatment for khat problems

Figures of people seeking treatment for khat problems are collected by the National Drug Treatment Monitoring System as part of the regular monitoring provided by treatment agencies for national statistics, and published for providers and commissioners.

PHE produces quarterly reports for individual areas with detailed data about their in-treatment populations, which will include information about khat use in relevant local authorities.

Helping local commissioners plan to meet khat-related need

The Joint Strategic Needs Assessment (JSNA) is a key document drawn up by local authorities to inform coordinated action across health and social care. PHE has developed JSNA guidance and data for local public health commissioners, which includes information about khat.

Commissioners are expected to understand their local populations, and plan substance misuse treatment services to meet identified need. The very small numbers of khat users currently in treatment can provide a good indication of the local areas where khat is most used and where there may be emerging demand.

PHE will support local areas in England where there are centres of khat use and related concerns, so that local commissioners and providers can act appropriately. If possible, we will facilitate communication between areas which have khat-using populations, to share information and good practice.

We will ensure that local public health officials in those areas are aware of policy developments on khat so that they can make advance preparations in case previous khat users need help once they find it is no longer available.

PHE will shortly send out a brief guide providing advice for local health and care commissioners on the forthcoming control of khat under the Misuse of Drugs Act 1971 and implications for strategic and service responses to local populations that use the drug.

Yours sincerely

Rosanna O'Connor
Director of Alcohol & Drugs

20 November 2013

Written evidence submitted by Advisory Council on the Misuse of Drugs [DFU 02]

LETTER FROM THE COMMITTEE SPECIALIST TO PROFESSOR LES IVERSEN, CHAIR, ADVISORY COUNCIL ON THE MISUSE OF DRUGS, 13 NOVEMBER 2013

I am writing to you regarding a brief follow up session that the Home Affairs Committee is holding on New Psychoactive Substances and Khat. Whilst you have recently published a report on Khat which we will use for the inquiry, it would be helpful to get an update on your 2011 Novel Psychoactive Substances report. Please could you inform us as to:

1. Your assessment on the progress of the recommendations accepted by the Government?
2. Whether you are still supportive of all the recommendations within your novel psychoactive substances report?
3. What work the novel psychoactive substances committee has carried out in the past two years?
4. Whether you believe the Temporary Class Drug Orders are sufficient for tackling NPS'?
5. Whether you consider the prevention and education work around NPS' to be sufficient and if not, what further work could be done?
6. Any further conclusions drawn or opinions formed as to the effectiveness of the UK in tackling the problems of NPS' since your report.

It would be helpful to have a response to this letter by Wednesday 20 November.

Committee Specialist

13 November 2013

LETTER FROM PROFESSOR LES IVERSEN, CHAIR, ADVISORY COUNCIL ON THE MISUSE OF DRUGS, TO THE COMMITTEE SPECIALIST, 20 NOVEMBER 2013

I am writing in response to your letter of 13 November 2013. I attach below the ACMD's response to the Home Affairs Committee inquiry on NPS.

QUESTIONS 1

In response to the ACMD report on novel psychoactive substances (NPS) "Legal Highs" in October 2011 a number of positive actions have been taken by the Home Office. These have included careful consideration of the ACMD recommendations regarding the use of the "Medicines Act" and consumer protection legislation to control the NPS market—there has so far been only limited success in the implementation of these, however, and considerable legal obstacles make this difficult. ACMD continue to consider the "Analogue Act" in the USA as another approach, and have discussed the possibility of streamlining the Misuse of Drugs Act, 1971 (MDA) to allow the updating of the list of banned substances as new NPS emerge. This is again beset with legal difficulties.

The Home Office have established a "Forensic Early Warning System" (FEWS) which undertakes sophisticated chemical analysis and identification of new NPS as they emerge—this has proved very valuable to ACMD in alerting the Council to new and potentially dangerous substances. The Home Office have also established a "Drugs Early Warning System" (DEWS), which collects up-to-date information from a network of intelligence sources around the country—and provides a valuable picture of the prevalence of new NPS and their potential dangers. In addition, the Government has introduced the "Temporary Class Drug Order" (TCDO) as a rapid means of temporary control of new NPS that are initially judged to be significantly or potentially harmful.

The ACMD recommendation that: "The UK should be proactive in developing EU and international networks to address the issue of NPS" has been answered by the formation of the "Roma-Lyon Group"—an international network of officials and experts tackling the issues around NPS. I have attended two meetings of this group in London under the UK Chairmanship of the G8 group in April and October 2013. In addition to the member state experts, the meetings were attended by representatives from the US Drug Enforcement Agency, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC), INTERPOL and EUROPOL. This has helped to develop an international network to address NPS, which has become a global problem.

QUESTIONS 2

The ACMD are still supportive of the recommendations made in our 2011 report. We understand, however, that the US Government have encountered legal difficulties in implementing the Analogue Act in controlling NPS and are considering a revision of this—we will follow this with great interest. We are also following developments in New Zealand, subsequent to the Psychoactive Substances Act (which commenced in July 2013), to see what the implications are of their attempts to regulate the NPS market through licensing.

QUESTION 3

The ACMD Novel Psychoactive Substances Committee (formerly a Working Group) has undertaken the following since September 2011:

- *September 2011*—recommended that the psychostimulant *desoxypipradrol* be controlled under the MDA. The Home Secretary imposed an import ban in November 2011, and the drug was subsequently controlled under the MDA.
- *October 2011*—ACMD presented its report and recommendation on the NPS market and suggested ways that might be used to control it.
- *March 2012*—ACMD recommended the first use of a TCDO to control the synthetic ketamine analogue *methoxetamine* This was accepted and was followed by a more detailed report from ACMD in October 2012, leading to the control of this drug under the MDA, together with a number of related synthetic analogues.
- *October 2012*—ACMD recommended that the psychoactive metabolite of the pain reliever tramadol—*O-desmethyltramadol* be controlled under the MDA, this recommendation was accepted and implemented.
- *October 2012*—ACMD provided a further recommendation on the control of a number of *synthetic cannabinoid* substances under the MDA. These had emerged since the earlier report from ACMD on such substances in August 2009—showing how rapidly the NPS field moves. This recommendation was accepted and implemented.
- *June 2013*—ACMD recommended two TCDO's for the synthetic *benzofurans (eg 5- and 6-APB: "Benzofury")* and a novel class of LSD-like synthetic hallucinogens, the *NBOMe* compounds. Both recommendations were accepted and implemented, and fuller ACMD reports on these drugs are due to be submitted later this month.

QUESTIONS 4

ACMD has recommended TCDOs in three instances, where we had sufficient information to judge that new NPS were significantly harmful or potentially harmful. We believe that this is a useful "fire-fighting" mechanism, but it does not address the wider question of how to control this important new drug market.

QUESTION 5

There is never enough work on prevention and information on NPS, although progress has been made, for example, with the Home Office's summer communications campaign on NPS. The FRANK information site continues to be updated with information on NPS.

QUESTION 6

The UK has proved to be a leader in bringing together the international authorities responsible for controlling NPS, particularly through the G8 Roma-Lyon group. The use of "generic definitions", that is, widening the control of particular substance or group of substances to a larger number of closely related chemical analogues is a measure pioneered by the UK, and likely to be adopted elsewhere (eg in Japan). The FEWS and DEWS systems are also models of mechanisms designed to meet the challenges of the fast-moving NPS field.

Yours sincerely,

Professor Les Iversen

ACMD Chair

Written evidence submitted by Chief Constable Andy Bliss, ACPO lead on drugs [DFU 03]

When I appeared before the Committee on Tuesday 19th November 2013 I offered to share with you a short report prepared for me by Detective Inspector Trevor Williamson in relation to prescription drugs from the organised crime perspective.

This was prepared for me as Chair of the UK Drugs Threat Reduction Board. The Board at that time coordinated law enforcement activity across a range of agencies, including the police and SOCA in relation to drug related organised crime.

I attach a copy of the restricted document.[4]

In relation to evidence that medical professionals have been prosecuted; such data is not readily accessible at a national level. In the time available I have sought a view from Inspector Caryn James-Bailey, the Metropolitan Police Drugs Directorate whose role involves managing Controlled Drug Liaison Officers and who writes as follows:

[4] Not printed.

> *"In the past 18 months in the MPS we have had several investigations involving healthcare professionals where they have either sold prescription medicine and CD's under the counter to patients. Most recently we have been investigating 17 people in the London area linked to the BBC undercover investigation of pharmacies. Here we had seven pharmacies selling medication without prescriptions. We unfortunately we were only able to prosecute three due to CPS advice. We also have arrested nurses and doctors who have been prescribing for themselves or family members. The most common incident for us in the MPS, Suffolk and Dorset is the prescribing of prescription medication to be sent abroad. On one occasion a registered doctor asked for out of date stock to be left outside peoples houses for him to collect (like a charity bag) this was then being sent abroad to be sold. Our biggest concern is the over prescribing of medication by doctors which maybe diverted by their patients. However, due to the guidelines and advice of the GMC prescribing by doctors to their patients is a grey area."*

I am afraid that, in the time available, this information is not fully comprehensive but I hope that it is of some assistance to the Committee

Andy Bliss QPM, Chief Constable, Hertfordshire Constabulary
Association of Chief Police Officers lead on drugs

November 2013

Written evidence submitted by the British Medical Association [DFU 04]

Thank you for your letter dated 25 November 2013 regarding the follow up to your report, *Drugs: Breaking the Cycle*. I reply outlining our thoughts on the issues that you highlight in your letter.

The BMA's Board of Science published a report *Drugs of dependence: the role of medical professionals* in January 2013. Whilst the main focus of this report is on illicit drugs, it highlights that the use of various novel psychoactive substances is becoming increasingly prevalent in night-life setting and amongst specific populations such as the lesbian, gay, bisexual and transgender (LGBT) community.

Our report found that whilst there is only limited information on the use of psychoactive substances in the general population, they appear to be used more by younger age groups, and are increasingly being sought as an alternative to illicit substances such as ecstasy. In light of the rate at which these new substances are coming onto the market, it is not yet clear whether they will be more or less harmful than the psychoactive substances already commonly used. It is our view that the focus of the policy response to these new substances should be on understanding the risks associated with their use, as well as educating against risk behaviour.

The Board of Science is in the initial stages of a project considering the role of medical professionals with regards addiction to prescribed medications. We are planning to work collaboratively with a range of stakeholders to collate evidence on the scale of the problem, raise awareness of the harm caused by involuntary dependence to prescription medication, promote best prescribing practices, and identify policy changes necessary to improve the identification and management of patients affected by this issue. We are also exploring an e-learning module on the subject with the aim of improving doctor's knowledge and understanding in this area. I would hope that the areas you highlighted in the letter in relation to NHS systems will be reflected in this planned work.

Your letter also asked whether information collection systems in the NHS are sufficient to monitor "doctor shopping". Anecdotal evidence from our members suggests that most GP practices would be wary of prescribing drugs of addiction to anyone who is a temporary patient without first checking with their normal registered practice if possible. This would also be the case for a newly registered patient if the notes were not available. For a small number of patients, the Primary Care Trust (PCT) used to alert all practices that there was an individual going into a number of different practices asking for particular drugs. Whilst there is not a formal mechanism for doing this, individual practices raise concerns about this. We would expect local area teams to continue to do this in the new health service structure.

Regarding the monitoring of over-prescription of potentially addictive drugs, I should highlight that all prescribing activity is collected centrally and is closely monitored by Clinical Commissioning Group (CCG) prescribing advisors. This process should highlight any unusual variance in controlled drug prescription and may trigger a review.

Whilst I am not aware of any figures held about individual GPs treating patients w1th addictions, a large numbers of GPs are involved in shared care drug treatment schemes and the numbers of patients seen in these schemes will be collected by the CCGs. Unfortunately, I do not know of how these data are used and analysed. You may also find it useful to seek views from the Royal College of General Practitioners on this.

I hope this information is of use to you in your follow up inquiry.

Professor Sheila the Baroness Hollins
Chair, BMA Board of Science

December 2013

Written evidence submitted by Royal College of General Practitioners [DFU 05]

LICIT DRUGS, NOVEL PSYCHOACTIVE HIGHS AND PRESCRIPTION DRUGS

Q1. *Work which we have done specifically on new psychoactive highs*

The RCGP provides training and education for GPs and primary healthcare practitioners wishing to identify and provide interventions for individuals with problem substance misuse (drugs and alcohol).

The assessment and management of individuals taking new psychoactive drugs is considered a specialist competence over and above the generalist competencies. The RCGP Substance Misuse and Associated Health unit, through its network of national and regional champions work to raise awareness of the documented growth in the use of so called legal highs/club drugs working with officials in Public Health England and colleagues in SMMGP (Substance Misuse Management in General Practice).

Basic level awareness and the key principles in the identification and management of patients who misuse legal highs are "touched upon" in our Certificate in the Management of Drug Misuse (Part 1) and further elaborated upon in our Certificate in the Management of Drugs Part 2 course. The latter provides an opportunity for detailed learning supporting practitioners, largely GPs, to gain competencies associated with that of an intermediate practitioner or GP with a Special Interest. RCGP SMAH acknowledges that the current courses which mainly cover recovery oriented treatment of Class A drugs, safe and effective medically assisted withdrawal/detoxification, the principles of safe and effective prescribing for recovery from opiate dependency and the management of poly pharmacy means we are not able to offer in-depth training in psychoactives. We believe this would need and benefit from a dedicated educational programme targeting primary care professionals and supporting practitioners. There is currently no dedicated funding to design and deliver such a course although RCGP SMAH has access to the relevant expertise who would be able to work to develop and disseminate/market such a course.

SMAH has also discussed the option of joining forces with partners such as the primary care network SMMGP to develop targeted CPD such as webinars and/or face-to-face programmes. *The RCGP Certificate in Harm Reduction; Health, Recovery and Wellbeing for People using Drugs* contains learning materials based on a body of literature and evidence that whilst no longer being run centrally by the college is available as a resource for clinical leads and champions to work with RCGP SMAH to run a local face to face training day in a particular locality/region and individuals wishing to do so can contact the medical director, the certificate programme lead or any of our network of regional leads.

The RCGP and The Centre for Pharmacy Postgraduate Education (CPPE) has launched a new e-learning programme called **Addiction, misuse and dependency: A focus on over-the-counter (OTC) and prescribed medicines.**

The course which was co-designed by professionals from general practice and also community and specialist pharmacists has been designed to help identify groups of patients who could become dependent on medicines and recognise the treatment interventions that can be used.

More information on this course which is currently only available on the CPPE e-learning platform is available from the CPPE website and GPs are signposted to a link through the SMAH website.

A series of factsheets on the identification, assessment and management of addiction to prescribed medications and over-the-counter drugs has been under development and is currently out to consultation to peer review the content. The fact sheets are aimed at the generalist practitioner and provide useful pointers on who is at risk, red flags, best practice on safe prescribing of drugs commonly associated with iatrogenic dependency and tips on management and signposting to specialist help including patient-led agencies and organisations.

Once ready RCGP SMAH be working with the College to disseminate to the generalist.

In answer to the specific question as to whether the "NHS systems are sufficient to monitor and deter":

- "Doctor shopping."
- Over prescription of potentially addictive drugs.
- The numbers of GPs treated through their GPs as opposed to the treatment programmes run through Public Health England.

Personally I do not think there is sufficient emphasis placed on prioritising the analysis and tracking of the prescribing of drugs which are at risk of misuse for example, opiate pain killers such as tramadol and neuro-modulating drugs such as pregabalin and gabapentin.

My understanding is that current GP clinical systems do have the capacity to report on such prescribing.

Similar emphasis could be placed on the need to develop and join up systems of monitoring of such prescription and OTC medicines between GPs and community pharmacists.

RCGP SMAH would welcome greater emphasis and signposting for the treatment of addictions to prescribed medicines *through primary care*. We believe for this to happen GPs would need adequate hands on support, education and training and guidance on the identification, audit, assessment and management of such problems in the primary care setting. This would require additional resources for dedicated training, continuing development and championship.

RCGP SMAH, with appropriate levels of resource would be well placed to deliver training programmes and support a network of GP champions working in partnership with local public health centre resources, local CCG GP IM and T and medicine management leads.

In our experience training is successfully embedded when championed by local GP and medicine management expertise. In addition, primary care professionals need to be made aware of local information/ joint strategic needs assessment data on rates and levels of need and access to local education coupled with targeted support/incentives.

Dr Linda Harris FRCGP
Medical Director, RCGP Substance Misuse and Associated Health

December 2013

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