# Cynulliad Cenedlaethol Cymru
# The National Assembly for Wales

## Y Pwyllgor Iechyd a Gofal Cymdeithasol
## The Health and Social Care Committee

### Dydd Iau, 6 Tachwedd 2014
### Thursday, 6 November 2014

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

**Aelodau'r pwyllgor yn bresennol**
**Committee members in attendance**

| | |
|---|---|
| Alun Davies | Llafur<br>Labour |
| Janet Finch-Saunders | Ceidwadwyr Cymreig<br>Welsh Conservatives |
| John Griffiths | Llafur<br>Labour |
| Ann Jones | Llafur (yn dirprwyo ar ran Lynne Neagle)<br>Labour (substitute for Lynne Neagle) |
| Elin Jones | Plaid Cymru<br>The Party of Wales |
| Darren Millar | Ceidwadwyr Cymreig<br>Welsh Conservatives |
| Gwyn R. Price | Llafur<br>Labour |
| David Rees | Llafur (Cadeirydd y Pwyllgor)<br>Labour (Committee Chair) |
| Lindsay Whittle | Plaid Cymru<br>The Party of Wales |
| Kirsty Williams | Democratiaid Rhyddfrydol Cymru<br>Welsh Liberal Democrats |

**Eraill yn bresennol**
**Others in attendance**

| | |
|---|---|
| Angela Cronin | Gweithiwr Datblygu Iechyd a Lles, Gwasanaeth Ieuenctid Pen-y-bont ar Ogwr<br>Development Worker for Health and Wellbeing, Bridgend Youth Service |
| Joanne Davies | Cyfarwyddwr Cynorthwyol Cynllunio, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg<br>Assistant Director of Planning, Abertawe Bro Morgannwg University Local Health Board |
| Jackie Garland | Rheolwr Gwasanaeth, Cynhwysiant Cymdeithasol, Cyngor Bwrdeistref Sirol Caerffili<br>Service Manager, Social Inclusion, Caerphilly County Borough Council |
| Jamie Harris | Rheolwr Gwasanaethau i Deuluoedd, Plant a Phobl Ifanc, SANDS Cymru (sef Prosiect Cyffuriau Abertawe gynt)<br>Families Children and Young Persons Services Manager, SANDS Cymru (formerly known as Swansea Drugs Project) |

| | |
|---|---|
| Nicola John | Cyfarwyddwr Iechyd y Cyhoedd, Bwrdd Iechyd Lleol Cwm Taf<br>Director Public Health, Cwm Taf Local Health Board |
| Andrea Lewis | Cynghorydd, Dinas a Sir Abertawe<br>Councillor, City and County of Swansea |
| Dr Julia Lewis | Seiciatrydd Ymgynghorol ar Gaethiwed ac Arweinydd Clinigol ar gyfer Caethiwed, Bwrdd Iechyd Lleol Aneurin Bevan<br>Consultant Addiction Psychiatrist and Clinical Lead for Addiction, Aneurin Bevan Local Health Board |
| Kathryn Peters | Rheolwr Diogelwch Cymunedol ar gyfer Cyngor Bwrdeistref Sirol Caerffili<br>Community Safety Manager for Caerphilly County Borough Council |
| Professor Philip Routledge OBE | Cadeirydd Bwrdd y Rhaglen, Prosiect Cyffuriau Newydd ac Adnabod Sylweddau Newydd Cymru (WEDINOS)<br>Chair of the Programme Board, Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) |
| Dr Quentin Sandifer | Iechyd Cyhoeddus Cymru<br>Public Health Wales |
| Jeremy Sare | Sefydliad Angelus<br>Angelus Foundation |
| Harry Shapiro | DrugScope |
| Josephine Smith | Arweinydd y Rhaglen, WEDINOS<br>Programme Lead, WEDINOS |
| Richard Webb | Cymdeithas Prif Swyddogion Safonau Masnach, Cyngor Sir Rhydychen<br>Association of Chief Trading Standards Officers, Oxfordshire County Council |
| Dr Jonathan Whelan | Cyfarwyddwr Meddygol Cynorthwyol, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru<br>Assistant Medical Director, Welsh Ambulance Services NHS Trust |

**Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol**
**National Assembly for Wales officials in attendance**

| | |
|---|---|
| Amy Clifton | Gwasanaeth Ymchwil<br>Research Service |
| Sian Giddins | Dirprwy Glerc<br>Deputy Clerk |
| Gareth Howells | Cynghorydd Cyfreithiol<br>Legal Adviser |
| Llinos Madeley | Clerc<br>Clerk |

*Dechreuodd rhan gyhoeddus y cyfarfod am 09:48.*
*The public part of the meeting began at 09:48.*

## Cyflwyniad, Ymddiheuriadau a Dirprwyon
## Introduction, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome Members to this morning's session of the Health and Social Care Committee, in which we will hold our first oral sessions of our inquiry into new psychoactive substances. May I do a bit of housekeeping, first? I remind Members, please, to switch off your mobile phones, or put them on 'silent', and your iPads and other

equipment, which might interfere with the broadcasting equipment. There are no fire drills scheduled today, so if the fire alarm does go off, please follow the directions of the ushers. The meeting is bilingual and if you wish to have the translation from Welsh to English, the simultaneous translation is on channel 1 on the headphones, or if you wish for amplification, it is channel 0. We have had apologies from Lynne Neagle this morning and we welcome Ann Jones as her substitute.

09:49

## Ymchwiliad i Sylweddau Seicoweithredol Newydd ('Cyffuriau Penfeddwol Cyfreithlon'): Sesiwn Dystiolaeth 1
## Inquiry into New Psychoactive Substances ('Legal Highs'): Evidence Session 1

[2] **David Rees:** I welcome Jeremy Sare from—forgive me if I pronounce it wrongly—the Angelus Foundation and Harry Shapiro, who is the director of communications for DrugScope. Thank you both for your written evidence to the committee on this particular topic. Obviously, we have some questions. We met with focus groups in our earlier sessions, which gave us indications from the various points that they raised with us. I think that, as a consequence, we have some quite interesting questions to ask, which they have brought forward. So, let us start off the questions with Gwyn Price.

[3] **Gwyn R. Price:** Thank you, Chair. Good morning. What is your perception of the scale of the problem of new psychoactive substance use in Wales?

[4] **Mr Shapiro:** As far as I am aware—. In fact, I was talking to a youth worker from Swansea quite recently, who was very concerned about the use of mephedrone in that area, among both young people and people who are already known to drug treatment services. I think that, alongside that, you would be looking at the range of synthetic cannabinoids, which some people kind of call 'fake cannabis', but that is slightly misleading because synthetic cannabinoids do not really bear any relationship to the plant. They are entirely synthetic. The reason why they call them cannabinoids is because they act on the similar brain receptors that cannabis does, but are quite often far more toxic than cannabis itself.

[5] I think that it is probably true across the UK that those two groups of substances, mephedrone and the synthetic cannabinoids, are the two main groups of drugs that have found an element of traction on the UK drug scene, particularly in areas with more acute poverty and economic and social deprivation—which certainly persists in the north-east of England and, I think, also in areas of Wales—but less so among the people who go to festivals and those in the clubbing and dance scene. They do not seem to be that interested in these substances as those people who may already have existing problems with drugs or are at risk of that. Actual statistics are really quite hard to come by, because we do not really know what our baselines are for trying to determine this, not least because quite a lot of the substances out there are still legal, so they do not necessarily turn up on crime statistics.

[6] So, there are certainly, I would say, an increasing awareness and a general availability. Certainly, problems are now beginning to manifest themselves particularly, for example, in youth offenders' institutes and in prisons, around particularly synthetic cannabinoids. It would be sort of foolhardy, really, to try to put facts and figures around this, other than to say that a number of drug treatment professionals, youth workers and criminal justice workers around the country, including Wales, are expressing concerns about some of these substances and the effects that they have.

[7] **Gwyn R. Price:** You say in your paper that there is evidence of return-to- street sales. When we have been out and about taking evidence, that has come over to us as well—you can

pick them up quite easily on the streets.

[8] **Mr Shapiro:** Yes. I think that mephedrone was controlled by the Westminster Government in 2010. Of course, at that point, you had an unknown number of people who stopped using it because it became illegal. It is always hard to determine the number of people who do not do things as opposed to the number of people who do. However, since then, it has become part of the kind of repertoire of street drugs. Synthetic cannabinoids are readily available across the UK, not just in so-called head shops, but in a number of other sorts of outlets as well, which DrugScope and the Angelus Foundation identified, namely kebab shops, garages, fast-food outlets, newsagents, and so on.

[9] **David Rees:** You talked about the UK, and in terms of that aspect, have you noticed whether Wales is on a par with what is happening in the UK, or are there differences in Wales compared with the UK?

[10] **Mr Shapiro:** I do not think that Wales has necessarily got a specific problem that is different from the rest of the UK, except in as much as that where, like I say, you have areas of more acute social deprivation, that may well marry against what is happening in similar areas in the UK, rather than Wales having a special problem in that respect.

[11] **Mr Sare:** Could I add that any particular area within the UK that does not have good supply lines of ecstasy and cannabis is going to be vulnerable to these substances? So, the more rural areas—and certainly the most rural areas of Scotland—have traditionally had quite a bad drugs problem.

[12] **David Rees:** I now call Darren.

[13] **Darren Millar:** Thank you, Chair. Thank you for your written evidence. Can I just ask you this? You suggest that the data demonstrate that most young people get information about drugs and substance misuse from their parents rather than other sources. That is where they get the bulk of their education. Do you think that the current efforts that are being made to engage parents in the fight against new psychoactive substances are sufficient? If they are not, what would you recommend we should do in Wales in order to engage parents more, so that they can help inform their children?

[14] **Mr Sare:** I think it is a long way short of what we would call sufficient. The role of parents, I think, in drugs education has not received much support over the years, and now we have a residual problem with parents who have a significant worry barrier to overcome. There is also their level of knowledge, as the younger generation often has superior knowledge. However, that has not really received significant support, I do not think. I mean, certainly Angelus has identified this as an area that needs addressing, and we wrote the parents' guide, which is a free download from our website, with Adfam and the Club Drug Clinic. That gives quite general advice, and reassurance that you do not have to become a drug expert and you do not have to identify lots of different products, names and chemicals. It is just generic information, building your confidence to have conversations with your children, in the same way as you would talk about alcohol, or safe sex.

[15] **Darren Millar:** Do you think that the telephone helplines—like Talk to Frank in England, and we have a slightly different one in Wales, Dan 24/7—are effective in supporting parents, in helping to tackle the young people in their families' abuse, perhaps, of new psychoactive substances, or not?

[16] **Mr Sare:** I think that maybe they are not intended to be for parents, but Frank is probably quite helpful for parents, as it does contain quite a lot of accurate information. Some of the stuff on the legal side is less helpful, I think, but the Dan 24/7 is a bit more. I find Frank

to be quite two-dimensional. It is a resource that you have to seek out. It does not reach out to young people. There is no social media, which Dan 24/7 does have, significantly, with huge amounts of tweets, et cetera. So, I think Frank could learn a bit more from the Welsh approach, and also the Scottish Know the Score, which is a bit more proactive.

[17] **Darren Millar:** In terms of the marketing that is behind the Talk to Frank campaign, though, there seems to be a greater awareness among the general public about it rather than the Dan 24/7 helpline. You are nodding, Mr Shapiro. Is that your experience? Do you think there ought to be a more co-ordinated effort between the UK nations?

[18] **Mr Shapiro:** Frank has been around since, I think, about 2002, and initially there was a pretty substantial financial investment in Frank. From a purely marketing point of view, it has achieved quite a high brand recognition. There was a recent study, I think it was last year or the year before, among Nottinghamshire school students, and a very high percentage of them knew the Frank brand. I think it was quite interesting that a far smaller proportion of them actually used it, but they knew what it was and they had heard about it. Of course, there has been television advertising and poster campaigns on bus stops, and all kinds of things over the years, so it maybe is not surprising that it has got that level of recognition, as opposed to the other initiatives in other countries.

[19] **Darren Millar:** Just in terms of perhaps those groups that are at higher risk of engaging in new psychoactive substances, where a head shop might have opened in the locality, for example, what do you make of some of the specific targeted efforts to engage with parents by organisations like Care for the Family with its How to Drug Proof Your Kids course, which of course engages with new psychoactive substances as well as the other myriad drugs out there?

10:00

[20] **Mr Shapiro:** I think that targeting is quite important. I mean, with parents, it is always difficult in a sense because even though, now in 2014, we have probably got one or even two generations of parents who actually grew up in a drug culture, a UK drug culture—I mean, all my parents knew about was alcohol and tobacco—. There are generations of parents now who did grow up with that. So, therefore, you might imagine that they were kind of more savvy, more aware, and maybe even a bit more tolerant. But, in fact, once you become a parent, things change and your perspectives change. I know that, over the years, a number of schools have tried to run parents' evenings about drugs because parents have expressed concerns about drugs in the area, not necessarily in the schools but in the locales, and three people turn up. The problem can sometimes be that people are very worried about it, but it is actually quite hard to engage people because people think that, if they turn up to a public meeting, people might think that it is their children who have got the drug problem, and maybe they have. So, I think trying to identify people in a targeted kind of way, maybe in environments where they are more receptive, and that could be through GPs or a number of different scenarios—. I think that it is the same with young people. I think that the Home Office is now looking at having targeted campaigns around NPS, not the general kind of drug stuff that has been done in the past. However, I think that, at the moment, they are looking specifically at young people who are at risk of offending as one of the target groups.

[21] It is also looking at the idea that you have got a group of young people who are just never going to go down this route—they are just not interested. And you have got another group of young people, older teenagers maybe, who are already fairly immersed in the drug scene. But there is a centre group, if you like, which I call 'the casual and the curious', who are not really quite sure which way to jump. They may be in the 15 to 17 age range, and maybe that is the group that you might try to shift away from experimentation, as well as a group of young people who are clearly going to be at risk, particularly if they are going to

find themselves in young offenders' institutions.

[22] **Darren Millar:** But parents are a key component of encouraging people not to dabble in these sorts of substances.

[23] **Mr Shapiro:** I think so. I think that the role of parents in this is underplayed, in the sense that people imagine, 'Oh, nobody takes any notice of their parents', but when they do surveys of young people they find that the general social and emotional values that are inculcated within families do have an impact on young people. Yes, of course, there is peer pressure and all of that that goes on outside the household, but what goes on, in a sense behind closed doors, is very valuable.

[24] **Lindsay Whittle:** On this issue, Chair, I notice in particular, Mr Sare, that Angelus has delivered a film, *Not What it Says on the Tin*, and that three quarters of young people said that they were shocked by the content and 95% said it changed their minds about the substances. Do you think that the answer—. I do not think that it is with parents, personally. I think that many young people sometimes rebel at a certain age against their parents. When we visited Merthyr Tydfil, some young people there had produced their own film as well. I am not sure whether it was to the same quality as yours, but, nevertheless, it was a very positive film because they too are angry about the use of these substances. Do you think that one of our recommendations should be that we should perhaps encourage these young people who are against the substances to talk to their friends? Is that the answer perhaps—that it is from within young people? I think that your survey in the three universities in England, showing that 19% of so-called educated young people had tried these substances, is very alarming indeed. Perhaps universities in Wales should take heed of that as well.

[25] **Mr Sare:** I think that it is right to look at things as very age-specific. I would certainly agree with Harry's assessment of the different groups, but those who are more likely to take heed of parental advice are the younger, 11 to 15-year-olds. I think that where parental advice would be effective tails off quite rapidly. Our films are aimed at the 14 to 18-year-olds, and they are, broadly, in that centre group that could go either way. What is most surprising about these sessions at schools, which I have run, is that the pupils are seemingly reluctant to engage and then, once the film starts, everything stops, and they really are very much taken up with the subject and realise that this is important information for them, not so much as potential users of synthetic cannabis, for example, but, certainly, their friends or brothers and sisters may be. This is quite an important safeguard and life-saving information—

[26] **Lindsay Whittle:** Just a quick supplementary question: did you find evidence that it was all social classes of young people? We did, and I am sure that, in England, it is probably no different to Wales.

[27] **Mr Sare:** It is. I do not see any particular difference based on income level.

[28] **John Griffiths:** In terms of universities and university students, the universities have been criticised at times for encouraging—in some people's view—irresponsible drinking and binge drinking with some of the activities within their own student union premises, with some of the promotions that they run and so on. Obviously, they have a big responsibility for the welfare of the students who go to their universities. You have identified usage among university students as a significant part of the problem. Do you have a view as to what the university authorities should do to deal with these issues? What are the most important steps that they could take to reduce the usage of these substances by their students?

[29] **Mr Sare:** As so often with these issues, recognition is the first stage, but also, it is a matter of organisation. We are in dialogue with certain elements within the student welfare

structures, whereby we are trying to pilot something in one university, and then we can demonstrate to others. I do not think that they expect a national roll-out immediately, but, certainly, in patches, and targeting areas, particularly like Wales, would be a helpful way forward. So, it is just a matter of having a concerted educational programme within that that works; one that is very much online is very effective. We have created an online challenge called the Real Deal. It is certainly a different perception for different generations, because when we present it to older experts, they are somewhat horrified to think that we are putting the young person who is playing the game in the position of a head shop manager, effectively. They accumulate points as they go through the game towards an incentive prize, they think that this is all a bit of a stroll, and then, suddenly, unexpected things happen, like their containment is seized at customs and their bank account is frozen. There is an incident whereby the daughter of a police chief is harmed by these products, and then they realise that the industry has no care for the individual's wellbeing and the way that things are manufactured is haphazard. Our evaluation shows that they understand the message that we are intending.

[30] **Mr Shapiro:** May I say that I think that universities have a general health and welfare responsibility here, and it is not just around NPS? Some years ago, we produced some work in association with the National Union of Students called Study Safely and it was not just about recreational drug use. It was about trying to persuade people not to take a stimulant drug so that they could stay up all night and finish their thesis. That was before the era of irresponsible drinking as well, which has been a more recent phenomenon. So, generally, bearing in mind that when young people go to university, it is often the first time that they have been away from home all the shackles and inhibitions come off at that point for some of them. So, I think that universities have a general responsibility around all drugs and alcohol to make sure that their student body is as well-informed as possible. Ultimately, people make their own decisions, but people should at least have the information and have access to help and advice should things get out of hand.

[31] **David Rees:** On that point, you have clearly highlighted a few things this morning about the nature of education, and clearly, the Welsh Government has areas for which it has responsibility, and there are some areas in here that we recognise are part of the UK Government's responsibility, particularly the issue of the criminal aspects or the legalisation of it. Is sufficient work being done in providing the education to young people and to their wider families, and are we using social media effectively? You mentioned social media; are we using it effectively? Is there a concept—. We have already identified the concept of 'legal highs' being very concerning terminology, in that it can create the wrong impression. Is that concept, in using the term 'legal highs', also affecting parents' understanding and, perhaps, parents' lack of understanding of the dangers presented through these types of drugs?

[32] **Mr Sare:** I think that, yes, the phrase 'legal highs' is deeply unhelpful. We are somewhat at a loss as to know how we could turn that around, because it is just an organic thing; it has grown up and it has been repeated through the media in the same way that 'ketamine is a horse tranquilliser' when it is not. So, that is a great difficulty. Generally, certainly at the meetings that we had at the Department of Education, we were discussing the Home Office review while it is ongoing, talking to officials, I said, 'What might be relevant for your department?', and the shocking response I got was, 'Nothing; we do nothing. There may be something for schools, but nothing for our department'. That is not something that our organisation really likes to hear in any way, that there is this social laissez-faire attitude that schools can do what they like, and most schools will not do drugs education. I think that there is a bit more of an effort in Wales, and you might remember that NPS have been incorporated into wider drugs education, which is very welcome. I am sure that more could be done, but the situation in England is, I think, quite desperate.

[33] There is the issue of compulsory PSHE, which is going backwards and forwards,

seemingly. The Labour Party supported it and actually proposed it in a Bill, which then ran out of parliamentary time in 2010. The Liberal Democrats, I guess, have been quite consistent in supporting it, and certainly the last Minister for drugs made that clear. Labour now seems to be turning its back on that, and the Conservatives, who rejected it under Secretary of State Michael Gove, are now thinking again about it. So, it is a rather confusing picture, and it is not least confused by an election in just a few months' time.

[34] **Ann Jones:** I would be interested to know what you are proposing. We were just talking then about schools playing a part, a role, in this, and I think that you are probably suggesting that, under PSE, it would probably fit in. The curriculum is overloaded at the moment, and we are often criticised in Wales for not achieving the standards that we should. Our PISA results are low. How would you suggest that schools would fit all of these things in under PSE? There is a raft of things. What would you suggest should drop from PSE to enable us to concentrate more on legal highs?

10:15

[35] **Mr Sare:** Perhaps it is going a little bit beyond my level of expertise on educational programmes. I think that the symptoms around school education and the lack of knowledge from key ages, such as 15 to 16-year-olds, are evidenced in the papers quite often. I was at the drugs conference in Rome in May, and while I was there, there were three incidents in separate schools—one was in Pembroke, where 15-year-olds were smoking synthetic cannabis during the lunch break. They do not know about the harm of these drugs and they are certainly not getting drugs education in their school. It is very urgent, when ambulances are being called. People think that it is a party drug that is very mild, but they find that it is considerably stronger than skunk. So, I find that the need is very urgent from our perspective. As to what can be dropped, I am not expert enough to say.

[36] **Ann Jones:** Do you recognise that there is a problem, though, by wanting to put so many items into the PSE part of a curriculum? It is like spreading icing very thinly across the top of the cake. Is that as good or bad as not doing it? Should it be youth services that look at this, or should there be outreach work? Is that the way to go, rather than doing it within the school setting?

[37] **Mr Sare:** I think that the school setting is the best. Certainly, in our experience, the impact and the feedback is very strong. We set a notional standard of one hour per term, per year, for drugs education, including NPS, but only 15% of schools are currently doing that.

[38] **Ann Jones:** So, you recommend an hour, per term, per school?

[39] **Mr Sare:** Yes.

[40] **Ann Jones:** Okay, thank you.

[41] **David Rees:** You recommended an hour per term, did you not?

[42] **Mr Sare:** Per term—yes.

[43] **Mr Shapiro:** May I add something? You mentioned youth services and community outreach, and I think that is also very important. We ran an NPS round table at DrugScope earlier this year, and we specifically invited young people's drug treatment representatives. They said that, as far as young people coming forward for help, cannabis and alcohol were still the number 1 and 2 substances that were causing problems until their outreach workers went out into the community, and there they found quite a different story of young people getting into difficulties with NPS, but not really imagining that there was anywhere that they

could go to get any help, advice, or even necessarily feeling that they needed it, of course, because there is always a large element of denial about all of this. However, I think that, across the piece, there is no magic bullet in the sense that resources are invariably thinly stretched in schools and in the youth service as well. I do not think that all of your efforts should go into one place; that is what I mean. As far as possible, there should be an NPS and a general drug element wherever young people are—that is in the community, and it could be in school exclusion units as well as mainstream education.

[44] **David Rees:** We have focused very much so far on the education of young people and parents, but are we doing enough as far as developing the skills and understanding within the service providers and the teams that go out to help young people?

[45] **Mr Shapiro:** I think that the short answer to that is probably 'No'. What has been happening in England since probably about 2009-10, when this issue first began to emerge, was that lots of drug action teams, police and various people were putting out alerts and warnings about this substance and that substance—clockwork orange, black mamba and all sorts of things that people did not understand. If you put an early warning out or an alert, there is an implication that you should do something about it. It is actually quite hard, if you get a notice into a local area that there is a dodgy pink pill floating around, to know what you are actually supposed to do about that. People just felt the need to tell everyone about it, and it has not really been structured or thought through. Hopefully, something will come out of the recent Home Office review. Some of us round that table were talking about trying to pilot what we started to call 'professional information networks' rather than early warning systems or alerting systems. There has been a pilot scheme running in Salford in Greater Manchester for about a year or so where a small group of professionals, which included the police, the local pharmacist, the local school nurse and local psychiatric workers, got together in literally a Google group—a very low cost network—just so that they could keep each other informed and ask questions of each other if they saw something they were not sure about, or wondered, 'I've seen someone with these symptoms coming into my service. Does anybody have any clues about this?' This is all extremely local stuff, and I am trying to do something similar in London across three central London boroughs.

[46] However, I think that there is a lot of concern among professionals, and a lot of it is being driven not just by the media but also by researchers and academics who are putting out reports suggesting that there were 20 new substances last week, 30 the week before and 40 the week before that. I think that a climate of fear, almost, has grown up around this subject, which I think needs to be tempered to some extent. The two main substances that I spoke about earlier—synthetic cannabinoids and mephedrone—are the ones that are the main concerns for UK professionals. Someone I know, who is very experienced drug trainer, talked about dealing with what is in front of you. In other words, the symptoms and the effects that people present with in services are going to be very similar to those of the drugs that those workers are already familiar with. So, you kind of ignore the street names and the slang names and all that kind of thing—you just deal with what is in front of you.

[47] It is also a question of being aware that drugs might be an issue with the person in front of you anyway. A good example would be urinary tract infection as a result of ketamine use. I am pretty certain that, if a young person aged 17, 18 or 19 came in with a persistent urinary tract infection condition, a lot of GPs probably would not even think about asking whether they had been using ketamine, because GP training, to the best of my knowledge, is only very peripheral when it comes to substance misuse. I think that it is the same for social work as well.

[48] So, in general, I think that professionals at all levels are not particularly well-informed about drug issues, and least of all are they probably well-informed about NPS.

[49] **David Rees:** Thank you. I have Kirsty and then John.

[50] **Kirsty Williams:** Thank you. I am just wondering whether you think that there are different approaches needed, especially in terms of creating professional networks, help and support for teachers, youth workers or people in clinical roles when it comes to rural and urban communities. What do you perceive to be some of the challenges of delivering services in a sparsely populated area, where perhaps there is a perception that things like that do not go on?

[51] **Mr Shapiro:** I would agree. In a sense, ''twas ever thus' in terms of trying to deliver drug treatment services in sparsely populated and rural areas, where there are long distances between services. In terms of keeping professionals in touch with each other, obviously we have internet capacities now that we never used to have. That makes it easier for people to stay in touch through various different mechanisms to try to keep each other informed. I think it was quite significant that, when mephedrone first arrived on the scene, it was in rural areas in Wales, Scotland and various places such as that where these substances made quite an impact, simply because they were easy to buy online and get delivered by the postman, and you did not have to go to your nearest source of street drugs in a larger town or city. What the way forward in terms of having more comprehensive coverage in rural drugs services is, I cannot really answer, because I know how much—. I know, particularly in England, the degree to which drug treatment services, since all of the money was handed to local authorities in terms of divvying up funds for drug treatment services—. The pressures that the local authorities are now under are acute. There are a lot of concerns, certainly in England and among organisations like DrugScope—because we are a membership organisation for people involved in drug treatment services—about the coming years, in terms of the services that are going to be available right across the piece, not simply focusing on this particular problem, but the money that is going to be available for drug treatment services full stop.

[52] **David Rees:** Kirsty, have you finished?

[53] **Kirsty Williams:** That is fine, thank you.

[54] **David Rees:** John is next.

[55] **John Griffiths:** In terms of the services that are provided, as a committee we took evidence around and about Wales. I was particularly struck by one man who had used these substances and other substances over quite a lengthy period of time but was now doing a counselling course. He seemed to me to have a great deal of credibility in terms of his own personal experience and understanding of the issues. I just wondered whether you think that a significant part of providing a service that would be effective and would have credibility should involve making use of people who have lived that life themselves, in terms of using these substances, and really understand the problems, but have now overcome those issues and are doing counselling courses and are wanting to contribute something positive. Do you see that as a significant part of providing an effective service?

[56] **Mr Shapiro:** Certainly in England, and, I am sure, in Wales, it already is. There is a large percentage of people, as part of the drug treatment workforce, whether it is in community services or residential rehabilitation, who themselves have come through that process and come out the other side, and have a wealth of experience and empathy. My only caveat on that is that simply having been 15 years a heroin user is, of itself, in my view, not enough. I think that there are significant issues around workforce training and development, and I think that it is absolutely crucial that people, who often want to give something back to the services that have helped them and who have a great deal to offer, are also properly trained and have proper experience. It is also important to say that services also need to have good representation from clinical and primary care staff as well—NHS staff, consultant

psychiatrists and so on. So, I think that it is important in any drug treatment service to have a balance between those people who have gone through a long and rigorous professional training process and people who have a lot to offer through their experience but who also need to be properly trained as well.

[57] **Mr Sare:** I would certainly agree with that. We have found that, regarding organisations that want to use those who have that experience, we would not rule it out because obviously there are those who have turned their lives around and want to contribute. If that is the core of their message, however, I think that that is wrong. If you are 16 and you have tried a bit of cannabis and you have tried a pill, and someone comes in talking about long-term heroin addiction, there is just no chiming there; it does not mean anything to them, unless it is just a scare tactic. So, I think that it is important to focus their training on using their expertise and their experience together.

[58] **Mr Shapiro:** It is a different and equally important point that Jeremy has made there. What I was talking about were the people who want to give something back in relation to other people who have those serious drug problems. Regarding the issue of parachuting ex-drug users into schools, I share Jeremy's concerns about that, and DrugScope has always, through various guidance over the years, suggested that that is not particularly recommended, but, if you are going to do it, at least make it part of a proper, planned drug education prevention programme and do not just think that you have ticked the drug education box by bringing in an ex-user to tell them how terrible and awful it was, and 'By the way, don't you do it, and by the way (sub-text) I managed to get through it otherwise I wouldn't be standing here talking to you now.' So, there are bear traps to taking that as your primary drug education response.

10:30

[59] **David Rees:** I am conscious of the time, but I have two questions that I want to ask. When we visited our group in north Wales, one of the young people who talked to us highlighted the proliferation effect within prisons and youth offending institutions. Have you had experience of the issues relating to the accessibility, and perhaps therefore the education, for people who are in prison or youth offending institutions?

[60] **Mr Sare:** Yes. We have had discussions. We learn, through Her Majesty's Inspectorate of Prisons reports, lots of anecdotal evidence and media reports, that the issue of synthetic cannabis, spice, in prisons is extremely serious. It is not just a health issue; it is just as significantly a security issue because of the high rates of addiction, which is not parallel to traditional cannabis, and the associated mental health issues with addiction to these substances, leading to psychotic episodes. When you have reduced prison officer numbers, it does not take a genius to work out that it is going to be a big security issue as well. We have spoken to National Offender Manager Service senior managers. We are a small charity, but we would really like to get into prisons, particularly looking at new inmates, because I think, in terms of getting educational programmes like we have in schools into a pretty harsh environment, it is not realistic to expect a film and a bit of group work to change people's behaviour. However, certainly for new inmates coming in, so that they are aware that these substances are going to be around, that they are at a massively inflated price—it is a real currency out there—that these are considerably more addictive than they might think, and that bullying, sexual assault and physical assault is a necessary consequence of taking these.

[61] **David Rees:** Okay. Thank you for that. My final question is this: last week, as you highlighted, the Home Office identified a paper and looked at it and it is talking about the possibility of an NPS ban. What are your views on the consequences if such a ban is introduced?

[62] **Mr Shapiro:** The proposal is that high street retail outlets are prevented from stocking these substances, not just the head shops, but all the other outlets that we have mentioned this morning. It has been tried in other countries—in Ireland, Romania and Poland—with varying degrees of success. I think that it is an almost inevitable step for any Government not to carry on allowing anyone just to walk in off the streets and buy these substances. The other thing to note about the report's recommendation is that it is only trying to tackle supply; it is not trying to tackle distribution or putting possession offences against this, which is an important consideration here. So, it is not trying to criminalise lots of young people who might be buying these substances. However, I think each country is going to respond in a different way. I do not think, for example, that you will necessarily suddenly see a wholesale reversion to buying these substances on the internet because I suspect that a lot of people who have been buying them in head shops probably do not have credit cards or the sorts of things you need to be able to buy stuff online. It is possible that some of these substances will reappear on the streets in clear plastic bags in the same way that most other drugs do, but I think as a way of at least trying to discourage casual and curious purchase, I think that it is a fairly obvious step to take. There are processes and procedures to go through, but there was no dissent, really, on the committee panel, of which I was a part, that that should go forward.

[63] **David Rees:** If there are no further questions from Members, we have exceeded our time, so I thank you very much for coming this morning and giving us evidence. You will receive a copy of the transcript for you to identify any factual inaccuracies. Thank you once again.

[64] I now propose that we break for 10 minutes or so according to our schedule, and we will reconvene at 10.45am.

*Gohiriwyd y cyfarfod rhwng 10:36 a 10:45.*
*The meeting adjourned between 10:36 and 10:45.*

## Ymchwiliad i Sylweddau Seicoweithredol Newydd ("Cyffuriau Penfeddwol Cyfreithlon"): Sesiwn Dystiolaeth 2
## Inquiry into New Psychoactive Substances ("Legal Highs"): Evidence Session 2

[65] **David Rees:** I welcome Members back to this morning's session, and we go into our next evidence session on our inquiry into new psychoactive substances. I welcome Professor Phil Routledge, who is chair of the programme board of WEDINOS, Welsh emerging drugs and identification of novel substances; Josephine Smith, programme leader for WEDINOS; and Dr Quentin Sandifer, executive director of public health services at Public Health Wales. Thank you very much also for your evidence, which has been provided, but obviously we have some questions that we now wish to pursue. I will start with Gwyn.

[66] **Gwyn R. Price:** Good morning, everybody. What is your perception of the scale of the problem of NPS use in Wales?

[67] **Ms Smith:** Essentially, taken as a whole, heroin, cocaine and the more traditional drugs are still more prevalent by a substantial degree. In Wales, we estimate currently that, in the more problematic uses, for example injecting drug use, NPS account for around 2% of injecting drug use, but there is a crossover between historic and existing heroin use, for example, and emerging drugs, for example mephedrone. Problematic drug users are incorporating new psychoactive substances into their patterns of use, if you like. I think that NPS, or new psychoactive substances, are a growing issue. Certainly we have seen a substantial escalation in use since around 2009-10, particularly in Wales with synthetic

cannabinoid use and stimulant use. So, we believe that that does represent a substantial public health harm and a growing harm.

[68] **Professor Routledge:** Just to put some numbers on it, I think, in England and Wales, there were 52 deaths as a result of mephedrone in 2012. So, we are talking about a significant public health problem.

[69] **David Rees:** Gwyn, have you finished?

[70] **Gwyn R. Price:** I was just going to ask this. Do you think they are becoming more available on the streets and are more common? We have taken evidence, when we have been out and about, that you can go to a local market or local street and it is there at £10 a go, sort of thing.

[71] **Ms Smith:** Yes, certainly. In terms of availability, unlike historic markets, where it is perhaps more subterfuge and about knowing people who have substances, ready access to branded products under the banner title of new psychoactive substances is far-reaching. As you mentioned, we know that you can buy them in tattoo parlours, open market stalls, and head shops, among other outlets. So, in terms of accessibility, they are most definitely not hard to find.

[72] **David Rees:** Alun, do you want to ask a question on that number, particularly?

[73] **Alun Davies:** Yes, if I could. Thank you, professor. Fifty-two was the number—

[74] **Professor Routledge:** I beg your pardon, I misspoke there. It was 52 deaths due to novel psychoactive substances, of which mephedrone would have been the commonest, so that is the scale of the whole problem. That was every death certificate on which there was no other drug mentioned.

[75] **Alun Davies:** That is the point that I was trying to get at, because, as I understand it, and from my experience in my constituency of Blaenau Gwent, there are two issues here. There is the potential of death from the direct use of the substance and then, as I understand it, a substance could cause psychiatric problems for an individual, which could then lead to a potential death as well, or to other significant issues. Are you able to understand? So, the 52 relates to the former rather than the latter, but do we understand and do we have any hard information on the scale of the position as regards the impact of those substances on people who will die later but as a direct consequence of that substance use?

[76] **Professor Routledge:** No, we do not, unfortunately. Because they are novel, emerging compounds, we really do not have any feel for the toxicity spectrum and the safety pattern. We do know, however, that there is evidence of dependence on some of these agents and also risks from sudden withdrawal of the agents. The long-term effects have not really been elucidated. One of the problems is having good toxicovigilance across not just this country, but the whole of Europe to try to identify those kinds of harms that you mentioned.

[77] **Alun Davies:** At the same time, we also know that these substances can lead to psychiatric illnesses and to episodes of illness, which in itself could lead, for example, to suicide or something else. Do we understand the scale of those sorts of impacts?

[78] **Ms Smith:** If I may, I will come in there. Yes, there has been some early work on the increase in mechanical suicides associated with the use and heavy use of mephedrone and other NPS—stimulants, for example. Again, it is slightly confounded because other drugs were involved, as well as mephedrone, for example. I think that this is work that can be well built upon if we are better able to establish clear care pathways and links with substance

misuse, with the using population and with psychiatric referrals, both via primary care, but also acute admissions into psychiatric units. I think that that is something that we really need to build on.

[79] **Alun Davies:** But we do not have any numbers on this.

[80] **Ms Smith:** No.

[81] **Alun Davies:** I know that academics do not like to be pressed on assumptions, but can you take an informed view of the scale of that wider issue?

[82] **Professor Routledge:** It is certainly not in my area. I am a toxicologist and my experience of this is of patients who come into the poisons unit with acute toxicity, rather than the chronic psychiatric issues.

[83] **David Rees:** Kirsty wants to come in with a supplementary on this and then we have Darren.

[84] **Kirsty Williams:** I appreciate that a lot of what we are talking about is ingested tablets that are taken, but if you cannot get a feel for the psychological harm, I am just wondering about other physical harm, such as hepatitis C infections through drug sharing or other risky practices, associated, perhaps, with other types of substances, so self-tanning, steroids and all that kind of usage. I am just wondering whether we have got any way of measuring those types of harm.

[85] **Ms Smith:** Yes, we do have a better sense of the harms associated particularly with injecting drug use. You mentioned tanning agents, like Melanotan, and steroid and image enhancing drugs, but also mephedrone as well as others. In terms of quantifying those, within health protection in Public Health Wales, we also lead on the blood-borne viral hepatitis action plan, and I have engaged with particular health boards in relation to increases in hepatitis C. As a consequence of a change from heroin use or an incorporation of mephedrone, M-CAT, along with heroin users or in a traditional heroin-using population, we have seen a huge escalation in hepatitis C, both in pockets of south-west Wales and also within the Cardiff and Vale health board area. We are in the process of undertaking an outbreak review specifically on the injecting of NPS.

[86] **David Rees:** Dr Sandifer, do you want to add anything?

[87] **Dr Sandifer:** Well, I was just going to say that, for certain outcomes like hepatitis, of course, infectious disease reporting arrangements apply and we obviously have a programme that specifically addresses blood-borne viruses. As we say in our report, the challenge for all of us is that the majority of NPS users in fact do not have contact with specialist treatment and related services, so even where we might have systems for capturing information about this group of people, there will be a much larger group outside of that who are not known to us, who are not necessarily making the contacts where we could identify. So, it is a real challenge in identifying the scale of the use and the associated harms.

[88] **Kirsty Williams:** You talked about a significant increase in hepatitis C infections. Could you give us an indication of what that significant jump looks like?

[89] **Ms Smith:** In terms of new diagnoses of hepatitis C infection in one small urban area, we have identified 70 new infections since 1 January 2013.

[90] **Kirsty Williams:** Sorry, how many?

[91] **Ms Smith:** It is 70 new infections among a fairly close-knit injecting population. I think that that translates to the risk behaviour that we identified with NPS injecting where, particularly with M-CAT, you are talking about going from a frequency of potentially three injections a day to upwards of 15 to 20, and the risks inherent within that. In terms of the nature of some of the new stimulants that we are talking about, they are very fiendish. You want to take more and more frequently and, as such, the relative risks of injecting and sharing increase as a consequence.

[92] Touching on other harms that we identified within the written evidence, such as the increased transmission of sexual infection, we know that certainly where drugs and NPS, particularly, are used in a sexual environment, there is also an increase in risk behaviour, and we have identified local outbreaks of syphilis, for example, where increased risk and unprotected sex is occurring.

[93] **Darren Millar:** May I ask you about the WEDINOS website? Obviously, it is a public-facing website; it is not something that is confined to the use of health professionals or people in the criminal justice system. It has been suggested, during some of the workshops that we have undertaken, certainly in north Wales, and in the media that it is potentially being abused by some people and used as a marketing tool, really, for some of the products that they might be trying to sell to individuals to use, or some other products that they are manufacturing themselves in a sort of cottage-industry style. What is your response to that criticism?

[94] **Dr Sandifer:** I will start, and I have no doubt that colleagues will contribute. Clearly, as a new initiative, our primary aim is to raise awareness of an important, emerging and growing public health threat. That is our prime motivation for establishing the project and the resources associated with that. So, WEDINOS, through its website and through the project itself, provides information in relation to the samples that are submitted. We make it very clear that that information should not be regarded as generalizable to all drugs that might have the same name attached to it, might look the same, or might even have been offered through the same source. In addition to that, we do not offer any statement of its purity. So, this—as far as we are concerned—is not a quality-control tool and it should not be used as such. Of course, people who look at the website, as you say, may choose to misuse it in that sense. That is a challenge for us. We are, obviously, mindful of that and we will carefully review our use of the website to make sure that the information does not allow itself to be misled in that way. I do not know whether colleagues want to add anything.

[95] **Ms Smith:** Yes, we have protocols in place—procedures and protocols that we have developed—to, insofar as is possible, minimise the risk of abuse and potential abuse of the WEDINOS system. Clearly, it is not designed as a quality-control tool. As such, we have mechanisms in place. Of the just under 1,900 samples that we have tested to date, we have not tested 11.5% of those where we believe that they were submitted in line with the situations that you are describing, where there is a potential or belief of abuse attempts.

11:00

[96] The other point to make really is that the website very clearly states the user's experience of adverse effects of that substance, and by reporting the negative or adverse effects that individuals have experienced following consumption it is a challenge to infer that it is a positive tool for promoting, if you like, drug use. Certainly, where we have had samples where we believe they have been submitted—and we have been aware of it and we do closely monitor the forums and the media in line with that—we have not tested and opened the door of communication via our e-mail address to the provider of that sample so that we can enter into discussion.

[97] **Professor Routledge:** To add to that, prior to WEDINOS, the only source of information many users would have would be the supplier of those medicines, and we know that a significant proportion—in fact the majority—have another substance in them. While we do not give the purity of each of the substances, we mention the major and minor ingredients. Some of those minor ingredients are not minor as a toxicological agent, and as a physician my primary goal is to protect the patient. I believe that it does provide that service.

[98] **Darren Millar:** However, you do recognise that it certainly has been abused in the past. I accept that you are trying to minimise the potential for abuse through the efforts you have taken, and that, where you have identified that certain people who have been contributing samples for testing have been linked to abuse, you have engaged with them to try to prevent that from taking place. You referred, Josephine Smith, to the user effects that are recorded on the website as well. Of course, one thing that we all know is that there are inconsistencies sometimes between the contents of the different branded products that are sent in for testing. So, how do you reconcile the user effects with the actual product that has been tested that you try to link those user effects to? Given the inconsistencies in the components and contents, it is impossible, is it not, to match it, without knowing precisely what somebody has taken?

[99] **Ms Smith:** Within the effects form that individuals complete, we request information on other substances that have been consumed at the same time. You are right that it is an absolute challenge, and certainly this is where we have drawn on our toxicology experts to try to tease out the majority adverse effects that individuals have experienced from consumption of one or more products. It is not—

[100] **Darren Millar:** But it is impossible to confirm what has been taken, is it not? Even though some may say, 'Well, I took gogaine', for example. I know that this was highlighted in one of your recent newsletters that three samples contained very different products even though they were all branded that way.

[101] **Ms Smith:** We were able to test that sample and therefore we know what is in the product.

[102] **Darren Millar:** You were able to test those samples, but you are not able to necessarily confirm to which samples, of those that you have tested, the effects of gogaine that the user is describing are attributable.

[103] **David Rees:** For clarification, do you identify on your website whether the effects that you are talking about are for a family of drugs? What we have heard is that a minor change in a particular drug has a technical implication and that, therefore, it does not necessarily have exactly the same content as something that somebody may wish to take. I think that that is what you were trying to get at.

[104] **Darren Millar:** It is, but my concern is that, sometimes, given that people do not necessarily know what is in the product they are taking, even though it may have been tested or a similar product with a similar name may have been tested, this could potentially give false assurances to users to experiment with certain products.

[105] **Ms Smith:** Referring back to the website, it very clearly states that the limitations of the project are that we can report on the profile of the substance that has been submitted and that that cannot be generalised to all products, for example, with the same name or packaged in a similar way or sold from the same individual or the same head shops. Certainly—

[106] **Darren Millar:** So, what is the point in even putting that user experience on there if you cannot give any assurances that it actually is a reaction to the product that has been

tested?

[107] **Ms Smith:** Certainly, prior to going live with implementation of the project, we had long discussions with users from various populations, and it was felt very clearly that user effects and adverse effects would be more powerful for them in terms of influencing what not to use and the dangers associated with use of particular substances than for us to purely indicate, 'If it's this, then the toxicology will report that,' because that relates to singular drugs, rather than the combinations of drugs that we are now seeing on the market.

[108] **Professor Routledge:** That is the important point about what we are dealing with. Most drug poisonings are from more than one substance; the second substance is often alcohol, but, in this circumstance, there are half a dozen different groups of novel psychoactive substances and, therefore, it is very important to observe the effects as they occur, rather than trying to package them under any one particular drug, because interactions are very important part of understanding and giving us a signal as to whether, perhaps, two particular drugs together are more damaging than the sum of their parts.

[109] **Darren Millar:** It has been suggested that one way of improving the WEDINOS service, which many people consider to be a valuable resource, particularly health professionals and those in the criminal justice system, would be to make it a closed site, not for public consumption, but more for professional consumption, if you like. Is that something that WEDINOS is considering and are you aware of a similar resource that is available and being used by at least one police force in Wales, called TICTAC, which I believe provides a similar sort of service, but on a closed basis, rather than a public basis?

[110] **Dr Sandifer:** Perhaps I will start and then, if you wanted to respond, you could. I understand the general premise of your questioning, but I repeat the point that was made just a few minutes ago, which is that without the WEDINOS project and prior to it, the only information available to someone considering using such a drug was from the person providing it to them. So, I think that there is a public benefit to the provision of information to the person both directly and through a public medium such as the WEDINOS website. If we think of the types of users we are trying to reach, as we set out in our report, many of those would be difficult to reach other than through media such as the website that WEDINOS has developed. So, I think that there is a public service, from a very real public health problem, in making that information—

[111] **Darren Millar:** So, how many users are accessing your site on a monthly basis?

[112] **Ms Smith:** I am not sure. Over 200,000.

[113] **Darren Millar:** You know that they are users, do you?

[114] **Ms Smith:** They are individuals who are accessing the website.

[115] **Dr Sandifer:** We can only measure the hits on the website, of course.

[116] **Darren Millar:** How are you going to evaluate, then, what proportion of those people who use the website are users and what benefits they accrue as a result? What evaluation have you built into the project?

[117] **Ms Smith:** We are engaged in ongoing discussions with other fora that a lot of new psychoactive drug users would access information from and have discussion points with a number of other fora. I do not know if that has come up in your evidence, but these are fora like Bluelight, Erowid—online discussion fora with users. We have engaged with them and been able to influence and work with them to assess the degree to which their members are

accessing WEDINOS and the information on it, and the outcomes of that. I can give you an example just from summer, when we had a number of samples submitted in the form of blotters, much like LSD would have been in years gone by, and we were able to identify a new substance, LSZ, along with quite serious adverse effects. Subsequent to that, alerts went out via linked user fora that indicated to other individuals not to use blotters, because, clearly, they are dangerous. So, we are linked in, and we recognise the value of linking in with other mechanisms and other systems.

[118] Touching, if I may, just on the TICTAC issue, we work closely with John Ramsey at TICTAC, and their system is slightly different. Their system is identifying, from a visual picture, what that particular tablet might look like, and it is very useful, for example, with the police service, forensics and the prison service, because they can visually match what they have in front of them with a picture on the website. It does not, however, deal with what we are finding now. A recent sample we had from a prison was a bright pink tablet, and they went on TICTAC and identified it, but also sent it to us for testing. It was actually a paracetamol that had been coloured in with dayglo colour and sold as a steroid. TICTAC is a very useful resource, and we are very close colleagues with John, but ours is different, and it does go beyond and clearly sees the value of engaging with the population who are using. As my colleague said, these are individuals who may not be in touch with any other services.

[119] **David Rees:** Okay, Darren—.

[120] **Darren Millar:** I just want—

[121] **David Rees:** Professor Routledge wants to get in.

[122] **Darren Millar:** Yes, but it is just that, briefly, before—

[123] **David Rees:** Let the professor answer and I will come back to you.

[124] **Darren Millar:** I do not want to lose it in my head; that is all.

[125] **David Rees:** Professor Routledge.

[126] **Professor Routledge:** It was to comment on TICTAC, Mr Millar, because I ran the poisons service in Wales for 20 years, and, during that time, I was involved in ensuring that TICTAC linked up with the poisons service as a source of information for those of us who were on call, advising health professionals about difficult cases over the phone. It is a valuable resource; it started as a tablet identification package, and it has been remarkably useful in that regard. However, in terms of advice, we also have, within the National Poisons Information Service, the Welsh poisons centre, which is one of four centres around the UK that works as a network. We have a database called Toxbase, which has information on harms and on management, and we are actively discussing with the National Poisons Information Service how we in WEDINOS can link more closely with it to use those resources to really join up the information. So, there are a variety of resources, including TICTAC, that are available on a private basis, but this is for a different purpose.

[127] **Darren Millar:** I understand that, and I recognise—

[128] **David Rees:** You can ask the questions in your head now.

[129] **Darren Millar:** Yes. I do recognise the benefits of testing products and the importance of doing that to reduce harm. Do you accept, though, that, if the site were closed, and you were still able to engage with user fora in terms of sharing alerts about certain products, you would still be able to accrue the significant benefits that you, Josephine, and Dr

Sandifer have referred to without opening up the site, potentially, to the abuse that it has been used for in the past, which has been to enable some marketing of individual products?

[130] **Ms Smith:** I think that the power of WEDINOS is putting the power back in the users', their families' and communities' hands. If you have a closed network, you are inwardly discussing—and there are many: there is the forensic early warning system, drug early warning system, and lots of European early warning systems, and professionals and academics talk to each other about NPS and new drugs—it does not go any further than that. This project is really aimed at reducing the harms, reducing the impact of NPS, and ensuring that individuals can make informed choices about what they do, and also enabling families to look at what is on the market, identify trends and what is available in their area, identify, potentially—and you touched on the psychiatric and psychological harm, Mr Griffiths—changes in behaviour that maybe as a consequence of a young person, for example, using synthetic cannabinoids and other NPS. So, it is really enabling and providing a credible source of information from the bottom up, utilising really robust clinical and toxicological evidence.

[131] **Professor Routledge:** I think that the support that we have had from colleagues in other parts of the United Kingdom, and the real interest shown in it, is encouraging, suggesting that others see the same.

[132] **David Rees:** Kirsty wants to ask a question, and then Alun has supplementary questions to this and then I am going to ask Janet to ask her question.

11:15

[133] **Kirsty Williams:** I am curious to see the evidence that came from the north Wales meeting, because we had, in our south Wales meeting, completely the opposite. There was unanimous support from all of the agencies for the project and how important the project was. So, I look forward to seeing the transcript of what came to pass in north Wales.

[134] **Darren Millar:** It is in your pack.

[135] **Kirsty Williams:** What representations have you received from the organisations that you are working with, and others in Wales, to make your site a closed site? Have you received any representations at all?

[136] **Ms Smith:** None at all.

[137] **Kirsty Williams:** There has been no feedback from law-enforcement agencies or other healthcare organisations to change the nature of the site.

[138] **Ms Smith:** No. Categorically, I can absolutely say that that has not been the case. Just to quantify it, we have recently engaged with all the prisons and they are happy to submit samples that are found within the prison environment. As my colleague said, we are looking to collaborate further with other organisations. In fact, of the samples of new psychoactive substances that we have received to date, 65% have come from organisations and 35% from individuals. So, this is very much about close engagement with services.

[139] **Dr Sandifer:** Very briefly, just to link the questions from the last two Assembly Members, the fact is that we understand the concerns that such an initiative might be perceived as promoting drug use, and therefore a negative. However, we are very clear that the information that we provide is drawn from reliable and expert resources. We pay considerable care and attention to the method that we have developed in delivering the project. We are fully supported by all our multi-agency partners. We believe that this does

contribute positively to challenging myths, highlighting potential risks, does not promote drug use, and represents a very pragmatic—and I emphasise the word 'pragmatic'—public health response to a very real and growing problem.

[140] **Alun Davies:** My experience is very similar to Kirsty's on that matter. However, in terms of the wider issue of communication with users, Public Health Wales identified three groups—recreational users, psychonauts and poly-drug users. In my experience in Blaenau Gwent, there is a significant issue among very casual users, based around schools—in Brynmawr, Tredegar, or somewhere. My concern is that we do not have the channels, the structures or the means of reaching and touching those people. You may be aware of some of the work that we have been doing in Blaenau Gwent with Gwent Police in order to try to address some of those issues. However, I am interested in understanding how, from your perspective, you feel that the public agencies, if you like, are able to directly, or to contract people to indirectly, reach younger people—people who are not habitual users at all, but people who are on the fringes of that and may, through experience in schools, come across people who use drugs more regularly and therefore become drawn into that casual use. I was wondering whether you have any comments on your evidence that would help us to understand how you are able to do that.

[141] **Dr Sandifer:** Perhaps I could very briefly introduce the response and maybe Josie can elaborate on particulars related to your question. We believe that this service is a service that can evolve, and we have suggested in our report a number of directions for the further development, first of all, as I referred to, of clear pathways for care and engagement, and to join up, if you like, the links through to the specialist substance misuse services. The second is to reflect the diversity of users and the range of products that we are talking about, and about the adaptation of specialist substance misuse services. The last bit, which I think speaks to the point you are making, is that, through raising awareness and increasing expertise and knowledge among professionals, but also among those who work more broadly with the wider population, hopefully we can begin to address the concerns that you are raising. I do not know, Josephine, whether you can add particularly to the specific points.

[142] **Ms Smith:** Just to add to that, one of the specific points that we made within the written evidence was to really promote community engagement. I think that one avenue is education for teachers and schools, and influencing perhaps the personal and social education curriculum to better and more credibly discuss the issue of drugs, because, as you quite rightly pointed out, young people are exposed—they have brothers and sisters who are older and these drugs are in the community. Certainly we have a role, as do local organisations, whether they are substance misuse-specific organisations or not: youth organisations have a role in working together to try to better understand what is going on in the community in terms of needs assessment and availability of and access to support, because, as you quite rightly pointed out, these are potentially casual users or on the fringe of using so they are not yet embedded in a drug culture or a drug world. I think certainly by engaging directly with that population and hence having a public-facing engagement, they would be better able to influence their peers to reduce use, potentially, or initiation. I think we really do need to take a much more proactive community-raised role, rather than community needs assessments that are perhaps undertaken as a paper-based exercise.

[143] **Alun Davies:** I understand that, and I think that both of you are right in what you have been saying. However, my concern is to understand how strong and how effective these channels of communication and these methods and means of engagement are. My concern is that we have—and you are absolutely right to describe it, Dr Sandifer; I absolutely agree with what you said—all these very formal channels, but are they professionals talking to professionals or are they means of reaching people? I have teenage children and I am not convinced that any of us in this room would have much traction talking to them—certainly I do not. I am concerned to understand how strong—if you talk about those community

organisations that may have that level of traction—our methods and channels of communication are. My concern is that they are not strong enough.

[144] **Dr Sandifer:** We share that concern. We understand that we need to adapt and evolve the model exactly for the reasons you describe, so that we can engage directly with NPS users in communities, but in a way that connects with them in a meaningful sense. That is why I also referred to the importance of raising local knowledge and bringing that alongside expertise and awareness-raising in risk populations. However, this is an evolving and complex issue, and that is why I think this service needs to respond just as you describe.

[145] **Alun Davies:** Could you write to the committee please and outline what you as an organisation are doing in order to address those issues?

[146] **Dr Sandifer:** We will take that question away and we will provide the committee with a further response.

[147] **David Rees:** Thank you. Janet is next and then Lindsay.

[148] **Janet Finch-Saunders:** Thank you, Chair. For me, it is about trying to establish what size the problem is here in Wales, and how we as a committee, with the limited time that we have to really get involved in this—. We know that this is a growing problem, but my concern is how the data collection is taking place on this—not mephedrone or any of those; I know that Betsi Cadwaladr University Local Health Board, my own health board, refuses to use the terminology 'legal highs', and that is a message that it gets across. So, we will say 'NPS'. From the evidence that we have taken and the reports, there is very little known about the profile in terms of the age of the people and the gender, but, for me, it is about numbers now. How big of a growing problem is it?

[149] We had some evidence that told us that people were switching from some of the more traditional drugs. We took evidence where some said that, actually, users were using a cocktail of drugs, and not perhaps realising. On their own, technically, they could manage them, but when they put them together, 'boom'. So, for me, I am really looking—and those substance misuse workers we met really were concerned about how we get effective data. So, my question to you, really, is quite simple: how can those who are working in the field to combat this collect those data and use those data, and what could the Welsh Government be doing more to realise that there is a problem? I mean, we are a committee. I have to confess that, when it was mentioned about making this an inquiry, I actually thought that it was not as big a problem. My eyes have been opened since we have taken evidence from those in the field and people coming here, and by going out to workshops and meeting with people. However, I still have no idea whether this is something that we should really be raising. I have not heard it mentioned, since I got here three years ago, by the Welsh Government. So, what should the Welsh Government be doing, and how can we as a committee influence what it should be doing?

[150] **Lindsay Whittle:** Could I just add one sentence, and then that is my question because it is on similar lines? The evidence that we have heard is that people are switching from the well-known, more dangerous drugs to these. Is enough money going into research on this, as opposed to the more dangerous drugs?

[151] **Janet Finch-Saunders:** And, this is a little tiny one on—

[152] **David Rees:** We will leave that question, because—

[153] **Janet Finch-Saunders:** I have waited nearly an hour for this.

[154] **David Rees:** I will come back to you, but there are a lot of questions there already.

[155] **Ms Smith:** That is fine. If I may, I will take the data collection question at the beginning. You are right: it is very difficult to get a tangible hold, but there are a number of sources of information that we could perhaps measure change by. Hospital admissions is one. We have seen an increase certainly in hospital admissions for young people, so those aged 24 and under, for cannabis—or cannabinoids, I might say. I can provide you with the data, but I can also advise that all the data that I am going to discuss were published last Thursday, as 'The Annual Profile of Substance Misuse in Wales 2013-14'. So, we have, by age group, through the life course, drawn on every routinely available piece of data across Wales: hospital admissions, access to treatment services, so your service provider organisations, and death data by drug type. So, we have quantified within that publication, insofar as is possible, every piece of information to, if you like, paint the picture of substance misuse and the role of NPS within that.

[156] Just to touch on some highlight data, then, we know that referrals for substance misuse treatment services for mephedrone exactly mirrored the pattern that we were seeing in the community. We saw referrals rise from, I think, eight in 2009 to a height of 312 referrals in a given year in 2011-12, but that subsequently dropped to 136 referrals in the last reporting year. As I said, hospital admissions have increased for cannabinoids but stayed relatively stable for other drugs. One point to clarify is that you mentioned a switch from historic and existing problematic drug use, but this is more of an addition to, rather than a switch. Among historic amphetamine stimulant users and cocaine users, we have seen the inclusion of other stimulants, not the move away from. So, this is about adding more drugs to the field rather than moving away, particularly with heroin. We did see a switch, if you like: a decrease in heroin use—

[157] **Lindsay Whittle:** So, heroin has come down, has it?

[158] **Ms Smith:** It has. It is, right across the UK, an ageing cohort. However, rather than stop heroin use altogether, they have merely added new drugs. I think it is a really important point to note, certainly in terms of the impact on substance misuse services, that this is polydrug use that we are talking about. This is no longer, 'They are a heroin user and don't worry about anything else.' We need to adapt services, as we highlighted in the written evidence, to recognise that individuals are not using one drug; they are using a number of drugs. So, I hope that the profile will better quantify for you the scale and nature of NPS within, if you like, the wider substance misuse data.

11:30

[159] However, I would also note as a researcher that, yes, further work is required to better understand not only the scale of NPS use in problematic drug users, so those who are visible to us, but also in the hidden populations, so the younger populations that may be coming through. We are in the process of developing and working through the ethics. It is a 10-year study looking at the prevalence of problematic drug use, so individuals who might come into contact with criminal justice and hospitals, and looking at substance misuse treatment data. Using statistical methods, we have been able, in the past, to model the population of heroin and cocaine users. However, given the change in the nature of the drug markets, we are now going to include amphetamines and amphetamine-like substances. So, hopefully, in the not-too-distant future, we will have a far greater understanding of the prevalence.

[160] **Dr Sandifer:** Very briefly, with reference to the Welsh Government, we are very grateful for the support the Welsh Government has shown to this project. I think it has been very enlightened recognition of an important problem here in Wales. Equally, we are working very closely with it. We are actively discussing how the project could be improved in the

ways that we have already discussed earlier, and also how we can better understand the prevalence of this as a public health issue. We set out briefly in section 4 of our evidence a couple of potential opportunities where, with Welsh Government support, we might be able to improve our data collection and get a better understanding, as you have pointed out.

[161] **Janet Finch-Saunders:** I know that, in the report and from evidence that we have taken, some agencies are quite precious about keeping their own data, and data sharing is a problem. However, I suppose the concern I have is that NPS are so attractively packaged that there may well be now a younger generation growing up now and starting out on these—not mixing, but actually starting out on these—using them recreationally, and so far so good. However, this could be like the tip of the iceberg. So, for me, now, I am really looking for some tangible progress on the fact that we are recognising that this is a problem in Wales, and how we then target resources and support. I know that there is a will not to criminalise those using it, because that then pushes it underground. How can we address this?

[162] **David Rees:** Perhaps Dr Sandifer can qualify how Public Health Wales will be addressing the issue.

[163] **Dr Sandifer:** I am grateful to you for your final comment, because I concur with you. I strongly believe that harm reduction is the approach that we should be taking to address this problem. We are clearly dealing with something complex and evolving. We need, I think, therefore not to restrict ourselves to any one particular approach. I think that we are increasingly understanding that some of our traditional services are not making the necessary reach into, and contact with, some of the users we are talking about today. Therefore, that demands some adaptation and changes to some of our existing programmes, but equally speaks to the need for new initiatives, such as the WEDINOS project, which, I hesitate to remind the committee, is just about a year old. It is a relatively new initiative and an initiative that is already recognising how it itself needs change. I do not know whether colleagues want to add anything to that.

[164] **Professor Routledge:** WEDINOS is certainly one component, but not the complete component, of all the things that are needed. What I find very valuable is the fact that, as well as awareness raising, it gives us local knowledge. Then, as part of our educational programme, through the national poisons information service, for instance, we are able to go to health professionals and make them aware of what the issues are. I hope that that will save lives, because they will be much more able to manage problems when they occur. So, I see this component as, perhaps, a signal generation component. It does not give us prevalence data because we do not know the denominator but we do know what the issues are and we can then pass that information on.

[165] **Janet Finch-Saunders:** As my final point, the key to all this is where it is being vastly produced and then retailed, and there is lots of money being made by quite a few people. Trading standards plays a huge part in going out around the head shops, identifying this kind of thing. This is coming at a time when we are seeing—. Local authorities are supposed to play this key role as one of the enforcers, or indeed—

[166] **David Rees:** They are coming in this afternoon.

[167] **Janet Finch-Saunders:** I know. They are one of the agencies, but with the cuts to local government budgets, why are we cutting budgets at a time when this is on the increase? So, I ask you to lobby that we need these, because without trading standards going around these places, places like head shops are just going to multiply. I have even heard that people are importing stuff by the bagful—and this was widely reported to us—and making it into lots of little packages and then selling it on. Really, it is those kinds of agencies like trading standards and the police that need the support to make a difference.

[168] **David Rees:** I am sure that they will take the advice and lobby in that sense, but we have got other questions.

[169] **Janet Finch-Saunders:** I have waited nearly an hour, and I have been interrupted yet again. If I could just finish—

[170] **David Rees:** The local government groups are coming in this afternoon. That question is actually better focused on the local government group.

[171] Thank you very much for your time. Time is actually up against us. You will receive a copy of the transcript to check for any factual inaccuracies that you may identify. Once again, thank you very much for the evidence that you have given today and for your written evidence.

[172] Janet, you can have the first question this afternoon. That is the focus for this afternoon.

[173] The next session we have is with the local health boards, and we will be receiving some representatives from local health boards and the ambulance service trust.

[174] **Darren Millar:** Chair, just for the record, it was suggested by the previous witnesses that TICTAC did not analyse the—

[175] **David Rees:** We will seek clarification on that.

[176] **Darren Millar:** There is a document in the information that has been sent in by TICTAC, which makes it absolutely clear that it does analyse the substances that are sent to it and it publishes them on the internet site that it makes available for use by professionals. So, I think it is important that we note that for the record.

[177] **David Rees:** We will write and clarify that with them.

[178] **Darren Millar:** To make it clear that it is not duplicating efforts.

[179] **David Rees:** Yes.

[180] **Elin Jones:** But it is what they are sent from amnesty bins, so there may be a difference there.

[181] **David Rees:** We will seek clarification.

11:39

## Ymchwiliad i Sylweddau Seicoweithredol Newydd (“Cyffuriau Penfeddwol Cyfreithlon”): Sesiwn Dystiolaeth 3
## Inquiry into New Psychoactive Substances (“Legal Highs”): Evidence Session 3

[182] **David Rees:** Good afternoon—or good morning. Just for information purposes, you do not have to touch the microphones, as they will come on automatically. If you need translation, headphones are available. Channel 1 is for the simultaneous translation, Welsh to English, or if you wish to have amplification, it is on channel 0. I, therefore, welcome you to this third session of evidence for the inquiry into novel psychoactive substances. I will go through your names in the order that I have—check that I am right—and welcome Joanne

Davies, assistant director of planning, Abertawe Bro Morgannwg University Local Health Board; Jamie Harris, families, children and young persons services manager of SANDS Cymru; Nicola John, director of public health, Cwm Taf Local Health Board; Julia Lewis, consultant addiction psychiatrist and clinical lead for addiction, Aneurin Bevan Local Health Board; and Jonathan Whelan, assistant medical director of the Welsh Ambulance Services NHS Trust.

[183] **Dr Whelan:** Good morning.

[184] **David Rees:** Good morning and thank you all for coming. May I also thank the boards for submitting their written evidence as well? Thank you very much for that. We will go into some questions. I am sorry for the delay, we will try to make sure that we allow extra time if it is needed. I will start with Gwyn Price and then we will go to Darren for the second question.

[185] **Gwyn R. Price:** Thank you, Chair. Good morning to everybody. What is your perception of the scale of the problem of NPS use in Wales?

[186] **David Rees:** As we have such a large representation before us, we will take one answer and if you feel that you have something to add to that, please do so. That would be helpful. So, perhaps we will take the SANDS project first—Jamie.

[187] **Mr Harris:** I suppose, anecdotally, what we could tell you is that what we are seeing is that the NPS scene is far broader and wider reaching than our more illegal controlled substances, due to availability, which has an impact, via the internet and social media sites and the advertisements that are attached to them. Also, there is availability in certain stores throughout Wales, where it is accessible and you can purchase it over the counter. What we are seeing as well is confusion around the terms ‘legal highs’ and ‘NPS’—novel psychoactive substances—and what they really mean to individuals.

[188] From my experience, this takes me back to about 2006 when festivals would come rolling into town and they had stalls there that were being frequented by individuals who were not really involved in the substance misuse scene, but were looking for something that was not breaking the law and less risky, shall we say? But, what we were seeing was that people were frequenting the welfare provision needing medical attention, due to the fact that these substances were a lot stronger and were not being adulterated with any other substances, so their experiences and other types of trauma, whether that was emotional or physical, were coming to the front.

[189] So, it goes back some time. What there has been now is opportunity through the entrepreneurial skills of these people, who are selling these substances through all types of means, mediums and whatnot, and that accessibility has a far broader reach and casts the net further and further afield. So, we are seeing young people experimenting with these substances and older people—from my experience, anecdotally, in this service—who, historically, have used illicit substances like class A drugs, such as heroin, who are now deviating from those substances and using NPS, because the quality is far greater than that of street drugs, because they are not as adulterated as what they would have purchased from, say, someone on the street.

[190] So, what you have to look at, on the other hand, is that young people are experimenting—and I put an emphasis on ‘experimenting’—with a drug that is much, much stronger than if they were going to the dealer on the street who is looking to make money and will make a profit, tenfold, by adding adulterates to it. So, their experiences of substances are almost at the higher end; whereas, before, you would go through a phase of experimental use, to recreational use, to problematic use, they are jumping in at the deep end because of the

risks that are being taken.

[191] The evidence base for the impact of these substances is not really out there as much. However, it is coming together. Across Europe, we are gathering information, data and studies, because we are experiencing similar examples and experiences across Europe, and we are pooling that information together. I have brought with me today a document by the Romanian Harm Reduction Network, which is backed up by UNICEF and Unite for Children. It is a risk assessment of new psychoactive substances consumption among children and young people in Romania. If you look through it, there are very similar data to what we can pull together right here, right now, if we were to look at a snapshot in time.

[192] However, one of the biggest things is that these substances are far more wide reaching—I emphasise that once again—and I think that, to criticise our own services, we have focused on a cohort of problematic substance misusers, because of their experiences with anti-social behaviour, criminality, et cetera. What we have got out there are individuals who are using substances in the recreational scene. That cohort is far greater in number. Far more individuals are experimenting with these substances. They are very methodical about their use as well.

11:45

[193] **David Rees:** Does anyone wish to add anything to that?

[194] **Dr Lewis:** Looking at things like prevalence, the usual area that you would get data would be the attendance at treatment services. We are not seeing the people who use NPS coming through to treatment services, and that is partly because, very often, they do not acknowledge that they have a drug misuse problem, but also, as Jamie has already suggested, traditional drug treatment services in Wales are set up as opiate treatment services, so we do not advertise the right wares to these individuals. So, I think that is why we do not have a clear idea of the prevalence of use.

[195] **Dr Whelan:** The data that we submitted to you in advance—the extraction from our control room data over the previous year—comes with a warning, obviously, which is that the data only include where one of those terms has been disclosed during a 999 call, so, not where use has been identified later. However, I have subsequently asked our informatics team to go back to look at previous years. We can almost ignore the actual numbers that are there, but if you assume that the proportions will be correct, in the 2010-11 financial year, we had 15 calls that we identified as including those terms; in 2011-12, it was 28; the following year, it was 62; and, for last year, it was 115. So, I would not place too much credence on the numbers, because that would potentially be scratching the surface of the total workload that we are seeing, but it is certainly going up and it is going up at the moment at an exponential rate as well. So, I think that just sits with what you have said.

[196] **Darren Millar:** I will be interested to digest the data in your submission. May I just ask about one aspect that we touched on earlier on with the Angelus Foundation, which is the awareness of parents about the risks associated with new psychoactive substances? It has been suggested that most young people, particularly those at the earlier end of the spectrum as it were, in the early teen years, are influenced greatly by their parents, in terms of them being able to deter them from experimentation. I think it was in your paper, Julia Lewis, that you referred to Care for the Family's How to Drug Proof Your Kids course. You talk about the need to expand that sort of provision as a resource for parents across Wales. Do you want to tell us a little about that and how it plugs the gap in knowledge and where you see it being of use? Should it be targeted? Should it be available in all schools to parents? How does it actually work?

[197] **Dr Lewis:** That was possibly in the paper that our area planning board submitted, so I am going to admit to not knowing too much of the details about it myself. Everybody, I think, in the drug treatment field is aware of the fact that, where you have had educational approaches that have targeted teenagers in particular, you do not get much bang for your buck out of that. It does not really influence behaviours. However, there has been research looking at educating parents, so that they can have the correct sorts of conversations with young people, very often not the over-reactionary sort of response, but helping the young people to have the correct knowledge to make decisions. That is where the evidence is. If you provide teenagers and those who are younger with accurate knowledge and not the over-reactionary sort of response the things, then you are hopefully helping them to make sensible decisions in the future. That is certainly where the evidence is.

[198] I know that, similarly, in the past Alcohol Concern has done work with parents and primary schoolchildren, doing joint educational sessions after school, and that was found to be incredibly beneficial to the effect, very often, that the children were having a go at their parents for how much they drank. So, there is certainly evidence out there that if you are going to try to influence the knowledge of teenagers and those who are younger, a joint or an approach directed purely at parents is probably the best way to go.

[199] **David Rees:** Nicola, do you want to come in? Joanne wants to come in afterwards.

[200] **Ms John:** I would agree with Julia in terms of the work that we need to do with parents, but I think we need to extend it to all sorts of professionals who deal with young people, be they teachers, youth workers, police or health service workers at any level, because they are not necessarily skilled in putting the right messages across. I would also advocate that we support schools more to deliver more of a behaviour change-type approach that focuses on risk taking, rather than on specific issues. We know that our young people will always be attracted to risky behaviour and we find that those young people are the ones who will be more likely to be drinking alcohol, to be smoking, to be having underage sex and to become teenage parents. We need to think about how we can skill-up our young people so that they are able to make better decisions.

[201] Very often, we will adopt a finger-wagging approach to young people, which just does not work. We need to adopt an approach that gives them the tools so that they are able to make decisions, but that means that we need to think about how we skill-up the people who are actually providing that education as well, so that they are skilled in providing that. That is in terms of not only the resources that are available, but the methods by which they get their information across as well. It is also about joining up messages within schools, because we often have very well-meaning organisations going in to talk to schoolchildren, but it will be a different message every day about a different risk. If we thought about how we could join all of those together, we could actually produce a generation that is better at avoiding very risky behaviours.

[202] **Ms Davies:** Again, I think that focus on risk is absolutely right. As a parent of teenage children, I do think there is an element that this whole debate is not happening in the public. I think that what parents are hearing is that children and teenagers are drinking a bit less than they have done in the past and that is good news. Actually, the reality is that they are drinking less, but they may actually be combining that with taking a whole load of other things to get the same combined high, if you like, but perhaps in a way that they feel is better because their parents are saying, 'Don't drink excessively', and giving those messages out. The fact that, sometimes, these are called 'legal' highs implies that they are not as bad as things that are illegal. So, they are not doing something illegal and they are not doing what their parents are telling them about, which tends to be more about illicit drugs and alcohol; they are doing something else. So, there is a risk that parents are not actually being given that information to have that sensible conversation with their kids.

[203] If you go to the high street and go to some of the stores that are selling some of this stuff openly, I am sure that a lot of the parents who say to their kids, 'I'll see you in half an hour, after you have been to whatever shop because the clothes are nice', would not do so if they knew some of things that were actually for sale there that their children might be buying while they are there. So, I think by not having that public debate and getting some of that information out there, we are doing our parents and children a disservice, because it is becoming quite a simplistic message about illegal drugs and alcohol and ignoring this whole area.

[204] **Darren Millar:** So, you think that a greater emphasis on parents and guardians is important. In terms of the way that we deal with education for young people in schools on substance misuse, it very much focuses on illegal drugs and alcohol, and I understand that there is little or no emphasis on NPS and that, where they are incorporated, it is on a voluntary, ad hoc basis, according to each local education authority, basically. Is that something that you would like to see addressed, so that it is more prescriptive and so that it has to include reference, through the education system, to NPS?

[205] **Ms Davies:** I think so, in terms of information giving, from our perspective, and we have talked about re-commissioning, for example, the healthy schools programme in our area to make sure that it is up to date. However, I think it is about Nicola's point, which is that, actually, we are trying to enable our children to make informed decisions, be they about smoking, drug taking, alcohol and all the other things that they might get tempted to do that have peer pressure attached and suchlike. It is actually about life skills and about how you weigh up those relative risks as an individual and make decisions about them, and when there are negative consequences, you live with them. It is that behaviour change that we are looking at. So, this is one particular element of that, but, actually, we are trying to do it separately at the moment around smoking and all those other things, but actually the skill is basically the same.

[206] **Darren Millar:** Okay. Thank you.

[207] **Kirsty Williams:** I would like to come back to the issue of whether our services are fit for purpose for the changing nature of referrals. The paper that was submitted by the Royal College of Psychiatrists says that they are not, in that there is simply demand that cannot be met. I am wondering whether we could hear from those who have to deliver the service and those who are charged with the responsibility of planning and commissioning such services what is happening in organisations to address the shortfall in the availability of service.

[208] **John Griffiths:** Could I just add to that with a question that is very much on the same lines? One issue is the level of awareness among NHS professionals of NPS. Would they necessarily recognise that somebody who is in front of them because they have been using these substances is in front of them for that reason? There is a question there about awareness among staff and training to be able to recognise the problem so that we will know the extent of the problem more accurately and also, of course, so that the people before them get the appropriate services.

[209] **David Rees:** Let us start with the ambulance trust.

[210] **Dr Whelan:** I am afraid that I have very little to offer in response to your question, Kirsty, but in answer to your question, John, I think that the presentation of many of these substances is quite varied, and that is what poses us the challenge as clinicians. As I was saying before, when I was a junior A&E doctor about 10 or 12 years ago, there were only really a handful of drugs that people would take recreationally or habitually. They presented in a fairly classic way. So, if somebody takes an overdose of heroin, that has a staged series of

effects, and most clinicians would recognise that, and we recognise how to treat that. More recently, we have started seeing drugs such as these and other illegal drugs. Ketamine, for example, presents in a very, very strange way, and one person will react very differently to another. So, the recognition of these substances and other drugs that we are now seeing used regularly becomes a lot harder for clinicians.

[211] Perhaps at our end, at the life-threatening emergency end, that is not actually a huge problem because the management is the same. So, it does not really matter, if we do not have an antidote to a drug, that we do not recognise that that drug has been taken. But, on the wider issue, which I think you both allude to, which is to a certain extent recognising the size of the problem and providing us with an opportunity to intervene perhaps with the patients who we come into contact with who are less seriously ill, we do not have the understanding. I think that it is partly because it is very difficult to really identify it, I think, unless people say to us, 'I have taken x', we really do not have a way of identifying it quite commonly.

[212] **David Rees:** Julia.

[213] **Dr Lewis:** I will talk to both questions, if I may. I think that, within the existing drug treatment services, the skills are there because treating a drug problem is treating a drug problem. Unlike the traditional opiate treatment, there is not a substitute medication that you can prescribe, so that is not an issue. However, staff will have the skills to be able to work with someone. However, I think that staff often do not believe that. I think that there are some staff who believe that this is something different and that they have not been skilled up on it. So, when we talk about awareness-raising, I think that it is almost a case of needing to reassure staff that they can deal with it. However, I also think that the way that services are commissioned—very traditionally as opiate prescribing services—will need to change in order to be flexible enough to deal with this, and maybe we even need to think of the way in which we performance manage services, because it may be that our current performance management framework suits the very prescribed treatment of an opiate user moving through a series of stages but would not suit people who might need to dip in and out and have more of a harm-reduction approach. I think that that is an issue as well.

[214] If I may answer your question, John, when we talk about the health staff who need to be involved, we also have to remember that it is not just about physical complications; there are very significant mental health complications as well, often associated with a lot of aggression and a lot of violent behaviour. I think that mental health staff, when someone's personality and behaviour suddenly changes, will generally think of drugs as a potential cause, which is why I think that, within mental health services, we are picking up the use of NPS, where that has led to psychotic behaviour primarily.

12:00

[215] I think that the difficulty is in the anecdotal evidence that we have of suicidal behaviour among those who are coming down off, particularly, the stimulant NPS. That is very difficult to deal with, because these are individuals who do not necessarily have an underlying serious mental health problem, so they would not be receiving services already, but, as a result of the use of the drug, they are ending up with suicidal behaviour. I think that from the physical health point of view, Jonathan is right—you treat symptomatically what you have in front of you and if that is a heart attack in a 17-year-old, which we have had as a result of this, clinicians know how to deal with that, but as to whether they would necessarily not just think of asking the questions, but have the time to sit down and do a drug history with an individual who is acutely ill in front of them, that is possibly not within their remit, currently.

[216] **David Rees:** Nicola, do you have anything to add about from the health board point

of view?

[217] **Ms John:** Just to add, in terms of the scale of this, that substance misuse services, as Julia said, were originally set up largely for opiate users, but, overwhelmingly, in recent years, the problems that present to our services are largely to do with alcohol. For about 80% of our service users, alcohol is the main problem and, for a lot of them, their only drug of abuse. So, whereas this is a growing problem, it is small in comparison with the problems that alcohol gives us.

[218] However, the other thing is that users of these new and emerging drugs will also use other drugs, and alcohol will be a key one among those. The staff providing our services are certainly skilled, because the skills for dealing with that sort of behaviour is what they are good at, but I would not like us to think that we should not also concentrate on alcohol. That, in our area, is the only rising cause of mortality. We have reducing deaths from every other single cause: cardiovascular disease, malignant disease and respiratory disease are all coming down. Alcohol-related deaths are still going up.

[219] **David Rees:** Joanne, do you have anything else?

[220] **Ms Davies:** I was just going to pick up Julia's point about how there is a real issue around the data that we collect and submit to the Welsh Government from drug agencies about being very focused particularly on opiate use, and about getting people quickly through the system. That is a bit of a perverse incentive, because if you set up drop-in centre provision, for example, which is what we are in the process of doing now, because that is about getting these kinds of service users who will probably have not accessed our services, it is very difficult to show what would be seen as 'positive' key performance indicators in response to that. So, there is a bit of a tendency for us then to get told off, because the information that is going into the system looks incomplete because people are dipping in and out of the system, which they will do, and we do not want to put them off because of that, but it does not lend itself to having clear, linear treatment plans. So, there is something about recognising that this will impact on the kind of information that we collect and the kind of 'performance' that comes out of that, because, otherwise, we will be doing different things to try to feed that beast and tick boxes, rather than what is needed by the individuals.

[221] **David Rees:** Jamie, I will take your perspective, because yours will be different from the others.

[222] **Mr Harris:** Yes, as a service provider in the Swansea area, what we have found is that engagement with these individuals who experimentally or recreationally use or are experiencing problematic substance misuse issues is quite different and very diverse, on the premise that the barriers to accessing drug treatment are there because some services are pigeonholed as being the best fit for opiate or alcohol use, and those individuals who use NPS do not see themselves as the kind of client group who would access those services. So, what we are doing on the ground is, as I previously alluded to, that we are trying to diversify into the general population to make sure that we can get the message across that we are accessible to anyone and everyone, and that is from a parent, a carer, a young person to someone who is in the throes of their substance misuse, and wants more information. Unfortunately, we find that drug services are set up, but people do not come to the service in time to be able to access it to prevent harm within general health or mental health.

[223] What we would like to do is probably to have a different approach from our perspective—almost to come in and have an MOT, to look at your own drug use, to break it down, and to give that harm reduction advice, but not to have the judgment to say, 'You need to stop this', because what we want to do first and foremost is to get the engagement of the service users, to continue the use, so they do not feel that they are going to be undermined in

any way or face judgment on their use. What we find is that that does definitely break down the barriers, and what it does is to plant the seed initially, whether it takes a week, two years, four years, or five years. The goal could then potentially be working towards abstention, as long as they feel that they can access the service as and when, whenever they can. However, due to the nature of the substance and the erratic behaviour, that can sometimes cause fluctuations in engagement with the service, and also positive outcomes, which are then dictated from the KPIs, et cetera.

[224] So, it is very varied, but, as we were saying, from what is being done out there, and from what we have discussed here today, it is slowly happening, but, obviously, it needs a lot more time and input, for more promotion, more understanding. I used the analogy of looking at our service, which will receive a couple of thousand pounds to do an alcohol campaign at Christmas time, and then looking at the alcohol industry, which receives millions and millions of pounds to do an alcohol promotion campaign, with a gesture saying, you know, 'sensible drinking'. It is completely unbalanced. So, you know, it is quite a difficult one to kind of challenge.

[225] **David Rees:** Kirsty, are you okay?

[226] **Kirsty Williams:** That is fine, thank you.

[227] **David Rees:** John, are you okay?

[228] **John Griffiths:** Yes, thanks.

[229] **David Rees:** Darren.

[230] **Darren Millar:** I have just a very brief follow-up. One of the things we heard about in some focus groups that we undertook in north Wales was that changes in the terms of use, in the term to describe NPS, were very important. Someone suggested that there had been a club drugs clinic established. It was in London, but it seemed to be that that sort of tagline, as it were, was attracting people towards using services and getting engaged and getting their lives sorted out. Do you think that that sort of approach might be useful here in Wales?

[231] **Mr Harris:** I think that, potentially, because we have an established building that has the label of, for instance—I will use my service as an example—something like SANDS Cymru, which is renowned historically as an opiate service with a very busy needle exchange, those individuals might not identify with our service. So, if you establish another service outside of, and as an extension to, existing provisions within Swansea, where everyone feeds into it in a one-stop-shop kind of building, let we say, then, potentially, we could see better engagement and improved service delivery through something that has been created under another guise. But then, geographically, with the rural nature in and around Wales, there is a big club scene in the cities, and you will get potentially good engagement. But we have that already, in many ways, in young persons substance misuse services, and we do see a better uptake when you are in a shared building with other provisions. So, it is a good model, definitely, to take on board and try.

[232] **Dr Lewis:** To add to that, I am not sure whether it is in Glasgow or Edinburgh, but there is a service that has been set up opposite a head shop. It has a shop front very much like a head shop, and they have found quite a bit of engagement with that sort of approach as well. So, there are novel and inventive ways of doing this that will yield some returns, certainly.

[233] **David Rees:** In relation to the information, we talked about looking at the understanding of it and trying to encourage people to come forward. Is there an element of denial in young people at this point in time in fact—because of the term 'legal', there is a

denial that they actually need to come to services for advice and help?

[234] **Ms Davies:** I think that, generally, they do not see themselves as druggies, in the way that they might see a heroin user. Or they see this as an extension of—well, you know, you have a drink, and you have something with a drink. They do not perceive it as a drug in the same way as they would coke or other things.

[235] **Mr Harris:** What we are seeing—looking back historically, now, to when we used to use the example of cannabis being a gateway drug, what this is opening up is access to those class A, B, C type drugs, because people are experimenting with these substances thinking that there is an element of safety and then, once they get that experience of enjoying it, going forth and experimenting with those illicit kind of street drugs. Unfortunately, from our service users' experiences, as I alluded to earlier, these substances are a lot stronger than the classified substances. So, because we get a crossover, we are getting people who are starting off using NPS and then going to illegal drugs but going back to them because they find that they are less hassle and much easier to access. What you have then is service users who, say, are using opiates and other substances and who are delving into NPS and are going 'Whoa, wait a minute, these are quite strong' and then going back to using those illegal, illicit street drugs. It is amazing to see. So, the concern is that young people are starting off on lot stronger, easily accessible substances and are delving into illicit street drugs and finding that they are not as good and then going back. We could, potentially, see a lot of issues with child and adolescent mental health et cetera. We see a lot of physical effects now with the availability of ketamine, such as ketamine bladder. It is an unknown world but it is interesting to see where it is going and the crossover from both sides from illicit drug use to individuals using NPS.

[236] **David Rees:** You talk about young people starting off on these types of products. What type of age groups are we talking about?

[237] **Mr Harris:** From our service's perspective, we have had young people as young as 11 experimenting. Luckily, if they get picked up—the ones that we have referred into our service—they will receive an intervention, short or long term, which includes education, family members et cetera, because we want to maintain that. We have a holistic approach right up to adult services. They display and mimic very similar withdrawals. The compulsion to use these substances is at both ends of the age spectrum. It does go to show that they are—

[238] **Dr Lewis:** Within our young persons' service, over the last few months, we have seen three individuals around the age of 16 or 17 coming through as injecting heroin users. That is very unusual. We have not had that for a number of years. When we have looked back into it, they have gone from injecting mephedrone to injecting heroin. They have broken down the taboo of injecting and, because of the illegality, it has brought them into contact with dealers who will offer them something else. So, instead of going through the normal natural history of heroin use, which is to smoke for a while and then possibly progress to injecting, they are going straight to injecting heroin, which is concerning.

[239] **David Rees:** Last week we also had the Home Office report, which had a proposal in it to look at a ban on the sale and supply of NPS. What is your view on that, because, clearly, that does not penalise or criminalise the user, but looks at the supply of the drug? Will that be a problem? Jamie, I see you nodding there.

[240] **Mr Harris:** As we have such a large proportion of young people using and experimenting with these drugs, for that to be put into the judicial system it could impact on future goals, aspirations et cetera. The last thing that we want to do is put them into the criminal justice system. Once we do that, we put them into a stressful environment, we pigeon-hole them and sometimes they can continue on in that vein and, potentially, make the

wrong choices. As the report from the Home Office suggests, punitive measures and sentencing et cetera in relation to the harder drugs do not work. Penalising those individuals at a young age and putting them into the youth offending system means that they will receive a very proactive and holistic approach but they will still be labelled and taken out of mainstream activity such as education, depending on the severity of the offences. Those are the risks that we will take if we do that. I think that the last thing that we want to do is criminalise it. For example, when we were doing our mephedrone campaign, what we found was that, when that substance became illegal, it attracted media attention. When it attracted media attention, the notoriety went up. The quality of the drug went down and the price of the drug went up and rocketed. So, there were lots of opportunities for making money from that substance because it became harder to source. There were lots of entrepreneurial opportunities within that area of area of substance misuse to make money.

12:15

[241] **David Rees:** Julia, you highlighted in your previous answer that they were going to illegal suppliers to get that. Is there a fear that, if it becomes illegal to supply, they have a larger pot to sell?

[242] **Dr Lewis:** That would be a concern. If you make them illegal, people will still try to get hold of them, and it will go to the illegal dealers. The illegal dealers will then have more on offer that they will want to entice people into using. That would be a concern, certainly.

[243] **David Rees:** Does anybody else want to add anything?

[244] **Ms Davies:** I guess our comment would be that we would not want criminalisation because, as Jamie said, it is a long-term thing. We would support there being well-resourced young people's services, like the shop front idea, because it is about getting that information out there. Shops selling these things are very readily available, without there being a discussion about the relative risks. If you go into those shops and have a conversation with the staff in there, you would be amazed at the level of detail and information that they will go through with you. I have been in there with my teenage kids and they will ask 'Are they safe?' and the response will be 'Yes, they're safe; no problem'. You will then ask 'Any side effects?' and the response will be 'No, none'. It is not only about the fact that they are readily available but also about the whole safety impression that it gives around that. Kids think that they are safe to take, so they do not have to worry about it.

[245] **David Rees:** Do Members have any other questions? No. Thank you very much for attending and thank you very much for your written evidence, which has been very helpful. You will receive a transcript of this morning's session to check for any factual inaccuracies that you may wish to identify. Once again, thank you very much.

[246] I remind Members that we will reconvene at 1.15 p.m. this afternoon for our final session today to take evidence for the inquiry into new psychoactive substances.

*Gohiriwyd y cyfarfod rhwng 12:17 a 13:20.*
*The meeting adjourned between 12:17 and 13:20.*

## Ymchwiliad i Sylweddau Seicoweithredol Newydd ('Cyffuriau Penfeddwol Cyfreithlon'): Sesiwn Dystiolaeth 4
## Inquiry into New Psychoactive Substances ('Legal Highs'): Evidence Session 4

[247] **David Rees:** I welcome Members back to this afternoon's session of the Health and Social Care Committee. We are going into our final session of the day with witnesses on the

inquiry into new psychoactive substances. I welcome representatives from local authorities. We have Councillor Andrea Lewis, chair of the people cabinet advisory committee, City and County of Swansea; Kathryn Peters, community safety manager for Caerphilly County Borough Council; Angela Cronin, development worker for health and wellbeing, Bridgend youth services; Jackie Garland, service manager for social inclusion, Caerphilly County Borough Council here with us in the Senedd. We also have Richard Webb, who is representing the association of chief trading standards officers, coming to us from Oxford via the video link. I welcome you all, and thank you for the evidence that has been submitted in writing to the committee as part of this process. As a consequence, I want to try to move into questions as soon as possible, if that is okay with you. If we have any time afterwards, and if there is anything that I have left out or anything that you want to add, we will allow that to happen. By the way, you do not have to touch the microphones; they will come on automatically. If there is a question in Welsh and you need translation, the headphones provide Welsh to English simultaneous translation on channel 1, and amplification on channel 0. Gwyn, do you want to start?

[248] **Gwyn R. Price:** Thank you, Chair. Good afternoon, everybody, and to the video link. Could I ask, what is your perception of the scale of the problem of NPS use in Wales?

[249] **David Rees:** Who wants to answer that one?

[250] **Gwyn R. Price:** Does anyone want to start off?

[251] **David Rees:** I tell you what: we will go from left to right first, so we will start with Kathryn.

[252] **Ms Peters:** In terms of my role, there are a number of factors by which I will come into contact with NPS, primarily through the anti-social behaviour process. I manage, on behalf of the community safety partnership, the anti-social behaviour processes around young people and adults coming through the system. Of around approximately 1,000 referrals a year, 80% are young people. I could not quantify it, but it does crop up quite frequently that those young people are involved in taking NPS, and it is believed that this is having an effect on their behaviour in the community as well.

[253] **David Rees:** Angela, what are the experiences that you have in Bridgend youth services?

[254] **Ms Cronin:** We come across quite a lot of young people who are taking NPS, because they are quite readily available for them through a lot of retail sectors and market-stall type of thing. So, it is something that they can quite easily get their hands on, and we are seeing more and more cases, especially violent cases, where young people are involved in scuffles and quite violent situations through the usage of NPS.

[255] **Ms Garland:** In Caerphilly, I would say that the awareness among our schools and other educational settings varies, in that there is a lot of work that is undertaken in terms of substance misuse per se, but the knowledge of whether a child is using NPS varies. Some schools are fully aware and have evidence of it. Other schools do not have evidence of it; they may suspect it. There is quite a fear as well of promoting NPS in the absence of guidance.

[256] **David Rees:** Andrea, what about Swansea?

[257] **Ms Lewis:** The scale of it from a local authority perspective in Swansea is that, obviously, you have a hotspot where a trader is trading these items over the counter. That creates a greater issue with anti-social behaviour, et cetera, in that area. However, we need to be mindful that in Swansea, for example, we have children coming from across the authority

and bussing their way to these traders. As was rightly pointed out by Jackie, it is difficult to monitor because not all of the usage is reported. However, in the Swansea area, we have had, in a local secondary school in the Morriston area, two or three hospitalisations because of this usage, and it has caused a real detrimental impact on the local community. The children who are using these substances have anti-social behaviour; it has caused issues with the families of these children, and there have been a lot of break-ups of families because of this, with children going into their own supported living. We have had difficulties with it causing an impact on the traders in the local area because people who feel vulnerable and elderly have been reluctant to come to satellite towns where these traders are trading, so it has had an impact on the trade. So, this is a real issue within our communities.

[258] **David Rees:** Richard, although the question was focused upon take-up in Wales, what is the view of the Association of Chief Trading Standards Officers as to the uptake of NPS across the UK?

[259] **Mr Webb:** Generally, we would endorse the view that is expressed by the Welsh heads of trading standards services in their recent submission that the systematic collection of data and the reporting of information on the use and harms related to NPS is quite poor at the moment and quite inconsistent. Some of our members have experienced that trying to identify the level of harm locally that is being caused by NPS can be quite problematic. Even in engaging with the likes of accident and emergency departments, you start to expose gaps where people are presenting with issues that probably relate to NPS. There is no systematic process for the collection of that information and data, and for reporting that through to other bodies, so that any organisation can get a very clear and reliable picture of the scale of the harm and the problem.

[260] **Gwyn R. Price:** We have taken evidence that some people have noticed that they are able to sell it on the streets a lot more now, in local marketplaces, and certain shops are being opened up in certain areas. Will you confirm that that is a trend that you are seeing as well?

[261] **David Rees:** Can I ask Richard to answer that first, clearly, because I think his advice on that one would be very helpful.

[262] **Gwyn R. Price:** There you are, then, Richard. Have a go.

[263] **Mr Webb:** Yes, I think that is correct. From our experience of what we have seen, it is easier—not easy, but easier—to tackle the open sale of these products through retail outlets: head shops on the high street. However, that does not seem to have a significant impact on the reported use of NPS by local agencies dealing with drug addiction and counselling and other services. What we hear anecdotally and what we see more of is street dealing, so people buying in large quantities off the internet and selling it on the street, once you have dealt with the open sale through head shops.

[264] **David Rees:** You also mentioned the fact that people were coming in by bus.

[265] **Ms Lewis:** Yes. Looking at what Richard has said, I do not necessarily disagree with it, but I have seen at first hand the negative impact that a head shop has had on the high street. I think that if we can tackle that and, through legislation, enable trading standards and the police to prosecute those traders and prevent the supply, that will prevent the user, particularly in my local community, because it will prevent access, from my perspective. Children have been accessing it via the bus service, so the high street sale is crucial and critical. We need to tackle that, in my opinion.

[266] **David Rees:** Do you have anything additional to add to that?

[267] **Ms Peters:** Could I just add that, from the point of view of the Gwent area planning board's research, it has just conducted its unified needs assessment into substance misuse services? Data going back to 2013 have just been reported, which are backed up by some research that we have done into a community-led project as well, and direct dealing to young people is a particular issue. Dealers are targeting young people as they leave school, or young people become aware that a dealer is in an area and will communicate with each other by mobile phone and then go to find that person. I know that head shops are a particular issue, but we have evidence that direct dealing occurs, as well, to young people.

[268] **Ms Garland:** Just to add to that, we are aware, locally, that teachers and senior managers in schools have growing concerns that children and young people are able to more easily access them, because of the use of the internet and what is out there on the streets, but we do not have hard evidence of the facts.

[269] **Ms Cronin:** Can I just come in there? I think that young people see it as harmless because they can buy it over the counter in a shop. They do not see it as being in the same category as illegal substances, because it is being sold in shops and by market traders, et cetera. So, they think that they are taking a safe substance.

13:30

[270] **Alun Davies:** I was interested in your reply to Gwyn's first question. It is all very anecdotal, is it not, in terms of the information that we have access to and is available to us? To some extent, that is obviously going to be the case, given the substances and behaviour that we are dealing with. I understand and accept that, but I would like to ask you how confident you are that you have actually got a grip on the extent, or an understanding of the extent, of this issue in your particular areas. Do you believe that you are able to provide us with harder information on the extent of this issue in different groups within different communities? I do feel that we are dealing a lot with anecdotes and not much with facts.

[271] **David Rees:** Councillor Lewis, as a representative of the council.

[272] **Ms Lewis:** The actual prosecution would be hard evidence, and the difficulty we have is that it is very difficult for the police to prosecute when it is not an illegal product. So, that causes the difficulties. The hard reality of it is that we do have evidence of young groups of people gathering and taking these items, they cause anti-social behaviour in and around the area where the head shop is operating, and there is erratic behaviour. For example, they just run into oncoming traffic and they are found unconscious in car parks. I have had dealings with families and in the past have referred them to the police to give their stories of what is happening in their families, with one of their adolescents or teenagers dealing with these products. We have got children as young as 11 and 12 in the Morriston area consuming these items. I appreciate that the difficulty is that most of the evidence is anecdotal, but I think that that is largely to do with the fact that it is very difficult to prosecute when you do not have legislation to back it up.

[273] **Alun Davies:** I accept that. The evidence that we have seen is that you believe that the current legislative approaches are unclear and problematic, and that enforcement is inconsistent. Why do you believe that the legislation is unclear and problematic, and why is there inconsistent enforcement? I would have anticipated and expected local authorities dealing with the same issue to take a similar sort of approach. Now, it may well be that there are particular issues that you need to deal with in a particular way and in a particular locality, and I accept and understand that. I think that local authorities must always have the right and the freedom to deal with issues in their localities in the way they believe is best. That is the whole nature of local government. However, would you prefer the Welsh Government or the National Assembly to provide a clear and more directive approach: 'This is what we believe,

we are going to ban these things whatever route we take, and this is how you must deal with them'? Would you prefer that directive approach?

[274] **Ms Lewis:** We would welcome any guidance and advice that would help support us as a local authority to deal with this issue. I would have to personally give credit to our trading standards department and the police, who have been working collaboratively, but they are restricted: within the legislation, they can only deal with the packaging and things like that. They are restricted with regard to the actual product and what is in the product. As you are no doubt aware, the small print says, 'This is not for human consumption' and 'This is plant food' et cetera. I think, with any local authority, there is inconsistency. I should imagine that, across local authorities, they are all seeking best practice and the best way to tackle this and what has worked. However, they are struggling to find any best practice, because of the lack of law and legislation to back that up. We would welcome any support from Welsh Government that you can provide.

[275] **Alun Davies:** My question—

[276] **David Rees:** I am going to ask Kath, because obviously Kath is from a different council.

[277] **Ms Peters:** I think, specifically in relation to the legislation that is applicable to local authority regulatory services, that might be a question better dealt with by my colleague via video-conferencing. In terms of legislation to tackle sales from head shops, there are particular closure powers that can be used in other pieces of legislation, but unfortunately, none of those closure powers is applicable to this set of circumstances. So, as well as legislation that directly tackles the sale of the products, potentially, there is an avenue to look at shops that are actually selling and activity against those shops, as well. There is nothing available at the moment to do that.

[278] **Alun Davies:** My question was—I understand your response—whether you would want the Welsh Government or the National Assembly to be more directive in their approach, not to provide advice and support for a local authority to take whatever decision it chooses. However, would you want—and I seem to see that in some of the written evidence and from what you were saying earlier—the Government to be more directive, not just supporting the choices that you make, but saying 'This is the choice you must make'? Would you prefer that?

[279] **Ms Lewis:** I would, yes.

[280] **David Rees:** May I ask a slightly different question before John comes in? Clearly, the UK Government has produced a plan last week, looking at a proposal to make illegal the supply of NPS. Would that, in your view, Richard, actually be beneficial or not, because there seem to be varying views among standards officers as to whether such legislation would be helpful?

[281] **Ms Lewis:** To legalise?

[282] **David Rees:** Not to legalise. To criminalise supply.

[283] **Ms Lewis:** Yes, I think that that would be beneficial. We have looked at different ways of approaching this globally. New Zealand has gone down the decriminalisation route, which has not worked. Australia, with its different districts, has tried different approaches, and it seems to me that the Ireland model is the most successful, with the banning of new psychoactive substances or of emerging psychoactive substances. That would force the regulation of these products so that then they need to meet a regulatory requirement to

become legal. I think that that is the approach that we need to take.

[284] **David Rees:** I call on Richard.

[285] **Mr Webb:** To lead back to the previous question as well, the issue at the moment for regulatory services is that each piece of legislation that we are seeking to apply has a range of different potential challenges around interpretation, because the legislation simply was not written to deal with this kind of issue. We mentioned earlier the use of disclaimers like, 'Not for human consumption'. There are evidential challenges around proving that products are unsafe when they are relatively new and very little is known about the harms, short or long term. Every piece of legislation that we are trying to apply has a lot of challenges, which is why it leads to inconsistent and unclear enforcement, and I think that that needs to be recognised if the committee is considering being more directive around which legislative approaches should be taken. Until we have had some clear test cases that answer some questions about whether, for example, disclaimers such as, 'Not for human consumption' should be considered effective, there will always be a problem, considering that we are using untried, untested means to try to tackle the problem. So, certainly, our view is that a clearer legislative route, particularly one that puts the onus on the producer to evidence that the products are safe before they are put on the market and changes the burden of proof, would make it a lot easier for enforcement bodies to tackle the problems that there are with the unsafe products or with the suppliers who choose not to comply with that regime. The onus at the moment is very much on the enforcement body to prove that the product either is unsafe or is incorrectly labelled, or is not being sold correctly, which is quite a high burden for us.

[286] **David Rees:** Okay, thank you. John, do you have a question?

[287] **John Griffiths:** Yes, in terms of the support that is available, in the evidence that you have provided, there is a suggestion that a national, Wales-wide resource be developed, and one aspect of that might be a toolkit. I am wondering whether that could be expanded upon a little in terms of what, essentially, that toolkit would involve. It obviously could be useful in terms of dealing with the variability from one local authority to another, and I know that that was also tied in your evidence to resources, namely whether trading standards are sufficiently resourced in the current budgetary difficulties to provide the necessary service. So, it would be interesting just to get a flavour of how that toolkit might relate to those resource issues, whether it might ease the pressure on local authorities, or whether there would be a need for additional resource to be provided to local authorities alongside it.

[288] **David Rees:** [*Inaudible.*]—on that one in the first instance?

[289] Richard? May I ask you to reply to that in the first instance?

[290] **Mr Webb:** Sorry, it cut out for a moment there. We are currently, in the Association of Chief Trading Standards Officers, working to produce a kind of toolkit or resource base that you are referring to. I will outline what the content of that is. What we were trying to do is to pull together information from local authorities that are taking action relating to the sale of NPS locally, which includes case studies based on what the scale of the problem was locally, what approach they took to deal with that, what evidence they used, signposts to sources of expertise and guidance, analytics and forensic support, because the big gap at the moment is identifying who can provide evidence on the contents and who can provide evidence on the toxicological effects of consuming those products. There are people who can do that; it is just that it takes a while to find them. We also want to pull together examples within the case studies and details of what the challenges that each authority faced were and what the supply chain they uncovered was, because we know the retail supply chain in particular is quite interconnected, whereas it initially appeared to be quite localised, so that we can understand better how products are reaching the market and where you can move

intervention maybe away from the point of retail and up the supply chain to have more impact.

[291] So, at the moment, that is work in progress. It is very early days. We have got some good case studies coming together and some good reference materials, but that is the start of a toolkit that we are preparing. I have not got it all in front of me, but I would be happy to provide later a breakdown of some of the content of the template case studies that we are putting together, if that would help.

[292] **David Rees:** It would very much help us if you could provide that information. Obviously, I do not think that any of the local representatives today are in the trading standards area, so unless you want to specifically answer that question—

[293] **Ms Lewis:** No.

[294] **David Rees:** I thought so. Okay.

[295] We have had various questions this morning in evidence on the aspects of education, particularly that people—and I think you mentioned this earlier—seem to think that they are the norm and that it is okay because they are safe and because of the term 'legal' and the misconception that that brings. What processes do you see in relation to improving the education that is available, in schools and perhaps through the youth services as well, and how they can improve that?

[296] **Ms Cronin:** It is very difficult, because we have some schools that are really good at doing personal and social education and bringing in outside agencies to deal with issues and to teach young people about substances, but we have schools that lie in ignorance—'It's not happening here'—or do far too little too late. They call us in when pupils are in year 11 or year 12, when they have already been on substances for the last four years. So, it is very sporadic and I should imagine that that is the case throughout Wales.

[297] The problem we get in Bridgend particularly is that we have teachers who are maybe geography trained trying to deliver personal, social, health and economic sessions and not knowing the subject of what they are actually teaching, which, in my opinion, is more dangerous—not giving young people the right facts. I am also qualified in sexual health and we see this quite a lot within sexual health, where teachers are giving wrong information. It scares me, to be honest, that teachers are not giving up-to-date and correct information and that young people end up with a misconception of what is good, what is bad and the effects. They are being told that it is legal so it must be safe.

[298] I think what we need more across Wales—. I know it is already in the curriculum, but it needs to be enforced better, so that all young people are getting the same education when it comes to substance misuse, and other health issues to be honest.

[299] **David Rees:** Kathryn, I could see you nodding there.

13:45

[300] **Ms Peters:** I think, as my colleague said, it is sporadic. There is inconsistency in the level of knowledge among people in education and within youth services. I say that because I have been involved in a project with colleagues in Blaenau Gwent around developing an education pack for mephedrone in particular, but NPS as well. It is specifically a community-led project because there was recognition among the community that there was nothing there—there was nothing available both for educators and parents. So, that project came about and was developed over a number of months, with some quite extensive research from young

people, which showed how they were accessing and how their friends were accessing NPS and the effects that that was having on their communities. As a result of that, a product was developed, which met the PSE curriculum. It is very much a community-led project that has come from locally elected members and community representatives. Nothing was actually available nationally. No guidance was available nationally for teachers and nothing was available that could be picked up off the shelf to give them the necessary skills and tools to be able to respond.

[301] **Ms Garland:** Building on what colleagues have said, from a local authority perspective, what I would say is that, yes, there is a paucity of guidance, notwithstanding that, obviously, local authorities have to take responsibility for adopting a strategic approach. So, in working together with colleagues in social services, police, health, et cetera, we do a lot of work around this. It is at a very strategic level, is it not? So, we would bring together expertise from youth services, health, healthy schools, and so on, and also embrace the learner voice—you know, what young people are telling us—because, actually, they have far more knowledge than the rest of us about substance misuse.

[302] We would look at it at a policy level—whether the policy was fit for purpose and what the ranges of resources are. The resource that Kath has alluded to would be one of a whole range that we would use in Caerphilly, along with materials that young people themselves have made. That would supplement the school-based activities through what I call PSE. It is not perfect, as we do need more guidance, but I think that authorities can adopt a strategic approach. I think the key point from a safeguarding point of view is around the need for schools to get support in terms of support strategies. You know, you cannot just put on a DVD in a classroom for half an hour without having the support in place, because that could lead to all sorts of issues. A child could end up disclosing without a teacher quite knowing how to deal with that, unless this was well thought through. So, it is a very strategic approach that is required.

[303] **David Rees:** Okay, we have questions now from Kirsty and then Alun.

[304] **Kirsty Williams:** Angela, you said that you felt that schools should be forced to comply with the requirements of the curriculum. Who do you believe should be doing the enforcing?

[305] **Ms Cronin:** I think it should be the education departments, to ensure that the schools are meeting the criteria that are set out within the curriculum. The curriculum is very woolly when it comes to substance misuse and each school interprets it in a different way. I hold an event yearly—it is called a ‘think about drugs’ event—and pupils will come along. The school can then tick the box that their pupils have had their education around substance misuse. That is a one-off, one-day session—is it enough? Should that be ticking that box, basically, or do we need to do more work that is ongoing throughout the year during PSE sessions? Does it need to be more joined up, so that all schools are doing the same or a similar thing, so that all young people are getting the same information?

[306] **Kirsty Williams:** Given the local management of schools, do you believe that local education authorities have the wherewithal to be able to dictate to schools and, indeed, governing bodies, which I think are sometimes problematical in these areas, what they should be teaching their children?

[307] **Ms Cronin:** To a certain degree, I think ‘yes’. I am not from education—I do apologise—and you may disagree with me, but unless we have that to some extent, I do not think things are going to change. If you look at faith schools, for example, you will know that you cannot get through the door of faith schools, but yet they have more issues, I would say, than mainstream schools. We see an awful lot of young people coming to us from faith

schools when things have escalated out of control, basically, whereas if we could get in through their door to provide this education, things might not escalate so far out of hand. We might be able to nip it in the bud.

[308] **David Rees:** Do not worry about—. We are here to try to find out what is the best way forward, so all the information that we have will help us tremendously.

[309] **Ms Garland:** Picking up on your points, clearly, wellbeing is a feature that is judged by Estyn, is it not? So, it is very much a high-profile area for schools. Substance misuse is about wellbeing, but if you look at that section in Estyn reports, it will be unusual to find much detail in terms of what the school does around substance misuse. If an inspection focused on that, there would be greater appetite across Wales to get that right, would there not?

[310] Having said that, my experience of schools is that we hold them to account. We cannot dictate to them on something that is not compulsory in terms of how it is delivered; it is impossible. However, we challenge them. If you have a well-embedded support-and-challenge process, you can do that. It is made harder if they are not judged on that area, is it not?

[311] **Kirsty Williams:** May I ask, given that local education authorities have an awful lot to do, and this might not be particularly high on their agenda because they are not being judged on it in their Estyn inspections, what role could the educational consortia play? They cover wider geographical areas and, therefore, could perhaps be working at a larger level. Therefore, the opportunities for a postcode approach would be lessened if we were to do it via the education consortia.

[312] **Ms Garland:** My view would be that it should be something that is done in a collaborative way so that it is an area that the local authority is making schools accountable for. I believe that we do that, but we are doing it in the absence of any robust guidance. However, the local consortium would also need to be monitoring and auditing what schools are doing in this area. Schools can apply for quality awards, an element of which is substance misuse, is it not? That is going to bode well for their inspections, but it is not a prerequisite to getting a ‘good’ or ‘excellent’ judgment, is it?

[313] **Ms Cronin:** May I just come in on the awards, because I am one of the inspectors of schools for the awards, and what we are finding in Bridgend is that substance misuse is always the last section that schools choose, for whatever reason. I think that schools are afraid of dealing with substance misuse, because it is illegal. I think that they are afraid of tackling it for fear of doing something that is against the law. I have just written the substance misuse policy for Bridgend for all secondary schools, and even though the policy is in place, with set guidelines to follow, schools are still really scared of doing something wrong in terms of the law and they think that they could get into trouble. They are calling us in to deal with it; because I have written the policy, they now call me in to deal with any substance misuse issues, which was not the idea of the policy. That was to give them the guidelines and step-by-step instructions on what they could do.

[314] **David Rees:** Is that the weakness of the lack of expertise that you have identified?

[315] **Ms Cronin:** It could be a lack of expertise, but I think that it is fear. I think that there is fear, because they do not know the law around substance misuse, of doing something wrong.

[316] **Ms Lewis:** There are several points that have been raised that I think it is relevant to highlight. Over 12 months ago, I knew nothing about drugs. As it was a local ward issue, the

local police invited me to a drug awareness day, when I became extremely aware of and up to speed on everything that was being tackled on our streets and dealt with in our communities. Collaboration has been raised, and I think that there is an opportunity to tap into the police expertise and to bring that to the school, to create awareness and to educate, so that the education is therefore accurate and the information is up-to-date, because we are dealing with something that is evolving and changing at such a rate that it is difficult for legislation to keep up with it, and it is difficult for awareness training to keep up with it. So, you could design something, and then, six months later, it will be out of date. So, I think that there is a real opportunity, on a local policing level to the schools, to deal with the local issue, because, across the authorities, I should imagine that the issues are very different. I should not imagine that it is just a blanket issue across Wales. We have an issue on the high street; other authorities might have an issue with internet sales. So, I think that we could tap into the police expertise and use that to bring that awareness to schools.

[317] **David Rees:** John and Alun want to come in. So, Alun, and I will come back to you, Kirsty.

[318] **Alun Davies:** Mrs Peters, you referred to the project in Blaenau Gwent. I was involved in that and I am aware of the background to it. That was born of a real sense of urgency, because there were some very difficult and distressing issues in the borough. As we were working on it, there was recognition and a realisation that neither the resources nor the expertise were easily available, and it was collaboration with the police and others that enabled that project to happen. Earlier, you said that you wanted the Government to be more directive in its approach, but do you believe that the approach that is taken by public authorities in total is somewhat too fractured and that it is sometimes too based on, 'I'll do my job in front of me, and I won't look left and I won't look right'? Do you believe that we perhaps need to work in a more holistic way, bringing in the expertise of different resources and people, to enable us to achieve the sort of project that we had in Blaenau Gwent and elsewhere, but without the need for the catalyst, if you like, that led to that being created?

[319] **Ms Peters:** I think that 'yes' would be the answer to all those questions. As you know, the project that we are talking about—this project, which you would be aware of—was very much prompted by serious issues and serious concerns within the community, and by a vacuum of information, not only for young people, but a vacuum of information for parents, who would have been completely unaware of what their young people were involved in. I do think that there is a role for the police in schools' education programmes. However, it tends to be delivered by the school liaison officers within each local police force, who probably have capacity issues—they are in schools periodically, now and again—and I do think that there is probably a need for a more structured, focused education programme throughout the school stages that builds on knowledge from one stage to the next and is age appropriate, with tutors who are properly informed about how they should be delivering these messages. I think the reason that the project that we are both aware of came off the ground is that big gap and that vacuum, with nobody confident and able to deliver the correct messages in the community.

[320] As an immediate response, I think that, really, the key should be about the preventative and getting in there early and educating people—particularly young people—before they get to the ages where they are likely to encounter these things, where they are likely to be making decisions or be influenced by their peers. So, in terms of it being throughout the school career, I think that that needs to be built upon from the first stage in comprehensive school. There should be something that goes in in a structured way. However, I do believe that, speaking to some of the teaching staff involved in the project, PSE tutors probably lack confidence in their ability to tackle some issues, particularly when the drugs are changing from day to day. As we know, legally, it is very difficult to control these drugs under the current regime, because it is very much dependent on their chemical composition, which changes, and, therefore, there is a new product on the market. To take a more holistic

approach to drugs education is probably needed.

[321] **David Rees:** Richard, may I ask you whether you have any experience of a holistic approach to education tackling this problem?

[322] **Mr Webb:** I can only speak from the perspective of some local work that we carried out, rather than anything more systematic, but I am aware of a number of local initiatives, and they will always have to break down—I will not go into too much detail, because I think that everyone is in agreement—among a range of different partners. I think that trading standards brings to that mix an enforcement opportunity.

14:00

[323] Police officers, although often we recognise that their hands are tied, bring a lot of expertise and weight to any enforcement activities. I totally agree with the comments being made about the different dynamic that the police can bring to education initiatives in schools and the different knowledge and expertise that they have about the consequences and harms that arise from misuse of these products.

[324] Certainly, our experience is that if your drug and alcohol teams are prompt with ensuring that NPS are included in programmes around harm reduction and harm minimisation, and education programmes relating to festivals and with schools, you can start to build quite a comprehensive programme. But, it is still based on a lot of incomplete knowledge about exactly what the scale of the problem is and the longer term harms of the product. Certainly, we would endorse any kind of programme that is built on bringing the expertise from a range of different partner organisations together into one holistic programme of activities.

[325] **John Griffiths:** I want to pick up on something that Angela said earlier around the fear factor that schools might have with regard to these matters. I think, Angela, you were saying that maybe it is a worry about doing something wrong, or something that is not entirely in accordance with the law. But, other matters that we have heard about with regard to schools and their attitudes to these matters are that they might be very worried about admitting that there is a significant problem in the school with regard to any substance. Obviously, it is very competitive now between schools in terms of recruiting pupils and so on and image is very important. Is that something that you think is particularly significant? Would the work that you describe that you have been involved with locally address that issue?

[326] **Ms Cronin:** It goes some way to addressing the issue, but you are right that schools do not want to admit that there is drug dealing or drug taking going on on their premises. I have just been involved in three different incidents in three different schools within the borough. One school tried to brush it under the carpet, but how can you brush nine pupils being admitted to hospital under the carpet? It is fear; you are quite right. There are league tables and schools want a good reputation, because otherwise parents will not send their children to that school. But, schools need to realise that they are not unique. I would not say that there is one school in Wales that has not had a drug issue. The more that that is fed through and the more they realise this, maybe they will start to speak out and say, 'Actually, we did have a problem here'.

[327] Part of the substance misuse guidelines for secondary schools is that they have to feed back to me every six months about the incidents that they have had within their schools. We are due to do this at the end of November, so it could be interesting to see how many schools will feed back that information about how many incidents there were. I have asked that they feed back what drug was involved, so that we can start to collate some of this evidence that

you are asking for and say, for example, ‘Nine schools out of 16 had an issue with cannabis’. I think that that will be very useful in the future for the work that we are going to do in schools. So, if you have one school that has a massive issue with alcohol, for instance—let us not forget that alcohol is a drug as well—we will go in and address the alcohol issue within that school.

[328] The problem that we have, obviously, is resources at the moment. I am only one of three, you know, and when we have 16 schools all asking for the same thing, it is very difficult to get around all of the schools. With cutbacks coming as well, I do not know whether I will still have a job by April, so these are challenges that would need to be addressed to deal with the situation with a holistic approach.

[329] **Ms Garland:** To add to that, there is no doubt about it, schools do not want to be known for having bullying or what have you, but across our schools, we try, do we not, to create a culture whereby there is transparency? So, if you have rolling programmes where you are meeting with senior managers who are responsible for pastoral care, and we are sharing the information along with other hard data about exclusions and so on, it becomes the norm, does it not? I guess that what we need to try to do is to build capacity in schools, because we are not going to increase our resources in local authorities, are we? So, we have to have a strategic approach to building capacity so that they self-monitor and self-evaluate.

[330] **David Rees:** Kirsty, I will come back to you.

[331] **Kirsty Williams:** On that point then, Jackie, are you aware of any work that goes on with school governors and governing bodies, which in my experience are sometimes barriers to doing some of this stuff within the school, because of these very public image issues that they are concerned about? Again, it is about a lack of knowledge, understanding or confidence. Are you aware of any work that goes on at a governing body level so that school governors can be the people who keep an eye on what is happening within the school?

[332] **Ms Cronin:** I will come in there, Kirsty, because I am a trainer on substance misuse and I offer training to headteachers and governing bodies. We had six governors turn up out of, you know, how many?

[333] **Kirsty Williams:** Hundreds.

[334] **Ms Cronin:** Yes, basically, and they were mostly from primary schools. All right, they need to know, but it is the secondary schools that we need to be targeting with this work. When you have got six turning up—

[335] **Kirsty Williams:** It is disappointing.

[336] **Ms Cronin:** Yes, and it was offered right throughout Bridgend.

[337] **Kirsty Williams:** Thank you.

[338] **Lindsay Whittle:** First, my apologies for missing 10 minutes, especially as I was complaining first thing this morning about Assembly Members being late to meetings. These are austere times with cutbacks affecting local government, in particular training for teachers and perhaps our trading standards officers being cut as well. What about working with the local health boards, because clearly any money that they can offer to local government can save them in the long term from people becoming addicted to hard and psychoactive substances? They also have a duty to work with local government. Has any work been done, do you know?

[339] **Ms Garland:** Yes, you are absolutely right; it is a very valid comment. Across our region of south-east Wales—I would imagine that it is similar across the other consortium areas—as part of the safeguarding board work, we look at substance misuse. All of the statutory agencies and voluntary agencies are part of the safeguarding board. Substance misuse by children and adolescents and the effect that parental misuse has on those children are key priorities. You will be aware that, in terms of serious case reviews that have been undertaken in Wales and across Britain, there has been a lot of evidence of young people being severely harmed because of the impact that parental substance misuse has had on them. So, we do a lot of work with local health boards.

[340] **David Rees:** I am aware that we have spent a lot of time on questions on children, schools and young people. Do you have any indication or knowledge of the services for other groups as well? Although we are very much focused on young people, because that is the terminology that we tend to get, clearly that is not the sole group that uses NPS. Do you have an understanding or knowledge of the services for other age groups as well?

[341] **Ms Garland:** I do not, no.

[342] **David Rees:** Does anyone?

[343] **Ms Peters:** I can speak from the perspective of substance misuse treatment services, which are funded by Welsh Government's substance misuse action plan funding. They are now planned and managed on a regional basis, and it varies across Wales as to how they are configured, whether they are adult drug and alcohol services, or adult drug services and adult alcohol services, but there are services provided across Wales that will work with people who are in treatment services. Therefore, they may have polydrug use—they may be using NPS and there may be lots of other issues—and the services then tackle their particular issues. They are recognising that mephedrone—or NPS, I should say—are being used, and there is a worrying trend that they are starting to be injected as well, which is causing particular issues, because the chemical does not break down in the bloodstream so it is causing crystallisation in the veins. So, those things are occurring.

[344] That does not pick up the population that may be using NPS that are not in treatment services. If they are using to the extent that they require treatment services or they may be involved with specialist services, then they will be dealt with, but there is obviously a population of users out there who are not, probably because they do not see any risk, or their levels of drug use have not got to the extent where they require those sorts of services.

[345] **David Rees:** May I ask Richard a question? Richard, the Anti-social Behaviour, Crime and Policing Act 2014, which has only just been enacted, clearly puts some aspects of behaviour into the orders for tackling NPS. Do you see that being a major game changer in one sense, or do you see it actually causing more problems?

[346] **Mr Webb:** It is not something that we had looked into, to be honest. I would be hesitant about answering or providing specific views on that point at the moment. I have certainly had no feedback from members during the consultation on that Act, as it now is, that gave any indication that anyone thought it was going to make any significant difference in relation to the issue, but I could take that away to consider it further, if that would help.

[347] **David Rees:** That would be helpful, because, clearly, the way in which the UK Government is working, and the aspects there, will be important, because we hope to maybe have an opportunity to ask questions of the Home Office Minister, if we are able to put a new time in, depending on the change that I had to that. Do any Members have any other questions? Is there anything that you wish to add to what you have been able to tell us this afternoon? Kathryn.

[348] **Ms Peters:** Could I just comment on the Anti-social Behaviour, Crime and Policing Act 2014? There is not anything specifically in any of the new provisions that are in there around community protection notices, public space protection orders, closure notices and closure orders. There is not anything specifically in there that would directly tackle NPS use. It would if the usage was affecting a community or was affecting individuals, as there are then obviously the tools in there to deal with that, but there is not anything available to tackle it in general.

[349] **David Rees:** But it is a possibility if anti-social behaviour arises around a head shop, for example.

[350] **Ms Peters:** Yes.

[351] **David Rees:** There is an opportunity there.

[352] **Ms Lewis:** If I may comment on that, I think that there was a lot of hope, when that Act came in, that it would have an impact and assist with dealing with the issue in the ward. Unfortunately, it has not had any impact to my knowledge and from the feedback that I have had from trading standards and the police.

[353] **David Rees:** That is very helpful, thank you.

[354] **Ms Garland:** There is one thing, and I think that it has already been touched on. It would be really helpful if there could be a change in the use of the term 'legal high'. That has such a significant impact, and it is so misleading.

[355] **David Rees:** We have recognised that from the very beginning, because it is misleading and it gives an impression that whatever is being used is technically safe, because it is legal. We recognise that aspect. Okay. If there are no further questions, I thank you for evidence today. Richard, I thank you as well for your evidence. You will receive copies of the transcript for you to spot any factual inaccuracies—let us know if there are any, please. Once again, thank you very much.

14:13

## Papurau i'w Nodi
## Papers to Note

[356] **David Rees:** I would now like to move on to the next item on the agenda, which is papers to note. I will go through them. There are the minutes of the previous meetings on 16 and 22 October, the notes from the visits and focus group events held on 2 October—

[357] **Kirsty Williams:** May I ask a question about that?

[358] **David Rees:** Which one?

[359] **Kirsty Williams:** The notes on the visits.

[360] **David Rees:** Yes, okay.

[361] **Kirsty Williams:** Earlier today, Darren Millar said that certain evidence had come forward, as a result of the north Wales meeting, that the WEDINOS website should be a closed website, and he then made an off-the-record comment, saying, 'Well, it's in your pack'. I have read it through, and maybe I have missed it. There are comments relating to

what Darren Millar said about those websites being misused, but I could not see anything in there about the website being changed to a closed website. Could you clarify for me whether I have missed something, please?

[362] **David Rees:** I cannot clarify it, because I have not read the note fully.

[363] **Kirsty Williams:** Okay.

[364] **David Rees:** But I do remember its being discussed and its being mentioned when I was in the Wrexham event.

[365] **Kirsty Williams:** I would be really grateful to see the evidence that lies behind that.

[366] **David Rees:** I think that it was more a remark that highlighted the fact that people—. We were hearing from the people who were submitting drugs to WEDINOS for consideration getting back what would be deemed a clean sheet—effectively a 'legal sheet'.

14:15

[367] **Kirsty Williams:** I can see that that is referred to, but Darren was suggesting that changing the website to a closed website came as a result of evidence received in north Wales, and that that was in the note—

[368] **David Rees:** It was a comment that was made, rather than evidence, I think.

[369] **Kirsty Williams:** Okay. Thank you. I just wanted to—

[370] **David Rees:** It was a comment that was made—

[371] **Gwyn R. Price:** He did imply that if Kirsty looked in her pack she would know what he was talking about.

[372] **Kirsty Williams:** Yes—[*Inaudible.*]

[373] **David Rees:** It was a comment that was made.

[374] **Lindsay Whittle:** Everybody in Merthyr spoke extremely highly of WEDINOS.

[375] **David Rees:** I have just clarified that there was a comment made, that was all. However, I do not think that there was any specific evidence—

[376] **Kirsty Williams:** There is no evidence, no. He suggested that there was evidence outlined in the note, and I could not—. I had read the note, and I could not see it, but I thought that maybe I was wrong. Sometimes, there are so many notes, and so I thought that maybe I had missed something.

[377] **Alun Davies:** Surely not, Kirsty.

[378] **Kirsty Williams:** It does happen, from time to time.

[379] **David Rees:** We have dealt with that, and we are still in public session.

[380] The next papers, therefore, are the survey results and the consultation responses from the inquiry, which you have in the pack. We note those.

[381] There is additional information from the Minister for Health and Social Services and the chief medical officer following the factual briefing on the public health White Paper, which we held on 8 October.

[382] Finally, we have received correspondence from the Petitions Committee, with an attached letter from the Minister for Health and Social Services, in relation to a petition calling for a public inquiry into Abertawe Bro Morgannwg University Local Health Board. The letter requests that the committee consider including this topic in its future work programme, or asks whether we were considering it in our future work programme. My intention is to respond to the Chair of the Petitions Committee to indicate that it is not in our work programme at this point in time, that we are aware that the Public Accounts Committee is looking at governance issues and we will await any outcome from that inquiry of the Public Accounts Committee before we take anything further. Is that okay?

[383] **Kirsty Williams:** I am content.

[384] **David Rees:** Thank you very much for those points.

14:17

## Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
## Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Remainder of the Meeting

[385] **David Rees:** I move that

*the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).*

[386] Are all Members content with that? You are. Thank you.

*Derbyniwyd y cynnig.*
*Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 14:17.*
*The public part of the meeting ended at 14:17.*