



House of Commons  
Committee of Public Accounts

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# Tackling problem drug use

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**Thirtieth Report of Session 2009–10**

*Report, together with formal minutes, oral and  
written evidence*

*Ordered by the House of Commons  
to be printed 24 March 2010*

## The Committee of Public Accounts

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The following members were also members of the committee during the parliament:

Angela Eagle MP (*Labour, Wallasey*)  
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The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at <http://www.parliament.uk/pac>. A list of Reports of the Committee in the present Session is at the back of this volume.

### Committee staff

The current staff of the Committee is Sian Woodward (Clerk), Lori Verwaerde (Senior Committee Assistant), Pam Morris and Jane Lauder (Committee Assistants) and Alex Paterson (Media Officer).

### Contacts

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## Summary

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There are 330,000 problem drug users in England. They are estimated, based on research covering the 2003–04 period, to cost society over £15 billion a year, £13.9 billion of which is due to drug-related crime. In 2008, the Government introduced a 10 year cross-departmental drug strategy to tackle problem drug use, which it defined as use of opiates (mainly heroin) and/or crack cocaine. The Home Office (the Department) has overall responsibility for the strategy, with a number of other government departments and agencies, at national, regional and local levels, sharing responsibility for its delivery. Central and local government collectively spend £1.2 billion a year to deliver the measures set out in the strategy.

Drug-related offending inflicts a trail of misery on communities and direct damage and harm to the victims of crimes. Drug treatment aims to reduce problem drug users' offending, to improve their health, and to reintegrate them into society. Problem drug users often relapse and reoffend, and around a quarter are hard core offenders for whom interventions simply do not work.

Given the public money spent on the strategy and the cost to society, we find it unacceptable that the Department has not carried out sufficient evaluation of the programme of measures in the strategy and does not know if the strategy is directly reducing the overall cost of drug-related crimes. Following a recommendation made by the National Audit Office, the Department has agreed to produce an overall framework to evaluate and report on the value for money achieved from the strategy, with initial results from late 2011.

The Department does not know how to most effectively tackle problem drug use. Residential rehabilitation may be effective for those who have failed to 'go clean' in other forms of treatment. All drug users receiving treatment require motivation to stay off drugs when back in their local communities. Support services help these people to reintegrate into their home environments and to resist temptations and pressures to return to drug use and offending. Some problem drug users receiving drug treatment while in prison quickly relapse on release. Meeting them at the prison gates and escorting them to community services and ongoing treatment may be important steps to prevent a quick relapse into drug use and reoffending.

We consider that measures to reduce problem drug use by young people have had limited impact. Preventing young people from becoming problem drug users is important in bringing down the future number of problem drug users and the associated costs to society.

On the basis of a Report by the Comptroller and Auditor General,<sup>1</sup> we took evidence from witnesses from the Home Office and the National Treatment Agency for Substance Misuse about the drug strategy, drug-related crime, drug treatment and reintegration and

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1 C&AG's Report, Session 2009–10, *Tackling problem drug use*, HC (2009–10) 297

preventing young people from becoming future generations of problem drug users.

## Conclusions and recommendations

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- 1. The Government spends £1.2 billion a year on measures aimed at tackling problem drug use, yet does not know what overall effect this spending is having.** We welcome the Department's commitment to evaluating this spending. From 2011, the Department should publish annual reports on progress against the strategy's action plan. These should set out expenditure on each measure, the outputs and outcomes delivered, and progress towards targets.
- 2. Around one-quarter of problem drug users are hard-core offenders who resist measures to reduce their offending or 'drop out' of drug treatment.** The Department's action plan should set out specific measures directly aimed at driving down offending by hard-core problem drug users for whom the Drug Interventions Programme and drug treatment does not work.
- 3. Problem drug users typically relapse several times into further drug use and offending during and after drug treatment.** The Department should introduce evidence-based measures to reduce the risk of relapse into drug use and offending. It should identify and implement support measures to enable people to reintegrate into their home environments while resisting temptations and pressures to return to drug use and offending.
- 4. Despite local authorities spending £30 million on housing support for problem drug users in 2008–09, up to 100,000 drug users in England continue to have a housing problem.** While accommodating drug users is concerning to those living nearby, evidence shows that by providing them with stable accommodation as part of their rehabilitation programme they are more likely to stop offending. However, there is currently no evidence on the effectiveness of the different measures being used to accommodate problem drug users. It is important that evidence is obtained quickly to establish which housing measures are most effective.
- 5. Some problem drug users quickly relapse into drug use and reoffending when released from prison.** In some intensive Drug Interventions Programme areas, drug key workers meet up to 80% of those prisoners who have received drug treatment in prison at the prison gate to escort them directly to community and treatment services. The strategy should evaluate the impact of this approach in reducing relapse and reoffending rates and the costs and benefits of applying this more widely.
- 6. Measures to reduce problem drug use by young people have had limited impact.** The Department should include reliable and consistent estimates of the number of new young problem drug users each year in its annual report on progress against the strategy. It should evaluate the effectiveness of measures aimed at reducing problem drug use by young people, including long-term residential care services, and should set targets to bring down the overall number of problem drug users, over time.



# 1 The Drug Strategy and drug-related crime

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1. Research covering the 2003–04 period estimated that problem drug use costs society over £15 billion a year. Of this figure, £13.9 billion is the estimated annual cost of drug related offending, consisting mainly of acquisitive crimes committed by problem drug users such as theft and burglary, to feed their drug habit.<sup>2</sup> The Department reported that up to half of acquisitive crime, primarily burglary, theft and similar crimes, is drug related.<sup>3</sup> It had defined problem drugs as opiates (mainly heroin) and crack cocaine, as most drug related crime was related to their use.<sup>4</sup> It estimated that there were around 330,000 problem drug users in England, and considered that the numbers were stable over time.<sup>5</sup> The Department told us that it did not categorise people taking powder cocaine as problem drug users as they were far less likely to commit crimes to feed their drug habit.<sup>6</sup>

2. In 2008, the Government introduced a new 10-year Drug Strategy which aimed to “reduce the harm that drugs cause to society, to communities, individuals and their families”.<sup>7</sup> It gave the Department overall responsibility for overseeing and coordinating the strategy, and a number of other government departments and agencies, at national, regional and local levels shared responsibility for delivering it.<sup>8</sup>

3. In 2009–10, total Government expenditure to deliver the measures in the strategy was £1.2 billion. Annual funding was expected to stay broadly constant for the three-year duration of the first action plan. Neither the drug strategy, nor the supporting action plan for 2008–2011, set out a framework to evaluate the actions and measures put forward, or defined the extent to which they were expected to reduce the harm from problem drug use.<sup>9</sup>

4. The Department told us that it now accepted the need for an overall framework to evaluate the £1.2 billion expenditure.<sup>10</sup> The Department also accepted that it had not carried out sufficient evaluation of the whole programme of measures to deliver the drug strategy, although it had evaluated individual areas of expenditure, including drug treatment and the Drug Interventions Programme.<sup>11</sup> While these accounted for large elements of total expenditure, there were a number of gaps in other areas of expenditure and it had not evaluated the degree of co-operation between agencies.<sup>12</sup> The Department

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2 C&AG’s Report, para 1.5

3 Q 3

4 Qq 38 and 40

5 Qq 62 and 63

6 Q 40

7 <http://drugs.homeoffice.gov.uk/drug-strategy/index.html>

8 C&AG’s Report, para 1.18

9 C&AG’s Report, para 1.11

10 Qq 1 and 60

11 Q 59

12 Q 1

had agreed to put together a framework for evaluation, with publication of the first results in late 2011–early 2012.<sup>13</sup>

5. The Department said that it did not know whether the strategy had reduced the £13.9 billion cost of crimes committed by problem drug users and it could not prove a causal link between the measures in the strategy and the levels of offending by problem drug users.<sup>14</sup> The Department had not updated its estimate of the costs of problem drug use since a 2006 publication, which estimated costs for 2003–04.<sup>15</sup>

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13 Qq 60 and 76

14 Q 27

15 Home Office, *Measuring different aspects of problem drug use: methodological developments 2006*, The economic and social costs of Class A drug use in England and Wales, 2003/04 <http://www.homeoffice.gov.uk>

## 2 Drug treatment and reintegration

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6. The National Treatment Agency (the Agency) told us that between 2004–05 and 2008–09, about 300,000 drug users had received drug treatment—on average 80,000 problem drug users had newly entered drug treatment each year and 60,000 people had left treatment.<sup>16</sup> The Agency told us that drug treatment aimed to reduce problem drug users’ offending against communities, to improve their health, and to reintegrate them into society through being able to care for their family and to earn their own living.<sup>17</sup>

7. However, a ‘hard-core’ of offenders, over one-quarter of problem drug users, showed a sharp increase in the volume of offending after entering treatment through the Drugs Intervention Programme, the Agency acknowledged.<sup>18</sup> The Department told us that it considered these to be problem drug users for whom the Programme initially, and perhaps for some time, simply had not worked.<sup>19</sup> It identified this category of problem drug using offenders as habitual offenders, and those who did not want to stop taking drugs, or receive treatment.<sup>20</sup>

8. For such problem drug users, for whom the Drug Interventions Programme and drug treatment had not reduced their offending, additional measures were necessary to protect neighbours and local communities from drug related crime.<sup>21</sup> The Department said that treatment trials had taken place in clinics in London, Brighton and Darlington for heroin users to attend each day to receive an injection of diamorphine.<sup>22</sup> This treatment may have helped protect local communities by reducing drug users’ offending, although the treatment had also maintained their dependence on heroin. Evaluation indicated that this could be a cost-effective treatment for those heroin users who had not responded to other forms of treatment.<sup>23</sup>

9. The Agency stated that the initial treatment for heroin users was normally methadone on prescription, in line with guidance from the National Institute for Health and Clinical Excellence.<sup>24</sup> It told us that while other types of treatment included psychosocial interventions and behavioural therapy, the treatment system was not as good at delivering these types of treatments.<sup>25</sup>

10. The Department reported that problem drug users often lead chaotic lives, in an environment with other drug users, drug dealing and wider criminality. They were among the most deprived people in society, claiming benefits, in and out of prison, and not in

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16 Qq 8 and 68

17 Qq 6 and 32

18 Qq 4 and 52

19 Q 52

20 Qq 4 and 52

21 Q 46

22 Pharmaceutical heroin

23 Q 35

24 Qq 21, 50 and 72

25 Q 73

work.<sup>26</sup> The Department reported that evidence shows that if it were possible to stabilise the housing situation of problem drug users as part of their rehabilitation treatment they were more likely to stop offending and to stay off drugs. It acknowledged, however, that in many areas drug users were going to be competing with lots of other people for accommodation.<sup>27</sup> At present there was no research on the effectiveness of the measures being used to place problem drug users in appropriate accommodation.<sup>28</sup>

11. The number of deaths among problem drug users has increased over the last five years to 1,620 in 2008–09. However, the Agency estimated there would have been 2,500 drug-related deaths in that year if drug treatment had not been increased over this time.<sup>29</sup>

12. Guidance from the National Institute for Health and Clinical Excellence stated that residential rehabilitation could be a better treatment option for problem drug users who had failed a number of times in other forms of treatment.<sup>30</sup> Taking problem drug users out of the environment in which they had begun drug use could help them overcome dependency until they were sufficiently strongly motivated to stay drug free when reintegrating into their local communities.<sup>31</sup> Bringing problem drug users to a secure place where they could receive long-term treatment could be a better and cost-effective course of action.<sup>32</sup> It could enable the problem drug user to get a better outcome, thereby reducing their reoffending on return from treatment, and the resultant misery to their communities.<sup>33</sup>

13. The Agency told us of a new type of residential facility within communities which were connected to local treatment services. Residential facilities could provide a ready route back into local support and to the drug user's family. It referred to examples in Warrington, Liverpool and Luton.<sup>34</sup> The Agency considered that such facilities could help problem drug users return to the community and re-establish their lives.<sup>35</sup>

14. The Department said that problem drug users received drug treatment while in prison and that there had also been efforts to reduce the supply of drugs in prison.<sup>36</sup> However, the Department reported that some prisoners quickly relapsed into further drug use on release shortly after, simply by walking from the prison gates to the nearest crack house, for instance.<sup>37</sup>

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26 Qq 4, 11 and 41

27 Q 17

28 C&AG's Report, para 2.19

29 Qq 23–25

30 Q 21

31 Q 53

32 Q 21

33 Q 5

34 Q 53

35 Q 16

36 Q 7

37 Q 75

15. The Department aimed to tackle this problem through its Drugs Interventions Programme, which involved a 'meet at the gate' process for released prisoners. It told us that in some intensive Drug Interventions Programme areas, about 80% of such prisoners were met at the prison gates by drug key workers and taken to assessment and treatment services, to prevent them going straight to drug dealers. The Department told us that it was working with the Ministry of Justice to develop guidance for staff in prisons and in the community to improve continuity of services on release from prison.<sup>38</sup>

### 3 Preventing young people from becoming problem drug users

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16. Measures to reduce problem drug use by young people have had limited impact. The 2008 strategy reported that the prevalence of Class A drug use by young people has stayed relatively unchanged since the first strategy in 1998.<sup>39</sup> The 2002 drug strategy included a target to reduce the use of Class A drugs and the frequent use of illicit drugs by young people by 2008 and, in particular, by the most vulnerable groups. It put a stronger focus on education, prevention and treatment to tackle problem drug use by young people.<sup>40</sup>

17. The Agency told us there were indications that the number of under 24 year olds coming into treatment for heroin or crack cocaine had started to reduce. However, it acknowledged that it would not know the picture for certain until the University of Glasgow, which had researched prevalence, had reported again.<sup>41</sup> The Department reported that overall drug use by young people had declined over the last ten years, and that drug related deaths among young people were very rare.<sup>42</sup>

18. Most young problem drug users found it very difficult to keep off drugs following drug treatment, due to a culture of drug use and crime among the people they knew.<sup>43</sup> We were told that for young people, peer pressure from friends was a key factor.<sup>44</sup> The Department reported that drug use was often passed from generation to generation, requiring a big emphasis on treating families.<sup>45</sup>

19. Middlegate Lodge in Lincolnshire had offered long-term, one-to-one, residential treatment for young people. However, the Children's Partnership in Lincolnshire had closed Middlegate Lodge, in line with the strategy of the Department for Children, Schools and Families to provide services for young people in their own communities.<sup>46</sup>

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39 HM Government, *Drugs: protecting families and communities: The 2008 Drug Strategy*, page 22 <http://drugs.homeoffice.gov.uk/>

40 Home Office, *Updated Drug Strategy 2002*, <http://drugs.homeoffice.gov.uk/>

41 Q 66

42 Q 56

43 Q 53

44 Q 53

45 Q 45

46 Qq 12–16

# Formal Minutes

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**Wednesday 24 March 2010**

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon  
Angela Browning  
Mr Paul Burstow  
Keith Hill

Mr Austin Mitchell  
Dr John Pugh  
Rt Hon Don Touhig

Draft Report (*Tackling problem drug use*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 19 read and agreed to.

Conclusions and recommendations 1 to 6 read and agreed to.

*Resolved*, That the Report be the Thirtieth 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.

Written evidence was ordered to be reported to the House for printing with the Report.

[The Committee adjourned.]

## Witnesses

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**Wednesday 10 March 2010**

*Page*

**Sir David Normington KCB**, Permanent Secretary and **Ms Mandie Campbell**,  
Director, Drugs, Alcohol and Partnerships Directorate, Home Office, **Mr Paul**  
**Hayes**, Chief Executive, National Treatment Agency for Substance Misuse

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## List of Reports from the Committee during the current Parliament

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First Report	A second progress update on the administration of the Single Payments Scheme by the Rural Payments Agency	HC 98
Second Report	HM Revenue and Customs: Improving the Processing and Collection of Tax: Income Tax, Corporation Tax, Stamp Duty Land Tax and Tax Credits	HC 97
Third Report	Financial Management in the Foreign and Commonwealth Office	HC 164
Fourth Report	Highways Agency: Contracting for Highways Maintenance	HC 188
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Ninth Report	The procurement of legal aid in England and Wales by the Legal Services Commission	HC 322
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Eighteenth Report	Vehicle and Operator Services Agency: Enforcement of regulations on commercial vehicles	HC 284
Nineteenth Report	Improving Dementia Services in England—an Interim Report	HC 321
Twentieth Report	Department for Work and Pensions: Management of Benefit Overpayment Debt	HC 444
Twenty-first Report	The Decent Homes Programme	HC 350
Twenty-second Report	The sale of the Government's interest in British Energy	HC 356
Twenty-third Report	Ministry of Defence: Major Projects Report 2009	HC 338
Twenty-fourth Report	HM Revenue and Customs: Handling telephone enquiries	HC 389
Twenty-sixth Report	Progress in improving stroke care	HC 405
Twenty-seventh Report	Ministry of Defence: Treating injury and illness arising on military operations	HC 427
Twenty-eighth Report	Preparations for the London 2012 Olympic and Paralympic Games	HC 443
Twenty-ninth Report	Scrutiny of value for money at the BBC	HC 519
Thirtieth Report	Tackling problem drug use	HC 456

# Oral evidence

## Taken before the Committee of Public Accounts on Wednesday 10 March 2010

Members present:

Mr Edward Leigh, in the Chair

Mr Ian Davidson  
Nigel Griffiths

Keith Hill  
Mr Austin Mitchell

**Mr Amyas Morse**, Comptroller and Auditor General, **Mr Rob Prideaux**, Director, Parliamentary Relations and **Ms Aileen Murphie**, Director, National Audit Office, gave evidence.

**Mr Marius Gallaher**, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL TACKLING PROBLEM DRUG USE (HC 297)

*Witnesses:* **Sir David Normington KCB**, Permanent Secretary, and **Ms Mandie Campbell**, Director, Drugs, Alcohol and Partnerships Directorate, Home Office; and **Mr Paul Hayes**, Chief Executive, National Treatment Agency for Substance Misuse, gave evidence.

**Q1 Chair:** Good afternoon. As I said to the NAO earlier, 400 down; four more to go, as far as I am concerned. We are in the final leg now and today we are looking at an important subject, tackling problem drug use. We welcome back to our Committee Sir David Normington, who is Permanent Secretary at the Home Office, who is a veteran of this Committee, Mandie Campbell, who is Director General of the Drugs, Alcohol and Partnerships Directorate at the Home Office, and also Paul Hayes, who is the Chief Executive of the National Treatment Agency for Substance Misuse. You are all very welcome. This is obviously a very big programme. The Government spends £1.2 billion a year tackling the problems or hoping to tackle the problems posed by an estimated 330,000 problem drug users in England. Sir David, if I may start with you and refer you to paragraph eight of the Comptroller's Report on page five, it starts off by saying, "Neither the current Strategy, nor the supporting action plan for 2008–11, set out an overall framework for evaluating and reporting on the degree to which the Strategy is achieving the intended outcomes . . ." Sir David, how are you going to evaluate and measure your success?

**Sir David Normington:** I think we have concentrated on evaluating so far the main areas of spend. There are a number of gaps in that and we have not had an overall framework of evaluation. We accept that in the new Strategy that is what we need to have, but I would not want people to think that we have not evaluated our main areas of spend. We evaluated, for instance, the huge spending that there has been on treatment and there is a very good return on investment for every pound. We estimate—and this is well validated—a £2.50 return for every pound spent on treatment in terms of benefit in cutting crime and other harms. We have also evaluated our other big element of spend which is the Drug Interventions Programme, which is the thing that

ensures that people who come into the criminal justice system get referred to treatment and take it up. Both those, which are the main areas of spend, are showing very good returns. Although we have not evaluated the whole programme and we accept that, we have evaluated the main areas of spending.

**Q2 Chair:** Obviously to get proper evaluation we need accurate figures. I should have asked the NAO to start this hearing by issuing a correction to the Report.

**Mr Morse:** We have given all the members of the Committee a sheet setting out the corrected information. This was information very helpfully supplied by the Home Office and I am afraid we had understood it otherwise than we should have done. I know we have been in discussion with you about it, so that is how that misunderstanding arose. The correction is set forth in that sheet and I have already discussed it with the Committee.

**Sir David Normington:** It is figure six on page 26.

**Q3 Chair:** Thank you for that. I want to ask you now, Sir David, about the very important problem caused by crime. If we look at 1.5, "The estimated annual costs to society associated with problem drug use are £15.3 billion . . . Of this figure . . ."—a staggering, in my view—"£13.9 billion is the estimated annual cost of drug-related offending (mainly acquisitive crimes . . .)". This is about protecting the public and many people feel quite strongly about this. We can talk about how to help these people in a moment, but some of these people in order to feed their drug habit may be knocking off as many as 30 houses a week and they are leaving a trail of misery and destruction, particularly with elderly people. A lot of us have had our houses burgled. We know it is just absolutely humiliating and horrible to come home to, so this is a terrible problem. I could ask you what you are going to do

about it but let us just start by getting you to comment on this and then we can perhaps pursue it further during the hearing.

**Sir David Normington:** If you take the category of acquisitive crime, which is basically burglary, theft and similar crimes, about 30% to 50%—and it is hard to estimate—is drug-related, ie, people doing it because they need the money to feed their drug habit. That is why it is so important that, when people get caught, get arrested and get to the police station, one of the things that happens now which did not happen before is they are tested for drugs.<sup>1</sup> They are assessed on what their need is for treatment and then they are put under quite a lot of pressure, although it is not absolutely compulsory, to take up that treatment. It is why we focus so much of the resource on first of all really stepping up the amount of treatment that is available and also making sure that people who come into contact with the criminal justice system take up that treatment. That is where we know it works. We know that the Drug Interventions Programme actually requires people who come into the police station and get drug tested to get assessed. If they go into treatment, it cuts their offending overall by 26%. That is a proven figure. The basic thing is to provide really good treatment, to make sure it is available very fast, to keep them in it and to make sure that when you are in the criminal justice system you are obliged to undergo treatment. That is the best way. There are lots of other things I am sure we will talk about but that is the core of it.

**Q4 Chair:** Listening to that, it sounds fine but why do we read then in paragraph 2.3, which we can find on page 22 of the Report, that over a quarter of problem drug users showed a sharp increase in offending while on the Drug Interventions Programme? We have to be absolutely fair. Around half showed a decline in offending but you obviously have this hard core who are leaving a trail of misery and destruction after them. Despite your no doubt good efforts—it is costing a lot of money—a quarter of problem drug users showed a sharp increase in offending.

**Sir David Normington:** These are the chaotic people who first of all often refuse to take treatment and then, if they go into treatment, drop out of it. We are dealing with a really tough group here. It would be amazing if everybody who went into this programme actually came out of it treated. You are really talking here about the prolific offenders. What is important about this group is that they are picked up by things like the Prolific Offenders Programme which gives them intensive attention and basically eventually they will be got into treatment and hopefully they will be got off drugs; but you may have to have several attempts with them because we are dealing with, as the Report shows and as you are describing, a very difficult group, a very chaotic group, people who are not used to being in any kind of pattern of

employment and so on. We are talking about that kind of person so they will be people who have got into the habit of committing crimes.

**Q5 Chair:** Speaking as an ordinary member of the public would speak, why can we not bring these people into secure accommodation—prison, whatever you like to call it—give them a proper course, try and get them off drugs and keep them off drugs? We have another Report which I have just been briefed on, which is going to come to the Committee soon, on how we are dealing with people who spend less than a year in prison. Ever since I was working in the criminal Bar, I have long been convinced that short prison sentences simply do not work. People do not have enough time to stay in a secure place for long enough. They do not get put on courses and all these other problems. It seems that too many of these people are coming in for short terms, being spat out by the system and then reoffending and causing misery in their wake. Better action is to get a grip on them and bring them into a secure place where they can receive long-term treatment.

**Sir David Normington:** That does happen. Paul Hayes may want to just add to this. The one thing in that Report today, which I have only briefly looked at as it is published today, is that it actually does commend the work that has been done on drugs. We are getting much better in prisons at keeping people in drug treatment and then meeting them at the prison gates and continuing them in treatment as they come out of prison, which is essential. Of course not everybody goes into prison and you may want to say something about residential and secure facilities.

**Q6 Chair:** Mr Hayes, you are obviously the expert in this. Would you like to comment now?

**Mr Hayes:** The first thing to say is the Drug Interventions Programme is not a sentence of the court. It exists to operate before people are sentenced so that we have every opportunity to get people in contact with treatment as soon as they are arrested and throughout their passage through the criminal justice system. The people who have been through DIP will eventually go to court. They will be sentenced. They will be sentenced to drug rehabilitation requirements, to a period in prison, to other forms of community supervision where there will be other opportunities to get them into treatment. The Drug Interventions Programme is the first stab we have at trying to reach them but not the only one. Exactly as has been said, what we know is if we get people into treatment—I emphasise “into”, not “through”—as soon as they are in contact with treatment, their offending reduces very significantly. That will be sustained while they maintain contact with treatment. Clearly, there are some people who will either not make it to treatment as part of DIP, because it is largely a voluntary scheme; there will be other people who will drop out early but, across the whole population in treatment not all of whom have arrived via DIP, we know if we

<sup>1</sup> *Note by witness:* The testing for Class A drugs (heroin/cocaine and crack cocaine) takes place in 173 police custody suites around the country.

get them into treatment the overall offending by that cohort will be halved. That is a very significant benefit to the community.

**Q7 Chair:** Sir David, you can convince us, can you, that our prisons are not awash with drugs?

**Sir David Normington:** I can convince you that there is quite a lot of evidence that drug use in prison is very sharply down. I cannot say to you that there are no drugs in prison of course. There have been huge efforts to reduce the supply of drugs in prison. I think the figures show that drug use in prison—it is very difficult to measure of course—is down from 27% to 7%, but that is still too many.<sup>2</sup>

**Q8 Chair:** Mr Hayes, if we look at figure five, we see that we spent £2.8 billion of funding treating drug users in the five years 2004–05 to 2008–09, so we know that more people are being treated but what I want to get from you is: what have we to show for all this expenditure in terms of fewer people relapsing and more people being less dependent?

**Mr Hayes:** Throughout that time, about 300,000 people have been in and out of the treatment system. 125,000 of them have left and have not only not relapsed and come back to treatment but also have not shown up in the criminal justice system. That is a very significant number of people who appear at the moment to have overcome their addiction and are actually beginning to make a fresh life for themselves. Drug treatment does not only deliver that. It delivers benefit in three dimensions. First of all, crime, as we have been talking about, very significant reductions in crime, and that is what has justified the huge increase in investment in drug treatment we have seen since 2001. That has been an explicit policy thrust, to invest health resources in drug treatment in order to reduce crime but also by doing that we improve public health and individuals' health. If we get people into treatment, we know within six months from the monitoring that we do, from something called the Treatment Outcomes Profile recently written up in *The Lancet*, so a highly respected medical journal, that two-thirds of heroin and crack users are either abstinent or have significantly reduced their use six months in. Similarly, readers of the *British Medical Journal* will have seen in the most recent edition another study that we have done based on treatment outcomes profiling into powder cocaine users showing 60% of them are abstinent and another 10% are well on the way to abstinence. In addition, we can also demonstrate very significant public health benefits. Once we started investing significantly in drug treatment, what appeared to be the inexorable rise in drug-related deaths that had been taking place between 1993 and 2001 abated and that has largely been flat lining since then. We also, because of the investment in drug treatment, have the lowest rate of HIV infection amongst drug users in Western Europe and dramatically lower than the figures in

Eastern Europe. Finally, around individual social functioning, one of the major drivers of family breakdown, worklessness, fecklessness, poor parenting, is drug addiction. We know, if we can get parents into drug treatment, their children will be at much less risk. They are more likely to be in work. They are more likely to be socially connected and therefore society gets a very significant return on investment.

**Q9 Chair:** All that we accept and your answer is very fluent, but when I was talking to the NAO they reminded me—it is in this figure here—you have 195,000 people receiving treatment but they tell me that only 9,300 are leaving free of dependency every year, so there are two figures, 195,000 and 9,300. Whatever you say, however fluent your answer, it does not strike me as if you are getting a lot of people off drugs.

**Mr Hayes:** Two things there. We have to be very careful with the terminology as we have already discussed before the meeting began. Of people in treatment, it is actually 25,000 left last year free of dependency. Of problem drug users, it is 15,000. The 9,000 is a sub-category of that.

**Q10 Chair:** Let us get these figures right. Aileen, explain this to us, will you?

**Ms Murphie:** 9,300 people left free of dependency on the drug that they presented with.

**Q11 Chair:** Is that not a reasonable figure?

**Mr Hayes:** No, because another 6,000 left free of any illegal drug use.

**Ms Murphie:** Plus 5,700 left free of any illegal drug use, which would include cannabis.

**Mr Hayes:** Hence 15,000 of the problem drug users who left free of dependency, which must include those who are not using anything at all. The reason for that is dead simple really. They are addicted. If they were not addicted, then there would not be a problem but addiction is a chronic, relapsing condition. It takes years to get better. You do not do it in one fell swoop. It is characterised by a number of failed attempts to get better, false dawns, and it would be like that for you and me. The problem drug using population is not actually like the rest of the population. It is a very distinct subset of the rest of the population. About 40% of people in our society use drugs at some stage in their life. They are much the same as the rest of us. They will tend to be rather more male than the rest of us and more inclined to take risks than the rest of us. They will be across all socio-economic groups and they live in all parts of the country. Only about 20% will use drugs at all regularly. Most of those 40% will stop once or twice. 20% will use drugs on a more or less regular basis, the vast majority of whom will be using cannabis and only cannabis. Regular class A use is about 3% of the population. The numbers who use heroin and crack, the people we are talking about here today, are so small that we cannot actually count them through the British Crime Survey that we normally use. We have to use special counting methods to identify them. That is where the 320,000 comes from. They

<sup>2</sup> *Note by witness:* The random mandatory drug testing (rMDT) programme which is the best measure of drug misuse in prisons has dropped from 24.4% in 1996–97 to 7% in 2008–09.

are very different to the rest of the drug using population. They are not drug users who were unlucky and became addicted. They will be concentrated in our poorest communities. They will be the people who have been in the care system. They will have been in and out of prison. They will have poor mental health. They will have been failed by the education system. They are people who would have a multiplicity of problems in their lives even if they had never stumbled across heroin or crack. If you can imagine how difficult it would be for you or me to overcome addiction, for that population it is much more difficult. On average, it takes four years, a number of goes round the roundabout and a number of false dawns but, in the end, most of them will either get better or they will be held stable, causing fewer problems to themselves and, through crime and public health risks, far fewer problems to the rest of us.

**Q12 Chair:** When it is quite obvious that the way to deal with this is to get these people into long-term residential care, one-to-one, why have you closed the wonderful Middlegate Lodge in my constituency which had a national reputation for getting in the most difficult young people, treating them one-to-one at great cost, I agree, but better to treat them there, in rural Lincolnshire for several weeks, get them off drugs and give them a life, rather than closing this centre down because it costs money. Why did you do it?

**Mr Hayes:** I did not, is the bottom line.

**Q13 Chair:** Your regional director?

**Mr Hayes:** No, not at all. There are a number of factors there. First off, you began by saying the solution is to get people into residential rehab. Are we talking about adult rehab or young people's rehab? If we are talking about Middlegate and the young people's system, it is very different. This Report does not touch on the young people's system at all. Before we can move on to Middlegate, perhaps we need to sketch in what happens with the young people's system.

**Q14 Chair:** I want to get on to Middlegate or my colleagues will get angry.

**Mr Hayes:** I recognise that you want me to be brief but if you bring issues that are not within the Report to the table then what do you expect? There are 25,000 young people receiving services because of their drug or alcohol use. 24,000 of them are not addicted. They are young people who are truanting, offending, where drug or alcohol misuse plays a part in that behaviour, but is not driving it. There is a very small number of young people who do have significant problems and a tiny fraction of them will need to be looked after in residential provision. This is the responsibility of the Department for Children, Schools and Families. Those services are commissioned not by the drug action teams and the partnerships that they represent. They are commissioned by children's partnerships locally and they are commissioned underneath a strategy that the Department for Children, Schools and Families

has for children with difficulties. Very few children who are addicted have only either an alcohol or a drug addiction problem. They tend to have a multiplicity of problems. DCSF and Children's Commissioners are looking to build a web of services around those individuals to deal with their challenging behaviour, their mental health problems, their offending, not just their drug or alcohol misuse issues. DCSF also says that children are dealt with much better within their own community.

**Q15 Chair:** You do not really believe that, do you?

**Mr Hayes:** I believe every word of it.

**Q16 Chair:** You do not believe that full-time, one-to-one residential care for the really difficult young people is the best thing to do?

**Mr Hayes:** What I believe is that very few of them actually need residential services, number one. Number two, those residential services can be provided nearer their home. One of the things we know about adult residential services as well as young people's residential services is it is the eventual return to the community that matters, particularly if you are 15 or 16. You need to be as near your family as possible. You need to be as near your mates as possible. You need to be able to re-establish your life once you have gone through a period of crisis. The Government have said that is their policy for troubled youngsters. One of the troubles that kids who have difficulties have is around alcohol and drug misuse. One of the problems we have is that as a society we believe that a drug problem trumps everything else and exists in isolation. What Middlegate sees and you are putting forward as its unique selling point, that it is focused on the drug problem and is located in the middle of Lincolnshire, is actually what the DCSF strategy would see as being what is wrong with it. It is too focused on drugs and alcohol and not enough on the rest of the problems and it is not in the young person's own community.

**Q17 Chair:** One last question to you, Sir David. Clearly, it helps these people to be housed. We are spending a lot of money, £30 million, on housing. We all accept that but let us be real. We all know that local people do not want these houses next to them so what are you going to do about it? How are you resolving this problem? I know it is an unanswerable question.

**Sir David Normington:** It is really. I cannot resolve that conflict of priorities. For any local authority that has all kinds of demands for its housing, in many areas drug users are going to be competing with lots of other cases which actually the public would think, probably rightly, were more deserving. What the £30 million represents is the amount of money that local authorities agree to spend on that. They are not compelled to spend that. They get a budget to support vulnerable people from the Department for Communities and Local Government and they actually spend £30 million of that on helping drug users. This can be, as you well

know, very, very controversial. On the other hand, we know from the evidence that if you can stabilise the housing situation of problem drug users they are more likely to stop offending and to stay off drugs. Of course I cannot resolve that. Locally, the conflict is enormous. What is true is that if you do not do this and these people become homeless or they move from place to place, they can create a lot of problems for the law abiding community as well. You can explain it to the law abiding but it is tough.

**Chair:** The hon Member for a less remote part of Lincolnshire, Mr Austin Mitchell.

**Q18 Mr Mitchell:** I am not commenting on whether Lincolnshire would drive anybody to drug use or to drug rehabilitation but I was interested in Mr Hayes's evidence and the impressive manner in which it was delivered. Two questions arose from it, to my mind. If it is not argued or claimed that residential care and one-to-one care is a solution for these people, why are celebs and the better off prepared to pay so much to go into The Priory and other places for exactly that care?

**Mr Hayes:** That is a very good question. I think that is one of the reasons why there is a sense that anything that does not mimic that must be sub-optimal. I do not know the quality of care those individuals receive. What I do know is they are very often back on the front pages shortly after, after it has not worked.

**Q19 Mr Mitchell:** You do not have the statistic, do you?

**Mr Hayes:** What we do know is that residential rehab is a very effective treatment.

**Q20 Mr Mitchell:** It is also very expensive.

**Mr Hayes:** It is. It is effective for the right people. It is cost effective if you get the right people there.

**Q21 Mr Mitchell:** What I am asking is: are we cutting down on that because of the cost—in other words, to save money—or because it is not an effective treatment?

**Mr Hayes:** Neither. What we are doing is trying to get the balance right. Every area is expected to draw up a plan each year for how it spends the money it is allocated for drug treatment. Three years ago, local areas were spending £50 million a year on residential rehab and residential detox. In 2009-10 they are planning to spend £80 million, so there is no way that the money has actually been cut back. What we have seen is a very significant improvement in the provision and increasingly the quality of community-based treatment. The National Institute for Clinical Excellence, who determine these things, say that the front line for heroin dependency is methadone delivered in the community. They say that, for some people who have particular problems or who have failed a number of times in other forms of treatment, residential rehabilitation then becomes the better option.

**Q22 Mr Mitchell:** You are saying that they believe in this methadone treatment in such a way as to indicate that you do not quite believe it?

**Mr Hayes:** No. Far from it. I am merely saying that it is their job to read the evidence and conclude what is the best intervention. I have read the same evidence and surprisingly I have come to exactly the same conclusion.

**Q23 Mr Mitchell:** You said the number of drug-related deaths has gone down and is now flat lining. Our brief—I will cite page eight for the NAO—refers to two figures in the Report, figure six and figure five, which do not say the same thing. It says the number of deaths has increased. Who is right?

**Ms Murphie:** The number of deaths has increased from 2004-05 to 2008-09 but if you take a longer timescale what Paul is saying is that it shows a decline.

**Q24 Mr Mitchell:** You are wrong?

**Mr Hayes:** No. I am absolutely right.

**Q25 Chair:** Are you ever wrong?

**Mr Hayes:** It has been known. You would be asking questions if I was wrong. You would want to know what I was doing for a living, would you not? If you start back in 1993, there were 787 drug-related deaths. It peaked in 2001 at 1,697. We did suggest to the NAO that they started the graph at 2001 but they would not have that. Since then, what we had for the first couple of years was a decline. It has gradually been edging up but it still has not got back to the 2001 figure. What we believe has happened is, since treatment has expanded, the international literature again identifies access to methadone treatment as the most effective way to restrict the number of drug-related deaths that are taking place. Since we began to expand treatment, the trajectory has very much been reversed and our view is that if we had not expanded treatment in 2001 there would now be something like 2,500 drug-related, overdose deaths every year rather than the 1,600 that there are.

**Q26 Mr Mitchell:** We are spending £1.2 billion a year tackling drug use. Problem drug use is estimated to cost £15.3 billion. £13.9 billion of that is the estimated cost of drug-related crime. Is there any way of indicating that, as the expenditure has gone up, drug-related crime has gone down?

**Sir David Normington:** It is undoubtedly the case that acquisitive crime, which is burglary and theft mainly and other similar things like shoplifting and so on—

**Q27 Mr Mitchell:** To pay for a drug habit?

**Sir David Normington:** Yes, to pay for a drug habit. That has declined by 32% since 2003 when we introduced the Drug Interventions Programme, which required people to be tested when they went into the criminal justice system. In parallel, the amount of treatment was increased. I cannot prove an absolute causal link but it is a fair bet that since our interventions have reduced offending and

reoffending for problem drug users that has been a contributory factor to the decline in acquisitive crime.

**Q28 Mr Mitchell:** Does that produce a return?

**Sir David Normington:** Yes, there is a good return.

**Q29 Mr Mitchell:** Can we turn to figure six on page 26, which has been slightly revised in terms of essentially problem drug users? Is it possible to produce those figures on a more local basis? We have instanced Lincolnshire and, in my case, North East Lincolnshire. Is it possible to give us the figures on a local authority basis?

**Mr Hayes:** It is possible to reduce it down to a partnership basis, which would mostly be a first tier local authority.

**Q30 Mr Mitchell:** Could you do that for my area?

**Mr Hayes:** Yes. We can do that for everything other than the last three.

**Q31 Mr Mitchell:** Thank you. I would like that. There is a category here: the number of problem drug users leaving treatment free of dependency, which is defined in a footnote, and the number of drug users leaving treatment free from illegal drug use. Is that also weaned from any drug dependency? Are these people on methadone?

**Mr Hayes:** No. People who are on methadone would be regarded as still being in treatment. They have completed their treatment; they are not on methadone; they are not receiving any sort of counselling interventions at all. They have left the treatment system.

**Q32 Mr Mitchell:** You are being successful there?

**Mr Hayes:** We would argue we are being successful most of the time. It is important that we recognise, as I said earlier, one of the things that the public find difficult to grasp is that the real benefit for them from treatment flows not from people leaving treatment having overcome addiction—although that is clearly what we want to do with everybody—the real benefit flows from people being held stable in treatment when their health improves, the risks they pose to others through crime and public health reduces and their ability to care for their children and earn their own living improves. It is not just the people who leave treatment who are actually delivering the value for money; it is the people who are being held stable in treatment.

**Q33 Mr Mitchell:** Do you regard methadone treatment as successful?

**Mr Hayes:** I regard methadone treatment as successful.

**Q34 Mr Mitchell:** Other people have argued that before 1970, I think it was, people used to be issued with heroin and that was the most successful way of dealing with the issue. Can you just tell us your views on that, because I get very confused by this debate?

**Mr Hayes:** There is a trial. The first thing is we still

do that. There is still a small number of people in this country who are prescribed diamorphine, which is pharmaceutical heroin, and have been since the 1920s.

**Q35 Mr Mitchell:** You say “small”. How many?

**Mr Hayes:** A few hundred. There have been trials in London, Brighton and Darlington of set clinics where people will attend every day to receive an injection of diamorphine. What that has demonstrated is that if you get the right people into that treatment—i.e., the people who have not benefited from other forms of treatment—then it can be cost-effective, but the number of people who will not benefit either from methadone or residential rehabilitation who need that treatment is actually very, very small indeed.

**Q36 Mr Mitchell:** I am glad to hear that. Just one final question on that table. The number of people leaving treatment who do not need treatment any longer and the number of people free from illegal drug use is rising and that is good. The number of people going through it is also rising. Is there any social breakdown of the social class or occupational class of these people? One gets an image from the media that Notting Hill is thronging with people snorting cocaine and that the pop world is full of people also snorting cocaine and doing it comparatively immune from arrest and trial. For those people who have to come to treatment, who are convicted of a crime or whatever, is this a culture of despair as opposed to an upper class culture of entertainment?

**Sir David Normington:** Those people who are using powder cocaine would not be in that table I think I am right in saying.

**Q37 Mr Mitchell:** Why?

**Sir David Normington:** Because this is a table of what is in my view slightly unfortunately called “problem drug use”.

**Q38 Mr Mitchell:** If I am posh I do not get in there?

**Sir David Normington:** This Report is about opiates. That is mainly heroin and crack cocaine. It is not about powder cocaine, though the Drug Strategy overall is about all drugs, including powder cocaine. What you are talking about is people who snort powder cocaine. Some of the media stories about the type of people who do it are very prevalent at the moment. There is some evidence of a slight increase in people using powder cocaine. They are over quite a wide range of social classes but, of course, the people who get into the press tend to be the people you describe.

**Q39 Mr Mitchell:** They do not come into contact with this treatment unless they commit an offence.

**Sir David Normington:** All we are talking about is they are not in that table. Drug treatment is available for them increasingly and, of course, if they go into the criminal justice system they are tested and if they

are tested positive then they are assessed and hopefully directed to treatment. It is just that they are not in those figures.

**Q40 Mr Mitchell:** Are you saying that powder cocaine or whatever does not create dependency in the same way?

**Sir David Normington:** It can do, yes.

**Mr Hayes:** It absolutely does. It creates dependency, it causes ill health and quite a few deaths. There is no way that it is not dangerous, but there is a different demographic around powder cocaine and heroin and crack. As I said earlier, the people who will tend to use heroin and crack are the people who struggle with life most. They live in our poorest and most disadvantaged communities. That is where they congregate. It is also where it is easiest to get hold of heroin and crack. That does not necessarily cause all their problems, but what it does do is make it much more difficult for them to resolve the other problems in their lives. A cycle of despair, as you called it earlier, I think is an entirely legitimate way of describing it.

**Sir David Normington:** If I may add one thing, most of the crime that is drug related, which is described in this Report, is related to heroin and crack cocaine and not as much to powder cocaine. That is why this is concentrating on that because the costs to society are very substantially in relation to crime. People who take powder cocaine are indeed committing a crime themselves but they do not generally to any degree feed their habit through crime.

**Q41 Mr Mitchell:** I am interested to hear that. I spent 10 days in a council flat in Hull and it was quite horrifying. There is a culture of despair of kids—and they were kids—injecting themselves in the stairwells at night, ringing every doorbell to get in, including mine. My reply was less than polite. They are leaving needles all over the place. It was quite horrible. Do you have figures on the social background of the 42,000 people who have gone through?

**Sir David Normington:** We do not. The sort of people you are describing are people who are in the most deprived communities. They are the most deprived people in society. Most of them are on benefit. They are not in work. They are the people completely at the bottom of the heap. We do not have a socio-economic breakdown of them.

**Q42 Mr Mitchell:** As long as they do not commit a crime, you will never catch up with them.

**Mr Hayes:** No, that is not true. 75% of them access treatment voluntarily. Only 25% access treatment through the criminal justice system.

**Mr Mitchell:** I am sorry, the questioning seems to have become addictive for me. I have overrun my time.

**Q43 Mr Davidson:** Can I just come back to this question of the profile of users? As I understand it, a high percentage—I am not quite sure which percentage—of the people who are taking these substances are basically poor, badly educated, in a culture of despair and all the rest of it, but there are

more people in those circumstances than end up as drug users. I am not clear what the determinants are that decide whether or not somebody goes down one route as distinct from another. Is there something that we can learn from that in terms of prevention?

**Mr Hayes:** I think it is a very astute question and I wish I knew the answer to it. We could ask similar questions around offending. We know that offending is associated with all those demographic factors. We also know that most poor people, most working class people, do not offend. It is a similar issue.

**Q44 Mr Davidson:** I am just interested in where this takes us forward, in a sense. We know, in terms of profiling, most senior civil servants are public school and Oxbridge but not everybody from public school and Oxbridge ends up being a senior civil servant and vice versa. I understand you are a grammar school boy, yes, I know that, but in terms of your colleagues. It is just a question of whether or not in terms of prevention there is anything you have come across that provides us with guidance and whether or not there are preventative measures that would be value for money in terms of avoiding the enormous costs that are incurred further down the road.

**Mr Hayes:** This Report does not deal with prevention.

**Q45 Mr Davidson:** No, but you are here.

**Mr Hayes:** I am here, but my agency does not deal with prevention. One of the subjects on which I am not always right is prevention.

**Sir David Normington:** One has to be careful because everything one says here tends to create broad categories. Basically, your chances are poorer if you are in some kind of broken family, if you do not have family support. That is why in the new Strategy that we have launched there is a big emphasis on trying to treat drug abuse within families, because often it is passed on from parents to children and that is where they leave it. If your father is an offender, then it is quite possible that you might become an offender. If your father is a drug user, it is possible you will become a drug user. It is not invariably the case, but what we have at the moment is it being passed on from generation to generation. That is why some of the things that we are doing with families are the most important things that we are doing in the social policy field.

**Q46 Mr Davidson:** The cost to society of problem drug use is estimated at £15.3 billion a year. £13.9 billion is the estimated cost of crime and related matters. Am I right in thinking that the vast majority of that is poor people on drugs stealing from poor people who are not on drugs? They do not actually go off and rob the big houses; they go and rob the neighbours and the neighbours' cars and all the rest of it. That is what I thought. Would it not simply be cheaper in economic terms to give them all free drugs, leaving aside the point I understand you were making earlier on about treatment and only a small proportion for whom that is deemed appropriate? That is in terms of the users' difficulties but in terms of their neighbours' difficulties, the

people I represent by and large, they would like to have this crime stopped. Have you considered giving them free drugs as a means of cutting crime in order to make everybody else's lives better?

**Sir David Normington:** There are those who think that should happen. That, of course, is absolutely not the Government's policy. I think it is a sort of counsel of despair because it does not take you anywhere. It means that you leave these people on drugs forever.

**Q47 Mr Davidson:** It is not a counsel of despair for the people who are living beside them, whose houses are getting broken into, with respect.

**Sir David Normington:** No, but the evidence is that if you put them into treatment and in some cases give them alternatives to illegal drugs, like methadone, actually that will stabilise them. We have some evidence here that through treatment of various sorts you can stabilise them and protect their neighbours. That, therefore, is a benefit to them and their families as well as to their next-door neighbours.

**Q48 Mr Davidson:** There is a relatively small number being given both methadone and diamorphine. Are they continuing to commit offences?

**Sir David Normington:** Some.

**Mr Hayes:** Some of them are. Overall, it is a 50% reduction in offending.

**Q49 Mr Davidson:** Is that greater than the proportion of those who are either untreated or undertaking other treatments?

**Mr Hayes:** Significantly so. The comparison is what would happen untreated and what would happen treated. Treated, offending halves.

**Q50 Mr Davidson:** If they are treated simply by being given free drugs?

**Mr Hayes:** In a sense, some people would argue that prescribing methadone is exactly that and will have that effect. We know if we can get them scripted a big chunk of them, about half of them more or less, will stop committing offences entirely, another proportion will reduce their offences and for some it will make no difference. Over the entire population it comes out at around about a 50% reduction. Your community, your voters, are already deriving that benefit. One of the difficulties though is that most people come into treatment actually want to get clean. They want to get off drugs in the end. If we just said to them, "We will give you drugs forever", we would not only be saying that what might be a relatively short period of time on drugs—for some people it might last 20 years; for others, it might only last a shorter time—we are actually condemning them to stay drug dependent for the rest of their lives. We are also condemning their children and depriving the rest of the community of the potential of their productive efforts and the taxes that they can pay if we can turn them round.

**Q51 Mr Davidson:** Up to a point I agree with that. I am reminded of the joke about how many social workers does it take to change a light bulb. Only one, but the light bulb has to want to change. The context is if you are putting people into this sort of treatment and they do not want to change, then it is clear, as I see in my own constituency, that it is not successful. People will go into drug treatments because the sheriff or the court or somebody else tells them they have to do it and they have not the slightest intention of going down that road. What I want to clarify is whether or not the wanting to change element can be genuinely identified as distinct from those who are having to do it. I would have thought that might actually be quite difficult in a sense because people who are users will lie repeatedly and convincingly about a whole number of things, like alcoholics. It is very difficult then to distinguish between who is genuine and who is not.

**Mr Hayes:** Surprisingly, there is no evidence that people who are coerced into treatment do any less well than people who have entered treatment on a voluntary basis. One of the things that is surprising is that for an awful lot of people who apparently enter on a voluntary basis, their mothers had their arms twisted up their backs, their spouse is putting pressure on them, their employer is putting pressure on them. The reality is that offenders do just as well in treatment as non-offenders.

**Q52 Mr Davidson:** That is distinguishing offenders from non-offenders. The category I was trying to identify was, as it were, those who genuinely want to be distinct from those who are quite happy.

**Sir David Normington:** We know—and, indeed, the Chairman said this earlier—that in the figures there are over a quarter of people who get into the Drug Interventions Programme who then go on not only to offend but to increase their offending. There are people for whom this programme initially and perhaps for some time simply does not work. They are the category of people we are talking about, I think, the people who just do not want to be treated and to get off drugs.

**Mr Hayes:** At that time.

**Q53 Mr Davidson:** That is right. I think that is an important point. I keep coming across people who lapse back and clearly are just going through this because they have been instructed to go through hoops. There is no genuine intention. It is in that context that I want to pick up the point about residential as distinct from community care. Lots of the youngsters that I come across will tell me that they find it very difficult to break from drugs because they are doing some treatment and then they are running with the same pals who have not been put into this context and, therefore, the peer pressure is all about involving themselves in that sort of culture again, being involved in crime because their pals are doing it. Surely the Chairman did have a point in terms of taking people out of those sorts of circumstances until they feel sufficiently strongly motivated to stay out of it is actually helpful.

**Mr Hayes:** It can be, but the trade off is the re-entry is then doubly difficult. What we have found over many years—the Americans have found the same thing—is if you take people out of the community they still have to go back there. They are then going back there in a situation where they perhaps have lost their social support. Over time, what is now beginning to happen is a new type of residential facility is beginning to be established that is not located at the seaside or in the big house in the country, it is located in Warrington, Liverpool or Luton, connected to their local treatment system, connected to local mutual aid organisations like Narcotics Anonymous or Alcoholics Anonymous et cetera, where you are able to build a ready route back into support systems, back to their family, because they are actually doing it within that community. That appears to be delivering the goods for us.

**Sir David Normington:** Let me just make one point because this keeps coming up. The pattern of drug taking and other substance abuse for young kids is completely different from that of young adults. Therefore, the treatment that you need and the support you need to give them is completely different. A lot of what I think we were talking about earlier with the Chairman was about how you treat the under 18s who might be abusing alcohol, smoking a bit of cannabis, sniffing substances and so on, and also who have all sorts of problems in their community. They are probably truanting from school. They are probably in and out of their family and so on. The treatment that they need, because that is a risk-taking group, is different on the whole from the treatment that people who are adults need. They are the ones who are more likely to get into addiction and to take more serious drugs. On the whole, young kids do not take the heroin, they do not take crack cocaine, that is not the pattern. You have to treat young people differently and actually it is better if you treat them at home, near home or in the community in the way that Paul Hayes is describing. You are right, though, peer pressure, the pressure from their friends, is one of the absolute keys here and that is one of the problems.

**Q54 Mr Davidson:** To what extent in drug use amongst the young is there a comparison to be made with youth offending? The police locally will often tell me that the best thing that happens to reduce offending is ageing, they just move on. To what extent are people changing and deciding they want to break the habit just simply because they age as distinct from seeing the light? Is it something, therefore, where you would be as well almost not bothering spending any money on because you will have a disproportionately high failure rate until they get to a certain age when they start seeing that other perspectives are open to them?

**Sir David Normington:** Most teenagers who commit crimes do not go on and commit crimes in adulthood in fact, so in one way you are right, but actually, of course, you do not know which they are going to be. The other way of looking at this is that by giving them various kinds of support, giving them

education about the dangers of drug use at school and so on through some of our campaigns, does have a beneficial effect because you do not know which of those kids are going to go on and become the habitual criminals when they get older.

**Q55 Mr Davidson:** It was suggested to me earlier on when I said to somebody I was coming to this that they reckoned that in fact more young people stopped using drugs as a result of death than as a result of treatment. Is that correct?

**Sir David Normington:** I do not think so.

**Q56 Mr Davidson:** I am aware in my community there are quite a number of regular deaths that people know about. You obviously do not hear as much about people giving up and I just wondered if that was the case.

**Sir David Normington:** There are some terrible instances of deaths among young teenagers but on the whole it is very, very rare. The really encouraging thing is that drug use amongst young people has been in steady decline over the last 10 years.

**Mr Hayes:** The number of under-18s who complete treatment free of dependency is significantly higher than adults.

**Q57 Mr Davidson:** The final point I want to make relates to the point that was made by my colleague about Notting Hill and related matters and the question of role models. Is there any evidence that many of these youngsters from poor backgrounds would just go down the road of drugs anyway, or is there evidence that pop stars, footballers and people in high, prominent positions being involved in drug use have acted as role models and served to make it more respectable and, therefore, ought we to be trying to crack down on them much more to make it clear that society disapproves?

**Sir David Normington:** I think I am right in saying—you may correct me on this—that surprisingly perhaps young people are not really influenced by celebrities. That is the evidence. They are not as influenced as one would think, particularly in relation to drug taking. That is not what causes them to take them and that is not, on the whole, what causes them to stop.

**Q58 Chair:** Ms Mandie Campbell, I am conscious you have not been allowed to say anything yet, but you have had quite a lot of competition. You are the director of the Drugs Partnership. You are obviously into cross-government initiatives. Would you like to comment? How do you justify what has been achieved to the taxpayer? Is it the most effective thing we could be doing?

**Ms Campbell:** I think that we have lots of evidence to show, as my colleagues have described, a really positive return on investment for the very big spends in the Drug Strategy, so those areas of drug treatment and of the Drug Interventions Programme. We work very closely with colleagues from across the whole of Government, from many

different departments, but also with the voluntary and community sector, to help drive down problem drug use.

**Q59 Chair:** How are you focusing across Whitehall on making people pool resources, pool knowledge, make sure there is collective delivery, all these sorts of factors, and that we are evaluating things comprehensively? What are you doing about this?

**Ms Campbell:** I chair a cross-government group that brings together people from many different departments and there are obviously sub-structures to that. We meet regularly to discuss a range of issues relating to the Drug Strategy to ensure the value for money spend that is required of us, but also to look at how we can be more creative, more innovative, how we can evaluate those areas that are new areas, as the Report illustrates, and we perhaps do not have sufficient evaluation for yet; and to make sure that we are continually trying new ways of ensuring that we are getting the best possible value for money.

**Q60 Chair:** So if you come back to this Committee in a couple of years' time we will have this overall evaluation at a more sophisticated level, will we? Remember that was the very first question I asked Sir David and he said, "We are doing it individually but we are not doing it comprehensively". This is your job, so you are going to be working with us now and you will be able to report back to us within a couple of years, will you?

**Ms Campbell:** Yes, I will. We have agreed with the National Audit Office that we will put a framework for evaluation in place that will look to identify and address those areas that are not evaluated at the moment.

**Q61 Chair:** Are you going to be allowed to stay in position or will Sir David promote you to another position within five minutes? Will you actually get a grip on this and be here for another two or three years, you personally?

**Sir David Normington:** I should not announce your promotion here, should I?

**Ms Campbell:** That is absolutely fine if you would like to!

**Sir David Normington:** I am in favour of leaving people in jobs so that they can see through what they have started.

**Chair:** Thank you, very good.

**Q62 Keith Hill:** Perhaps I could begin with Sir David. Do we have any notion about how many problem drug users there are currently?

**Sir David Normington:** The best figure we have is in the Report, which is 330,000. You can see why it is difficult to be certain about that but the result of what we have been doing is that we are in contact with more of them, therefore we know more about them. We are not just relying on what we did years ago, which was the self-declaring of a problem, which obviously is unreliable.

**Q63 Keith Hill:** How does that 330,000 approximately compare with the position at the start date of the Drugs Intervention Programme?

**Sir David Normington:** I do not know that I have that figure. Do you have that figure?

**Ms Campbell:** It was a much smaller number.

**Sir David Normington:** It was a much smaller number. What has happened in this strategy is that we have just worked harder at identifying them and counting them, so any other figure that we give for the past is not a reliable figure from our point of view. We think that problem drug use is stable. It goes up and down slightly. It has been just slightly nudged up by powder cocaine at the moment, class A drug uses, but the problem drug users figure has been coming down a bit, we think, although the figures are very unreliable. Some years ago we relied on people self-declaring in our surveys and, of course, this group does not self-declare.

**Q64 Keith Hill:** I understand the qualifications you made, but, forgive me, I did not quite pick up the exchange between you and Mandie Campbell. Did I pick up that you were suggesting that the figure might have been lower at the beginning of the programme?

**Sir David Normington:** Yes.

**Ms Campbell:** The figure was significantly lower because, as my colleague explained, it was because at that point we did not have a number of the programmes running that we now have running that enable us to give a much more accurate estimate of the numbers of people who have problem drug use. The counting that we are now able to do of all the numbers of people who come into the treatment system and those who have come into the system through the Drugs Intervention Programme, which only started in 2003, enables us to give a much closer estimate of the numbers than was possible before.

**Q65 Keith Hill:** How many people do come into the treatment programme new each year?

**Ms Campbell:** Currently around 4,800 people per month come through the Drugs Intervention Programme, so last year there were around 237,000 people who came through the programme into the caseload.

**Q66 Keith Hill:** I know this is a different question, but do we have any notion as to how many new problem drug users there are each year?

**Ms Campbell:** I am afraid that is not something that I would be able to answer now. I do not know if my colleague, Paul Hayes, is able to answer that.

**Mr Hayes:** The Home Office asked the University of Glasgow to look at this and they did a study over three years, I think it was, and it came out at 320,000–330,000 each year, so we have reason to believe that it is at worst stable, the number of problem drug users. The Drugs Intervention Programme is only one of the routes into treatment. About 80,000 people come into treatment each year and about 60,000 leave. There are some indications which are making us reasonably positive and optimistic that when we receive the next work from

the University of Glasgow, which looks at the prevalence estimates, we might see a reduction, and I emphasise “might”. As has already been said, the number of people using cannabis, amphetamines, LSD is falling. The number of under-18s coming into treatment with heroin or crack problems was 1,000 three years ago; this year it is 600. Similarly, the number of 18-24s is down 20%. We are beginning to see a reduction in the number of under-30s accessing treatment at a time when treatment has never been more available, so that gives us some optimism that there are fewer of them there. We will not know for certain until we see the Glasgow numbers.

**Q67 Keith Hill:** That is good to hear. Was I right in making a note that you said last year 15,000 people left the programme free of drugs?

**Mr Hayes:** Free of dependency, yes, the problem drug users.

**Q68 Keith Hill:** That implied, therefore, if the figure is stable, that maybe about 15,000 new problem drug users are identified each year?

**Mr Hayes:** No, it is a little bit more complicated than that. Across the whole population some people will complete treatment successfully, some people will drop out early, some of those who complete treatment successfully will relapse subsequently, some of those who drop out will relapse very quickly and come back into treatment, some of them will manage never to come back into treatment. We have a constant flow of people leaving for good reasons, people leaving for bad reasons, people rejoining in the current year and people rejoining in subsequent years. It is a complex flow and stock situation, but in total, over the last five years, on average 80,000 new people have come into the treatment system, 60,000 other people have left, both for good or bad reasons, and the treatment system has been growing.

**Q69 Keith Hill:** I think, also, you said that your statistics indicated that 125,000 people have been through treatment and had not shown up again subsequently in the criminal justice system.

**Mr Hayes:** Or in the treatment system.

**Q70 Keith Hill:** But that does not mean that those people still do not have a drug issue, does it, and I am talking about a problem drug issue?

**Mr Hayes:** We cannot know that for certain. One of the difficulties is that, particularly with this population, we cannot track them. We can track them whilst they are in treatment. What we cannot do is track them with any absolute accuracy after they leave treatment. What we have developed, together with colleagues in the Home Office and elsewhere in Government, is the ability to look at the various data sets: have they come back into treatment, have they died, are they in prison, have they been arrested, are they in a psychiatric hospital somewhere, so we can then get a handle on what is

happening to them and what is happening with their lives.

**Q71 Keith Hill:** What do you think is happening to them?

**Mr Hayes:** What we think is happening are two things. As I say, 25,000 people left last year, having overcome dependency; about two-thirds of them do not come back, a third relapse and come back. About another half of the people who left come back, most of them very quickly. The other half we know from long-term studies actually manage a drug-free life. One of the things that happens is that people do not leave treatment in a bureaucratically neat way. They decide that they have had enough of it and they go off and get on with the rest of their lives. One of the things that signals when someone is ready to leave treatment is that they begin to leave the addict identity behind them, so therefore we cannot guarantee, particularly with the clientele that we are working with, they will arrive for their last appointment and sign a bit of paper that says, “I am now clean. Can I leave, please?”

**Q72 Keith Hill:** One of the concepts that I am genuinely trying to understand, because I think it is probably very important in your approach, is this concept of people being held stable in treatment. You have talked about that already but could you explain a little bit more about that concept?

**Mr Hayes:** There are two issues there. The first is that we know—and the reason that the international evidence is so strong about methadone and accepted in most western countries, including the USA—that it can immediately give people a stable life back, a life where they can care for themselves, where they do not have to offend, where they can look after their children better, they can even seek employment. It is not an ideal life and it would be much better to have passed through treatment and left it behind, but it does give people a platform from which they can then go on and improve other things about their lives. The other thing we know is that what the academics call the treatment dose accumulates over time. If someone is in treatment just for a few weeks the probability is that it does them no good. If they are in treatment for 12 weeks or longer then the odds are that the next time they come back, even if they relapse, they will be in for longer still, and the time after that it will be even longer, and the time after that they will go all the way. Every time you can get someone in for treatment for 12 weeks or longer that is the biting point, if you like, at which long-term change begins to accrue. The longer we can hold people in, both the less harm they are doing to themselves and others but also the more likely it is that the benefits of treatment will accrue over time and they will eventually leave.

**Q73 Keith Hill:** What is the nature of the treatment they are receiving?

**Mr Hayes:** The nature of the treatment they are receiving depends on the drugs they are using. If they

are using just stimulant drugs then the treatment will be counselling, psychosocial interventions, behavioural therapy, et cetera, and they are very effective. The results we have had around powder cocaine that I mentioned earlier are impressive. For opiate users, which is the majority of people in treatment, in addition to those therapies they receive substitute drugs—methadone, buprenorphine—that enable them to be stable and then benefit from the psychosocial interventions that they are receiving. What is certainly true is that the system in many places is not as good at delivering the psychosocial interventions as it is at dispensing methadone, and one of the challenges for us is to make sure that the change effort within the system is as effective as the stabilisation effort.

**Q74 Keith Hill:** Can I ask you briefly about prisons, because I think Sir David said that we were getting better at keeping people in treatment while they are in prison and meeting them at the prison gate, and yet, notoriously, our prisons are said to be—and the word that was used was—awash with drugs. How do these things fit together? Is there not a risk of contradiction that we are seeing here?

**Sir David Normington:** I think the figures I quoted were that drug use among prisoners has come down from about a quarter of prisoners to just under 8%<sup>3</sup> over quite a short period, in the last three, four or five years, and that suggests that two things are happening. One is that the effort prisons are making to stop the smuggling of drugs into prisons is beginning to have some effect. In fact, the Ministry of Justice have just had a review of that work and have increased their screening and so on both of their staff as well as of visitors, so that seems to be having some effect, but also fairly recently treatment in prisons has been getting better. There is now a programme which is generally overseen by clinicians, by medical staff, and as long as you can (and this is a problem that your other Report deals with) provide a stable period for people so that they can have the treatment over a period in the same place and they are not being moved around, you have some really good results coming out for prisoners being treated and, in the same way as we are describing for other sorts of treatment, having benefits from that. There are all sorts of additional problems that prisoners have when they come out of prison about the re-integration back into the community.

**Q75 Keith Hill:** How good are we at meeting people at the prison gate? Let me give you a little bit of illustration. I have Brixton Prison in my constituency. Classically, what people say is that they come out of Jebb Avenue, which is where the prison is located, they turn left to go down to the Jobcentre

in Brixton, but the problem is that they know where the crack houses are *en route* and there is a risk that they will walk into those and, Bob's your uncle, they are back on the old routine. We need to be good, do we not, at meeting people at the prison gate?

**Sir David Normington:** I would like Mandie Campbell to take this because in the 2008 strategy this is what we have begun to move onto. We have to be good in exactly the way you describe. We cannot have people being treated and then falling off the edge, walking down the street and going into the crack house. That is what has happened. We cannot have that. That is what we are trying to tackle.

**Ms Campbell:** Absolutely. That type of approach is a key part of the Drugs Intervention Programme and what we are doing through that programme is trying to build that “meet at the gate” process. Now in our DIP-intensive areas where we have most of our resources around the country we have about 80%<sup>4</sup> coverage of people being met from the gates of prisons by drug key workers and then taken into assessment and treatment so that they do not do exactly as you say, which is go via their ability to get their illegal drugs. We have worked with colleagues in the Ministry of Justice to produce very robust guidance for staff in prisons and in the community so that we have that continuity of care which comes from being in prison right through to ensuring that they are met at the gate, taken out and helped then to integrate back into society. I would like also, in relation to the Drugs Intervention Programme, just to clarify the figures. In relation to the 237,000, that is the number of people who were tested last year under the Drugs Intervention Programme, and of those around 57,000 then went into treatment. I just wanted to make that absolutely clear.

**Keith Hill:** Thanks for that.

**Q76 Chair:** Sir David, thank you. It has been a very interesting inquiry and I think that concludes it. I have a very last question and you can use it to sum up. It has been said many times that we are paying as a taxpayer £1.2 billion a year on a range of initiatives and it is costing society £15 billion a year, so when do you think it would be appropriate, Sir David, for us to have you back with Mandie Campbell, and hopefully Mr Hayes as well, to see what progress you have made, particularly on this thing that I think worries us perhaps most of all, that for a quarter on the programme there is no change in their criminal activity and for a quarter they commit more crime? When do you think we can have a positive inquiry, because the whole point of this is not just to have a debating society or try and embarrass you; it is actually to make progress, so how can we help you in your efforts?

**Sir David Normington:** We have had a bit of an

<sup>3</sup> *Note by witness:* The random mandatory drug testing (rMDT) programme which is the best measure of drug misuse in prisons has dropped from 24.4% in 1996–97 to 7.7% in 2008–09.

<sup>4</sup> *Note by witness:* The figure relates to DIP research undertaken in May 2009 which showed that over 80% of intensive DIP areas provided a “meet and greet” from prison where this was considered necessary.

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exchange about this. We think in relation to this strategy in three-year chunks, so I think it will be late in 2011 or early in 2012, around that time, when we ought to have the evidence that you are asking for.

**Q77 Chair:** Thank you very much, Sir David.

**Sir David Normington:** May I say, Mr Leigh, that you and I have been adversaries over nine years, I think. I just want to say thank you very much for your courtesy and we wish you well.

**Chair:** Thank you. It has been very enjoyable.

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