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S1: = Speaker 1 - Lola Brittain

S2: = Speaker 2- Rachael Maskell

S3: = Speaker 3 - Kate Pickett

S4: = Speaker 4 - James Pierce

S5: = Speaker 5 - Matthew Gaskell

S6: = Speaker 6 - Councillor Michael

S1: Right, hello everyone. My name is Lola. I am the Yorkshire ambassador. I organised tonight's event. I just want to say thank you all for coming. It's really important. The point here is it's such a complex issue. All we know that the policy right now isn't working. So the point of tonight is really to try and understand maybe what will work. We can't do that without the input from you and without our panel. So without rambling on too much, I'm going to pass over to the event chair and to Rachel Maskell.

S2: Hello. Can I just say welcome and well done for finding this place. It's good seeing you all here in the room. So I'm going to chair today's session and I know that there's lots of expertise and experience in the room and I want to ensure that we take as many voices as we possibly can so think about the contributions that you want to make during the discussion. But we have got an excellent panel today. So we're going to start with myself in fact. I'm just going to say a few words and then hand over to Kate Pickett, who you'll know, who is base here at the university but also author of 'The Spirit Level' and 'The Inner Level'. I'm sure she's going to talk about some of those big issues of inequality and talk through her experience. Then we've got Michael (unclear 00:03:08) who is a local councillor but has spent most of his career working within the criminal justice system and about the system and certainly can speak from a practitioners point of view about his experiences there.

 Then on the end here we've got Dr Matthew Gaskell who is a consultant psychologist and is the lead at Leeds and York Partnership Trust and will be speaking from that perspective and finally James Pierce who has worked in the treatment services for about sixteen years and again has got such a wealth of experience and has worked around the whole sector. So lots of experience here at the top table. Obviously we want to gather your thoughts, gather your words and then it will feed in to the policy process within the Labour Party. So I'm just going to tell you a bit about my journey and why, as a politician, I'm so interested in this issue because needless to say , things in the House of Commons are operating in strange ways but it isn't just the systems and the processes but also the context of how policy is debated. Certainly as a Labour MP, I find myself up against a brick wall, a solid brick wall when talking about substance misuse in the chamber.

 Basically the government are still wedded to a theory which we know just doesn't show itself in practice around their war on drugs, replacing it in the Home Office, the agenda, within the criminal justice system and therefore not looking at really the impact that substance misuse is having on our communities and of course across wider society and therefore not looking at the causation, not looking at the roots around vulnerability in our society but instead treating too many people as criminals. As a result of that, we know that we've got a suppressive regime around substance misuse as opposed to a really proactive, positive regime about dignifying people who clearly have engaged in, whether it's drug or alcohol misuse and then being able to support and walk alongside them as we move forward. Obviously it's not just the government's approach which is wrong but also we know that the local authority here in York, and I know Michael will probably touch on his experience as a councillor as well but he actually stopped the mass slashing of the budgets here in York.

 But we already know so much of the funding has gone from services before he came on the scene. But of course, if you cut the services, we've got mental health services so stretched and of course a substance misuse service which just cannot deal with the capacity here in the city. Therefore it's of real concern again, as a local MP, that here we are sitting over a system which just cannot deliver the services it needs to to people. Mixed with that, we've got a housing crisis in the city. That has a massive impact, the fact that people do not have any base or stability, places of their own. The Housing First project is massively oversubscribed and just a few houses which are made available. People can't put those building blocks down in their life to start rebuilding and getting well again. As a result of that, I was alerted to how serious the problem was about eighteen months ago I think it was now when I got a letter in my post which just woke me up when I heard that there was about 54 deaths from substance misuse that year in York.

 Then reading the line that we're the highest population in the country. When I started having that engagement and debate with ministers, they kept saying, "York? York is a pretty little place." I think this really goes to show, and as I dive deeper and I think about the inequality in our city and the places of greatest inequality in the country, we start seeing some of the challenges which we have of even getting the debate aired in York, whether that's national government or local government. So in the light of that, and obviously then finding out about how many people are known to services in the city but also the capacity of those services, it made me realise that this is an agenda we are really going to have to fight for in the political realm to get the policy shift that we know is absolutely essential to put people in a safe space. I think that, for me, is the most important objective that I've got when looking at substance misuse, drugs or alcohol, is that we need to first of all ensure people are safe and then to look at how we can support those people through that process.

 I'm sure many of you in the room have worked in those environments and will want to share that. But I'm going to be taking notes as well because I need to have the questions from yourselves to then fire back up at ministers and to ensure that we are really putting them through their paces as to why they are absent on this agenda and of course seeing the real escalation of risk across our communities at this time. So I'm really grateful that you're here. I'm really grateful that our panel are here. Therefore I'm going to hand over to Kate now to lead on.

S3: Thank you. Welcome to the university. I'm really glad you've all made it in here. I sometimes struggle to find my way out of here at the end of the day. I've been researching the social (unclear 00:09:16) for a long time. But as well as doing academic research, I try to read a lot in other disciplines and books that other people will read. I read a book a few years ago by a man called Damian Thompson about addiction. The book is called 'The Fix'. He wrote about American soldiers fighting in Vietnam. Vast numbers of them took up heroin to cope with the lonely, stressful and frightening situation they found themselves in. The American government and the military were really worried that when they went back to America, they were going to have this huge insurgence of heroin addicts. But most of them just gave it up when they came home because they were no longer in that frightening context. They were safely back home.

 He says that, "For us in modern society, we are like soldiers drafted to Vietnam. We're disorientated, fearful and relentlessly tempted by fixes that promise to make reality more bearable. You don't have to be ill to give in, just human." What's so worrying about that analogy is that we are already home and it is our home that is so stressful and distressing and makes us so prone to addiction. We know that income equality is related to harmful drug use and addiction. I've got a chart up behind here which I just thought I'd bring along and leave up there which comes from our book 'Spirit Level' which was published in 2009. It shows in societies with more income inequality there is a higher prevalence of problem drug use and abuse. That's because if you live in a more unequal society where hierarchy matters more, where status matters more, where some people are worth so much more than others, we all worry more about our status. Some of us become depressed. Some of us become anxious.

 Some of us become psychotic even. There is more schizophrenia in more unequal societies, more bipolar disorder. Some of us become more narcissistic and try to self-enhance. You get more Donald Trumps, more Boris Johnsons in a more unequal society. But for many people there is a third way and it's not the new Labour third way. It's to try and comfort ourselves and compensate for the lack of respect we feel, for the status anxiety we feel, trying to comfort ourselves with use of alcohol, cigarettes, drugs, shopping, cupcakes, video games, the list goes on. These problems have always been seen as individual problems. It's a behavioural issue. It's a moral issue. It's somebody failing to make their own way in society and then compensate themselves for their own failings. But what this chart behind me shows is that it's a structural problem. You might argue about the statistics. You might say, "Is that the right number for the UK, the right number for France or the right number for the USA?"

 They might be a little bit off but look at the huge difference between different societies. There is something clearly different about how different countries make people feel and how people respond emotionally, psychologically and behaviourally to living in differently structured societies. So it's really obvious that we need a shift of policy. We also, in unequal societies, see higher levels of imprisonment, higher levels of violent and other criminal behaviour. So we're clearly not moving in the right direction. It's really obvious that we need to reduce harm. There is so many things we can do to reduce the harm of drugs. It's so obvious that we need to decriminalise certain drugs, that we need to legalise the use of certain drugs. All of that policy needs to happen. I hope that we'll talk about lots of the different policies that might be helpful.

 But beyond those policies that are specifically oriented at drugs and other addictive problems, we need to solve the poverty and inequality issues in our society because otherwise it's a little bit like upstairs in the bathroom someone's turned the tap on and the water is overflowing. If we just try and fix drug policy, we're just mopping up the floor. Really, what we need to do is turn off the tap. We need to fix the structural issues, inequality, poverty, discrimination that cause despair, distress, anomy, lack of social capital, lack of connectiveness, exclusion that give rise to the epidemic of addictive behaviours we see in our society as well as dealing with all of the legalistic issues around supply, demand, harm reduction, safe use, etc. I think I've used my even minutes so I'll stop there.

S2: Brilliant, thank you so much. James, can I turn to you next to lead on from that?

S4: Yes, so I was asked to come and share some thoughts on drug treatment. I started thinking about that and thought, "I don't know if I can really claim to speak for drug treatment," because it can be quite a sensitive area to talk about. So I thought what would be good is just to share some of the points made by Collective Voice, who are basically a consortium made up of treatment providers and then maybe share a few of my thoughts as well. So these are from Collective Voice from last year. They were talking about the benefits that drug treatment services brings to us all, to people who are affected by problem use in a family, to communities. So obviously drug treatment, we should see it as a provision that saves people's lives because we know it's a protective factor against overdose. We know that drug related deaths are rising dramatically in the UK and have been doing pretty much year on year and are now the highest on record.

 I forget the exact figure but it's somewhere in the region of about 4,500 deaths last year I think. So we know that keeping people in treatment, particularly if they're using drugs like heroin, that's a protective factor. We know that the evidence shows that being engaged in treatment reduces the potential for overdose. It also prevents the spread of blood borne viruses such as HIV and hepatitis C. Having worked in needle exchange for a long time, that's pretty clear. We've got very low HIV rates in the UK as a result of the good quality harm reduction services that we've had over the years. Hepatitis C rates are a little higher and that's to do with the way that the virus can live outside the body for a long time and be passed on in dry blood. It can live in blood for a long time. So we know drug treatment services help people recover when people are having problems with substances. Treatment can help people move away from that and build recovery, whatever that might mean to them.

 But there are some issues around that language and what recovery means, which we might come on to I'm sure at some point. We know that drug treatment reduces crime. The government identifies accessing drug treatment as an effective tool in reducing crime and suggests that about a third of the reduction in acquisitive crime has been attributed to the improved availability of treatment in the UK since 2001. So obviously a lot of people are using drugs problematically. They might become involved in criminality to fund their drug use, getting engaged in treatment. Reducing the use of drugs can obviously reduce that acquisitive crime as well. Then preventing the spread of addiction, that's probably not a term I'd have used but that's what it says in Collective Voice. So the suggestion is that people who are actively using drugs can often be a conduit for other people to start becoming involved in drug use and obviously getting people engaged in treatment can reduce that and be a preventative strategy for preventing people getting involved in problem drug use.

 In terms of challenges, well obviously funding is perhaps the single biggest issue facing the drug treatment sector. So there's been a 25% reduction in funding for treatment. In some areas it's been significantly more. The area where I work has had about a 50% something cut over the last few years. Obviously those kind of cuts to treatment mean that case loads go up, the amount of access to senior key worker reduces dramatically. Case load can be very high. Obviously somebody might see a worker every four weeks, every five weeks, maybe for half an hour. That's a snapshot in somebody's live and isn't really going to have too much of an impact on trying to break the cycle of their use. We know in terms of alcohol only one in five people with an alcohol problem is able to access treatment. We know that significant numbers of people who use opiates are outside treatment, at least 40%, maybe higher. There is a lot of anecdotal evidence to show that people are disengaging from treatment services for a whole range of reasons, which we might come on to.

 Two thirds of people are in prison who need treatment on release don't get it according to Public Health. We know that street homelessness has doubled since 2010. There's been reports out showing how high the overdose rate is amongst people who are street homeless in particular. Then in terms of other challenges, signs that drug related crime might be increasing, that's from the Crime Survey from 2017. So that's the Collective Voice opinion on some of the challenges and some of the benefits of treatment. In terms of perhaps some other things for us to think about that aren't included in that, I would say one of the biggest challenges is the complex and multiple issues of the ageing opiate using population. Most people who are using heroin are getting older. I've worked in services for a long time and got older alongside a lot of people who are in services. We've got people who are in their mid 40s, late 40s, early 50s or older who are using opiates, have been in and out of treatment for 20 years or so and might have periods where they're doing well but obviously addiction dependency, whatever you want to call it, is a chronic condition for some people and they're stuck in that cycle.

 Obviously as people are getting older, there is all of the stuff that goes alongside a drug using lifestyle, so complex medical conditions, a lot of lung problems, COPD, abscesses, ulcerations, blood borne viruses, poor diet, all that stuff. You throw all that stuff in together and you've got people who are very challenging. The drug use is just a small facet of that. We've got all the stuff around increasing purity and potency of substances. So street drugs are getting stronger and purer all the time. Cocaine purity in the UK is somewhere around about 80-85%, maybe even higher, about 637 cocaine deaths last year. Go into Leeds or York on a Friday night and ask people using cocaine, "Do people overdose from it?" a lot of people are probably unaware of the risks of using those really pure drugs. Then we've got other stuff. So we've got rising class A drug use among young people maybe, depending how you read the data. We've got increasing access to substances via the internet, via social media in particular. That poses a lot of challenges as well. We've got the rise in synthetic substances.

 We've all seen the stuff around spice and synthetic canabinoids but a lot of people are suggesting that the next wave of synthetic substances is going to be synthetic opiates and opioids which might prove even more challenging. Then perhaps around all this we've got the shift in emphasis in drug treatment from a harm reduction focus to one based on recovery. Obviously recovery is important but there is a lot of thinking that maybe that's shifted and perhaps contributed to some of these issues as well but that's not for me to get into too much. I think that's probably about it. Thank you.

S2: That was really comprehensive, thank you. If I can now turn to you, Matt.

S5: I didn't really quite know what to say this evening. It's hard to judge an audience. It's hard to know what colleagues are going to say. I've worked in this area for 20 years. I started out as a naive young psychologist working in high security prisons. I did, for a few years, sitting... I've always worked with people who seem to have the most severe and complex problems and difficulties. I started out thinking that in some way I can make a difference on a gradual, one to one basis. Of course over time you realise this is all about making a difference on a population level, on a legislation level, on a societal level. You can't just deal with an individual in a room and try and change the number of difficulties that come in this area. One of the things that I think doesn't really happen very much is truth telling, in all sorts of areas of life but certainly in the area of drug policy and drug use.

 So I'll just start by saying that we're talking a lot tonight about severe drug misuse and people who have multiple difficulties and lots of other problems in society but drug policy also has to represent the large number of drug users that are in society and recreational drug users, experimental use. It's very difficult to be honest and upfront about all of that but that's widespread across our society in all kinds of different forms and ways. Policy doesn't really help. It criminalises the illegality of drugs. It doesn't necessarily help the vast majority of people. It tends to target the more vulnerable black and minority ethnic groups and so on who are targeted more so and more likely to be stopped and searched or arrested and so on. The rest of us tend not to come in front of the law very much with drug use so there isn't very much truth being told about it which I think is difficult. As part of the process of the large number of people who use drugs, and the majority using drugs without the level of harm that we're talking about tonight, they are also, in my view, let down by the fact that they don't know what they're taking and that's the risk. It's not always so much necessarily the drug itself.

 It's actually the fact that you don't know how potent it is, you don't know what it's cut with, you don't know what else is going on and that's the problem. Those are the high profile cases that obviously you get in the media are usually middle class people at music festivals or such like who fit that kind of criteria. The people that I've been seeing for the last 20 years don't get near the front pages. We deal with between 12 and 18 deaths every month in Leeds where I work in our drug and alcohol service. So that's the first bit, it's just to talk more broadly I think about drug use as well as severe drug misuse and what comes with that. So I agree with what you were describing at the beginning about society. I was lucky to be taught by a university professor years ago called Bruce Alexander. I went to the University of Canada. I was very lucky to do that. He did a very well known study in this field called Rat Park, that some of you (unclear 00:27:15).

 You just need to look at that to really understand some of the things that we're talking about tonight. So yes, I'd encourage you to read about that. I'm sure many of you already know about that study. But really, what it's trying to represent is drug use can only be understood by moving beyond the individual (unclear 00:27:38) before looking at the environment. Of all the people I've seen on a one to one basis over the years, I must have seen thousands of people, all of those people have been so seriously harmed from the word go because they grew up and they were harmed by the people that they needed to trust. Then you could go out to a wider society. All the people I've seen have had childhood adversity. You think, "Well why would somebody end up perhaps taking multiple drugs, perhaps sedating themselves all day so that they can't live in their own mind and they can't be at one and present with their own thoughts. They want to escape the lives that we all try and battle with and live within. Why would that be?

 These are human beings. These are members of our community. These are people who are human beings who I really like, or they're people that I've worked with. They're all great characters and great people. They've had the most appalling suffering from the word go." So when you're thinking about why do people end up in the circumstances that they're in, the people that we pass who are homeless on the streets, which is a scourge on our society. It's absolutely horrific that this is going on. You have to think, "Well what has happened to this person? What does it tell us about our society?" So that's where I come from. I think very much about social factors, environmental factors as well as the harms that are brought to bear that help us think much more compassionately about people who end up having severe drug misuse problems and all the other things that come with it. I mean the research says 70-80% of people in substance misuse services have a diagnosable mental health condition.

 That's probably a conservative estimate. Mental illness and drug misuse go hand in hand. They're as one. Yet we have this rather strange arrangement where you have a drugs service and then you have a mental health service somewhere else. I work for a mental health trust. I speak to my colleagues in the mental health trust all the time. Try and getting them on board with drug misuse, which is their core business, at a senior level is almost impossible to do. They don't have the resources, the drivers, the interest (unclear 00:30:02), they feel it's something a bit different and strange, it's a problem because it gets in the way of a lot of the work that they do as they might see it. I speak to my colleagues in substance misuse and they're great people. They're really well meaning people. There is a lot of good people in the drug field but mental health is not their bag either. They don't understand it. They feel deskilled by it as well. They're not resourced and trained and supported to do that as well so that's a huge problem so I would highlight that. My patients are severely marginalised and stigmatised.

 They live with great shame. They walk around with their hoods up, their headphones in. They don't want anybody to come near them. They don't trust people. It's not helped by policy. It's not helped by politicians and the hypocrisy of politicians who convey a message that actually they're not really very worthwhile and they've got much bigger and better things to focus on than the homeless or the marginalised substance misusers and so on. I think that's not okay. I mean there's lots of things I'd like to talk about tonight. Very briefly, drug treatment services is a complete race to the bottom. Local authority budgets are being absolutely slashed so services have, unfortunately, succumbed to that. The quality of what goes on is not good enough. There is a brain drain. So my colleagues, the psychiatrists, the psychologists, the therapists that are needed in this space, as well as the drug workers and the recovery workers and the peer mentors who do fantastic work.

 The NHS is pretty much out of the picture, so the service that I lead. I sit on the NHS substance misuse provider alliance across the county. We have a very tiny role to play. It's largely due to budget cuts. So somebody who has got multiple psychiatric conditions, a poly drug user, physical health complaints, homelessness and violent, all kinds of issues in their life, they need people with expertise as well as the frontline workers that can do a great coordinating job. They're not there. They're just not there. I've been the only psychologist for 3,500 patients in Leeds on substance misuse. I can't recruit a consultant psychiatrist, they won't come because it's not a secure job. That's just scratching the surface of what's actually going on behind the scenes. That's it from me for a while.

S2: Michael, do you want to lead on from there?

S6: Thank you. I've always admired people that can talk off the cuff. I'm not one of them. So I hope you don't mind but I have prepared what I wanted to say. I've deliberately not included any figures or data sets in my section because we all know there's a crisis happening around us, of cuts in funding, of support services closing or cutting back on staff and a shortage of adequate housing. We know that people with addictions to substances often have no or little secure accommodation, precarious financial situations and poorer health outcomes. I use figures in my current job, such as the number of drug poisoning deaths which go up year on year to highlight failures in current policy. But statistics, understandably, take away from the individuals and their lives. What I wanted to talk about tonight are my reflections of a career in the probation service, running a supported accommodation charity and, latterly, as a councillor on York Council.

 I've been so lucky to have had the chance to be taken into my former clients lives, the trauma in their backgrounds and their hopes and dreams for the future. For far too many of them, I've seen those hopes come to nothing. I certainly don't claim to speak for every person with a drug problem but I hope that this account of my observation fairly reflects what I've seen. When I came to York in 1995, fresh out of university for my first job in the probation service, I thought I knew what I was doing. At that time in York, heroin was becoming a bigger issue. It seemed at times as if most of my case load was made up of clients who would turn up at the office under the influence. Home visits would be worse, seeing needles and drug paraphernalia just lying around with small children in the house was a real shock. I had to learn a whole new language of drug use in a matter of fact way that incidents that would have shocked the rest of the population were shrugged off.

 I remember one client with a burnt face who explained that he'd been lighting a cigarette on the cooker and had fallen asleep while doing it. He was laughing at the absurdity of it. I went to his funeral a few years later. His wife had also died a few weeks earlier of overdose and his child, who I had known since she was a little girl, a few years later. That's the reality for too many people. Even this week when I was asking a council officer about homeless deaths after reports this week about the rise this year, I was told the names of some of those who'd died. I knew four of them. That's why, when I was elected to represent Hull Road on York Council, I was determined to fight for a better deal for people who are homeless or suffering. That's what it is, suffering from substance misuse problems. When I found out that £200,000 is being cut this year from the substance misuse budget by Public Health, I asked the health scrutiny committee if I could lead an in-depth review of commissioner service for substance misuse.

 We got the money put back in but it's only for this year, and there's another projected £200,000 going out next year. I need to fight to make sure that services to help those with substance misuse problems get more funding. I'm not making myself out to be some sort of saint. There are a lot of people who are fighting for fairness in the system. But I have a platform in which I can influence decisions. It's my responsibility to use it to speak on behalf of those who don't get listened to because even in the (unclear 00:36:42) times in which we live in, there is still a sense of the deserving and non-deserving of help. For too long, people with addictions have been seen as undeserving. They're seen as a drain on the health service. They steal and cause misery to their victims and their own families. All these things are often true. Hepatitis C and HIV, deep vein thrombosis from injecting into the groin, unwillingness to get medical treatment until problems are so far advanced that it's often too late to save a limb or a life.

 There's a reason that homeless people die 30 years sooner than the rest of the population and it's not just sleeping out in the cold. It's the health problems that don't get treated. This year we've had deaths from cancer, sepsis and suicide as well as overdose amongst the homeless. All of them had substance misuse problems. With much earlier medical or psychological intervention, would some of them have lived? No one will know for sure. But what I am sure of is that early intervention is key and not just around drug treatment but how we look at the individual in the round. No one wakes up one morning and decides they will get addicted to heroin or crack or amphetamines. But however they got to where they are today, there is almost always a story of abuse or trauma of which drugs was a coping strategy but also of loss, loss of hope, loss of direction, often the loss of a family, loss of self-esteem. We need to start to rebuild hope for a better future. I must have visited clients in most of the prisons in England at some time or another. I see people clean and optimistic.

 There were so many good intentions of staying clean, getting a job, getting their relationships back and being happy. That normally lasted about three weeks on the out. I came to believe that was my window of opportunity to start the process of change. Unfortunately, whilst for some the active choice was to go straight back to drugs, for those who were motivated to change, the reality for too many is that they came out of jail with just a discharge grant of £46, went to a homeless hostel or crashed with a mate, invariably somebody from their past who equally, invariably, was a user. They couldn't access benefits or a flat. If they were able to access the drug services on release, they had to wait to see a doctor to get prescribe Methadone or Subutex. Instead, they found acceptance with their friends. With that acceptance there were consequences. That involved getting back into what they were doing and so the cycle began again.

 That's why we need to intervene early, make sure that they're safe and in stable accommodation ready for the day of release, make sure there is an appointment and ready access to treatment with counselling to keep motivation going and help to get benefits quickly. Many have no ID so couldn't get a bank account to get their money paid into, no GP practice or access to get medication for health problems or psychological support to address the issues that underpin their addiction. In the probation service, we went from one hour appointments to 30 minutes or signposting to other agencies. Now, with many, it's a phone call as their supervision. Is it any wonder that many feel that the outside world seems to be stacked against them and that it's easy to either drop out of services and go back to the only coping mechanism that they've known, back to drugs with their friends or to reoffend and go back to jail where at least it's a roof over their head and regular meals. That's reality for too many people.

 Until we say, as a society, that it's the system that has to change as much as the individual, I fear that the piecemeal initiatives addressing housing or drug treatment or employment will go the way of so many other government initiatives, well meaning but ineffective. We need to treat people with addictions as complex, needing a whole person wrap around level of support. I hope that the coming Labour government will bring health, housing, justice and benefits departments together to formulate a plan to offer a realistic and achievable way forward. Thank you.

M: Guys, I just want to explain the laptop situation really quickly because we've got a lot of people from drug treatment here and they're very funny about confidentiality. I want to make sure confidentiality is really clear, especially this front bench, very lively front bench. I'm (unclear 00:41:59), we're a drug advocacy organisation in London and we're the secretariat for the campaign. The laptop at the front is recording the audio of this session. What we do with that recording is it's transcribed and once it's transcribed, it's given to a working group of academics and other policy people. You can see it on the website, if you go on the Labour website (unclear 00:42:21). The minutes that are all typed up are collated and a series of recommendations are made from those minutes. Those recommendations are being presented to the Labour front bench with several MPs that are involved in working with the campaign.

 So the idea of this part of the session is that you guys provide comments and questions to the panel but the point of this is that we have suggestions for the Labour front bench to look at. So I know it's really tempting, I've worked in treatment for a long time. I'm very passionate about this issue and I know it's quite tempting to get really fired up and go on a bit of a rant. That's cool. It's good to have a rant. But during that rant, try and make sure that the end of that rant has a policy recommendation so that Rachael and the rest of the Labour MPs have something concrete that could turn into a policy. Does that make sense? The other thing is try and make sure we cover quite a lot of topics as well. There is quite a big drug treatment crowd here but I appreciate that drug policy is fairly broad. Does that make sense?

S5: What about service users?

M: What about them?

S5: Their contribution.

M: Is very, very welcome and encouraged but there is no need for anybody to identify as such. I mean I imagine this is probably for a Labour crowd, unless there's any (unclear 00:43:30). We don't ask people to identify or anything for the recording. The recording is kept confidentially. This is a safe space for people to identify whether they want. You can say whether you work in treatment or you're a service user or whatever else. But yes, any contribution is welcome. That's obviously a really important voice. All the ones that we've done so far have had lots of people who represent services.

S2: Can I just check for everybody's information, if they want to say their profession or perspective, will that be recorded but not the name?

M: Yes. I mean names or anything... the recommendations of the working group we'll see might have a psychologist said this, a psychologist said that. It's not going to be identifiable by name. Unless Ant's laptop goes missing, that's the only place the recordings are going to be on.

S2: Everybody okay with that? That's great. Just what I would say is that obviously we may be moving quickly, in a political situation, into trying to formulate some of these policies so some real practical stuff would be really helpful as well about how you see that policy context. Okay, who would like to begin the debate? What I'll do is I will bring back the panel after we've taken contributions to reflect back as well. But I think it will be good questions probably less so but more contributions. So you're going to kick off first.

M: I'm (unclear 00:45:11), I work in this university. My background is originally as a service user, then an addictions councillor. I'm currently an academic working particularly in prisons but historically around very marginalised groups with opioid problems in York as well. I think it was Mike's last point that we actually have a policy ready to go. We've been working on, I don't know if you know (unclear 00:45:31) Patel. It was Mike's last point that really touched on this. So Lord Patel wrote the prison review group for drug strategy in prisons. I mean this ties into a broader point. What we've been working on at the moment, people access treatment within prison, as Mike was saying. To give an example from a study we ran a couple of years ago, we met government pilot initiative, drug recovery wings and an ambitious abstinence focus treatment. We spoke to about 60 people in prison.

 Some of them, many of them were signing hallelujah by the time they came out. They come in physically broken, in a real state. They're coming out, one young lad had been living in a tent, came out singing hallelujah, really in a great place. When we spoke to them three months later, six months later, not one of them had been found housing who needed housing. Not one of them had been joined up with services. This one young lad who sticks in my mind was saying to me, going back to adverse childhood experiences, "The first time in my life since I was nine years old I'd had a drug in my body. I've given up smoking. My body is a temple. Nobody was born with a cigarette in his mouth." But when I spoke to him after six months, he'd tried to commit suicide three times. He'd come out of hospital that morning. He was selling cocaine because it was the only way that he could make a living. Now where this is going really is back to that point about the report that we put out a short while about called Ex-prisoners Recovering from Addiction, which has the buy-in of Forward Trust, the buy-in of Phoenix Futures, the big prison agency.

 It's saying that there is no point in delivering these interventions in prison if it is not tied up to that support outside. If people cannot be guaranteed secure abstinence focused housing, some kind of job prospect then the whole of this huge potential that is created within prison goes nowhere. The broader point that I briefly want to tag on to that is that that applies to community populations as well. The work we did in York was with people who all of them had been prescribed opioids, Methadone, for 10-15 years. It was in a context of reducing Methadone. Everyone has got to be in recovery, reducing Methadone. It was people, some of whom were living in fantasy, literally severe post traumatic stress disorder, severe bipolar disorder, living in worlds where they would not enter in reality all day, not even bouncing off it and they're having their Methadone scripts reduced.

 Really, for me, that comes back to this whole point about if we want to see progress in people, just expecting that change to magically happen isn't going to... it is that point about the whole system needs to be in place. The whole driver needs to be in place around it but it's those points.

M: If any of you guys on the front, sorry to keep interjecting, Rachael, I'm already being annoying, if anyone on the panel, what's helped before is if you agree or want to back it up, then that can be useful for the working group because sometimes things are said and (unclear 00:48:19).

S5: I agree. This product also might end up in a mental health admission or a hospital admission, physical health. Then you've got to think about joining up on discharge or whatever as well and that doesn't happen enough. Also, when people have lost tolerance and they're now in a vulnerable place as well, that's a particular problem as well. People don't have the awareness to know how to connect things up properly. Briefly, I'd also mention about the way that the drug treatment system is commissioned and competitive tendering as well does not serve the community or the people that we're trying to serve as well. So you get into these short contracts where the performance if you like isn't very good. Then you get into a place where you can start to deliver and the staff start to settle and feel like they can understand the model and what's happening and the service users start to settle and then we're on another round of competitive tendering as well.

 That's all mixed in with the changes in government and the changes in direction from Methadone maintenance then to it's all about abstinence and getting people on to suboptimal doses and short duration and getting them off Methadone much more quickly than otherwise they would want to do so. There's all kinds of things that link on from what you've just described there that hasn't been said.

M: Hi there, my name's Jonny. I'm an ambassador for the campaign in Grimsby. Thanks very much for your speeches. It's really, really interesting. I apologise I have to leave after this. I'd really like to stay but just a short thing, the message from all of you seems to be that drug use, particularly problem drug use, should be seen as a Public Health issue and not a criminal issue. So in the interests of the manifesto, can we all commit to stopping giving criminal records, criminal sanctions to drug users?

S2: Thank you. Yes?

S5: Yes for personal possession and for personal drug user, 100%. The barrier it presents to where we really want to get to with people is actually reforming and helping them achieve a better life for themselves. The numbers of people who come to me and say, "I'm totally constrained. I can't get anywhere because of my criminal record," is a complete injustice and self-defeating.

S3: Can I just say though, we have academic evidence on so many issues that shows that treating issues as a Public Health issue rather than a criminal issue, whether it's drugs, juvenile violence, all kinds of things, whether it's the importance of social support and welfare benefits, problems in people's lives, we've got evidence in spades but we don't know how to get our evidence across when people are actually simply interested in using emotive and ideological arguments and they just dismiss our evidence. That's getting worse. I mean it used to be that actually you might be able to go out with some statistics and actually get a little bit of movement politically. Now you go out with some statistics and you're told it's fake news, the British public don't want to hear from experts. It's dismissed so it's even worse than it used to be. Academically we've not yet figured out how to respond to that. So I'm struggling to know how we bring an evidence based perspective to Labour Party policy but yet give them the stories that they need to counteract the mainstream Conservative, right wing narrative that isn't interested in evidence.

M: Well surely the service users, the very people that use the services are the best people to talk to about their experience within drug addiction services but also, I don't like using the term dual diagnosis but my mental health issues have ran alongside my drug use throughout my 45 years nearly. What frustrates me is that alcohol tends to be pushed to one side because it's socially acceptable. But in terms of what you're talking about now, surely it's to talk to the people that have been through services, particularly in recent years and the changes that have happened in York with the new contract, which I understand is seven years long, as far as I know. But it's the voice of the people that are using these services that is the most important to convey to the MPs in discussions.

S3: Can I respond? I think both are important. Actually I think it's really important to recognise that there's not necessarily no overlap between those who produce evidence and those who have lived experience. I know plenty of people who sit in both camps. When we produce our statistical evidence, that's one kind of thing that we can use to try and change policy. When we produce our stories from our lived experience, that's another kind of evidence. They're both really powerful and they're both needed. One without the other won't work but at the moment I think even when we bring them together, we're fighting against an ideology that doesn't want to see evidence and it doesn't want to hear the lived experience of people.

M: I just think for people voting, if we can be more relatable in terms of providing a sort of response in terms of... like people tend to switch off with figures and percentages and what have you but if you listen to someone telling their story, I think it's a far more powerful tool in terms of getting the message across to the public. It's not necessarily all about the MPs.

S2: I mean I'd certainly agree. It's the combination. I think we've got the backdrop at the moment where a set narrative and a media delivery is driving policy as opposed to going back to the sources, whether that's academic evidence or lived experience. I think that's the challenge we've got and therefore it's a crowded space where, if you like, the real voice we need to hear isn't happening. Now Labour want to take that other approach to really get to the crux of the issues. Then with that voice and with the evidence, we can not only say, "This is what we're going to do in power," but also to keep throwing that at the government whilst they are still there to say, "We demand this." But as politicians, we need education, which is obviously what I've been through over the last few years around this policy area. It is, again, a crowded space because there are things that are pulling you in all sorts of directions.

 But this group here is set around other... I don't know how many MPs are involved but there is quite a handful of us which are serious about progressing the policy arena and therefore having that focus is about how we cut through. So we're going to focus on delivery of that. Loads of people, I'm going to take James first and then I will go to the back and then work forward.

S4: So I'll just say on that point I think obviously the important narrative around drugs needs to be just an honest conversation about drugs that we just don't have as a society at all. The biggest group of people who use drugs are non-problem users. They're just people who use drugs. We all know people who use drugs. We work with them. They're in our family. Everyone knows people who use drugs but that voice doesn't get heard much because drugs are illegal so people keep it very quiet. So the narrative we often get presented comes through treatment services and it's that narrative around somebody has had a problem, they've had addiction, then they get into recovery and then they celebrate that recovery. I'd like to hear about stories from people who haven't really had problems with drugs, who got on with life. They might be a politician. They might be a journalist. We don't hear those voices. It's about having that honest conversation because without that we're just left with this very skewed perception of what drugs are, what they do to society.

 That narrative around addiction is a very small number of people. Most people don't have a problem. I think that's the important narrative that needs to shift to get us to a place where drugs are seen as actually not unusual or deviant or problematic for most people, just a normal thing that people do. That's where we need to get to with effecting drug policy.

F: I just wanted to say to you, that's kind of the point of this campaign. What you're saying we need to hear from people who have experience, well that is (unclear 00:58:12) from your perspective, politicians will hear it, it will go via expert working groups. Then policy absolutely needs to change. We're all here because we probably agree with that. It's not got to be made in office in Westminster. It's got to be made on the back of people like yourself who actually know what they're talking about and they're making recommendations based on that. I think that's actually why it's so important and why we're doing this. What you've just said, I think you were saying about we only hear certain voices. There is a massive (unclear 00:58:51) around it because we heard in the Conversation leadership election people talking about what drugs they take. It became some kind of funny... it's like well Sir Michael Gove was talking about cocaine but then the next day he was saying, "Well we need to take harsher action around it."

 What is the timescale? Do you think that? You need to bridge that. That doesn't happen. So either it's the policy needs to reflect reality. There can't be one reality where people are taking cocaine and that's okay and then another reality where it's not okay (unclear 00:59:37). There needs to be an approach actually of drug use on all levels.

S2: There is a lot of overlay of class and all sorts of issues which are mixed into this agenda which we've got to be very aware of as well.

F: Bringing it back to housing actually, I work for a Labour run local authority. I work in the housing (unclear 01:00:04) which gets... when I say the shit rolls down the hill and lands in our office, it feels like that sometimes. But yesterday I saw somebody who is street homeless. They're with me (unclear 01:00:20). The night before, he'd been beaten up quite badly. Well somebody had found him on the street, another street homeless person had taken him to QMC in Nottingham. His heart stopped while he was there because he's got two heart valves. He was resuscitated obviously. He's got Hepatitis C, deep vein thrombosis. He was ODing when he went into hospital. He is an alcohol abuser, heroin addiction, crack addiction, huge psychological problems. (unclear 01:01:11) but should have been I think, wasn't engaging with any services. He left hospital as well with just his gown. He had nothing else to wear. He came to us for housing. He wasn't considered a priority need and he was sent away.

S2: That whole thing of the joined up pathways is absolutely crucial.

F: For the record, he said, "Well I'm going to go and kill myself."

S5: You can't do that in isolation. You can't just get a good... even if we were able to get a drug policy, a good one, which we don't have, even if we did, it can't be done in isolation. It has to build around a number of other developments, housing, employment, attractive alternatives to drug use as well. People tend to move away from drug use if there is a meaningful attractive alternative for them. They will choose that.

F: But he was not a priority need. I mean he was a dead man walking.

S5: A house, these are just basic things.

F: He just probably wanted somewhere for the night. He probably wouldn't even engage for two nights but I don't make the decisions, my duty manager and they're gatekeepers. Make no mistake, they are gatekeepers for the cash. That's what it comes down to. It is a Labour run authority, dare I say it but...

S2: We've got real challenges here around housing as well.

F: Yes. So I work in the drug treatment service in York and I think it's just really to bring it back to the point that you initially were saying, Matt, and then what you said since that about how we need a policy that appeals to everybody because sometimes I think when we're talking about the really chaotic users that have multiple needs, the people that really do see the inequalities in society, that almost doesn't appeal to a lot of people who we need to get behind this policy. I think a way of doing that is through education and through prevention but trying to get people to resonate in some way with addiction, the fact that most people either know of someone who is using drugs, whether that be recreationally, problematically or alcohol, I think is a really good point with that. So many people use alcohol and it might be recreationally but still above the levels that are recommended. I think that if you can tailor education about what addiction is and how it can happen to anybody, talk about that and normalise it, people can relate to it more and people can support the policies more.

 So in our role we don't, at the moment, because of the cuts, we don't do any education. We don't do any prevention. That's something that I think is really important because it's not that we don't know this. We know there is inequalities with society that cause problems but we also know that there are difficulties people experience themselves, anxiety, depression. That's one of the biggest burdens of disease in middle income class as well. I think it's important that we're targeting everybody when we're moving forward, about what's needed in drug treatment, not only the small cohort of complex clients because I think if we're tailoring it more broadly, people can understand. If they're going into schools educating people, if we're educating just the general society, people, just like mental health with the destigmatising campaigns, if we did something like that it gets people talking.

S5: The messaging is so important. So I grew up with the Grange Hill Just So They Know campaign. I lead the Northern Gambling Service as well that we've just opened in the NHS and the message there is responsible gambling is again down to the individual to just take responsibility and when the funds stop, stop. The messaging is awful. So you have to have messaging that engages people and it's part of lived experience, as you were describing. It's got to say something that actually catches people's attention, that means something, it's real, it's truth telling rather than nonsense telling.

M: Recently I've become really passionate about this subject. I'm in a place whereby I'm well enough, I think, to offer forward my opinions and generally they're taken quite well but for instance, it's taken me four and a half years of engagement with Lifeline as it was and Changing Lives and mental health services. It's taken me four and a half years to get to see a doctor next week for my complex post traumatic stress disorder which was from a period of domestic abuse over thirteen years ago. On top of that, I've had to deal with the alcohol and cannabis use as a self-medicating thing. It's terribly frustrating that my life has been on hold for that period of time. Trying to relay that to bodies of people like this without getting on my soap box and it being ineffective is very tricky.

S5: There is policy development in what you've just described. The one thing in drug treatment services tends to be GPs who do the prescribing and it tends to be frontline staff who are non-professionals from a non-professional background. The one thing that could happen is actually amalgamating mental health specialism with drug treatment so that people aren't waiting for years and years or sitting in a drug treatment system for years and years before they get to see somebody who is able to deal with treating post traumatic stress disorder or complex trauma or all the other psychiatric conditions, really severe anxiety that cripples people and holds them back. So that's one policy development, to bring it together rather than have this ridiculous separation. We've known this for 20 odd years and it hasn't moved forward.

S6: I mean I think progressive policy change is the removal of the short term prison sentence. There can be nothing more frustrating than you're so far along with somebody, they're maybe a few days away, a week away from a flat, they're in treatment, they've committed an offence. It may be a lot less than they'd done historically and nowhere near the frequency and then they get sent down for twelve weeks and everything stops. Everything has to start again. That's the frustration.

S2: James and then people with their hands up that I have seen, I've got seven people at the moment so I will come to you.

S4: Yes, I totally agree with what Matt said, a single policy recommendation coming to bring drug treatment services and mental health services together. Nearly everybody I've seen over the years, I'm not a psychologist, I'm not qualified to deal with childhood trauma or PTSD, that's the stuff people need. It's not a Methadone script or whatever. They need much more comprehensive psychotherapy, psychological therapies and that needs to be a solid part of drug treatment. That should be a clear recommendation.

S2: Okay, one and then two.

F: I'm a student at the University of Leeds and I just recently wrote an article on harm reduction for students. That just made me realise the little sense (unclear 01:08:50) there is between the stance the uni of students say and the university say. There is one side, the student union, telling us that they're going to take a harm reduction approach, that they're going to help us, offer us support in education. On the other hand we have a university that says, "You take drugs, you're going to be evicted. You're going to be taken out of university. You won't have a professional future." The fact that the university is in the way of students getting the help they need, getting support, learning important things to keep themselves sane, there needs to be a change coming from our time to make universities allow a harm reduction approach to come through because the lives and future of young people are at stake here. It's a bit sad that we can't...

S5: Totally agree with you. That goes back to what we were saying about a policy that actually works for the whole people, not just for the cohort we were talking about before.

S2: It's about having one policy. I think the problem at the moment, the policy is sitting in too many different places and as a result of that, clearly conflicted messages are coming out that it is...

S3: But it's also about institutions reflect the societies they're in. Universities used to be more progressive, liberal places and they have been affected by neo-liberal capitalism in all kinds of unpleasant ways. They've been complicit with tuition fees. They've been complicit with spying on students to see if they're terrorists, all kind of unpleasant things. Some I think try harder than others to resist those forces in society but they reflect, like schools do, universities, workplaces, they reflect the nature of the society they're in. They're not helpful in a holistic way but we ought to be able to expect them to be given what their state of values and missions are. So we do need to hold them more to account.

F: Sorry, I manage a complex needs service but I've now got two things to say. What that lady just said, we see that in society. We see people that daren't be honest because treatment is punitive. They daren't tell their probation officer what they're really using. They daren't tell their doctor what they're really using because there are sanctions. That creates issues. It's not helpful with (unclear 01:11:31). The other thing I was... I can't remember what I was initially putting my hand up for. So we've just received money through our SI funds which has allowed us to get two new workers as part of the reducing rough sleeping act, which is great and is needed and I'm not here to say it's not needed. But I think if you're looking at policy, rough sleeping can't be eliminated when the services that feed into that are underfunded and ineffective, mental health services, substance misuse. All of them, they're being ineffective because they're underfunded. So the government are putting money into one area of a massive problem. That problem can't be fixed. Why aren't we looking at joint commissioning of services like the Plymouth model and other areas?

S4: Absolutely. That's a great recommendation, to cut across the different departments.

S6: There was talk of doing that ten years ago. All departments were going to come together and they were going to develop a coherent strategy and it didn't happen and it doesn't happen. We've got budget heads of one department and they all sit under the health and wellbeing board. You come up with a really great idea and everybody says, "Yes, great." You walk out of the meeting and they say, "Of course our accountants will never agree to that." That's where you are because everybody is protective of their own silo. So if it's health, we'll deal with it when there's a health problem. We won't deal with the prevention, we'll deal with it when there's something acute that causes an admission. Dealing with the criminal justice system, well we'll deal with them at the point of arrest. It's not about what can you do before you get to that stage because if you invested that money earlier, you would reduce the likelihood of there being a call on that service.

 When the review that I did talked to the hepatologist at YBH and he was saying, "If you did work at the front end, the £400,000 that it costs for a liver transplant, we probably wouldn't need to do." So it makes sense to combine.

S2: Okay, one, two, three, four.

F: I just wanted to go back to that point you were saying about education. I really agree that kids should be taught more about drugs and things like that and how addiction can affect everyone. But just more broadly, Matt was saying, I think it's Matt anyway, that most of your patients that you see had horrific childhoods, lots of trauma, things like that, just starting young in the education and just equipping kids when they come up to school, they need to know how to pay their bills, how to find a job, things like that. There is still none of that education in schools. I was quite privileged with my schooling. I came out with loads of GCSEs but I still don't really know how I pay my bills and things like that. If kids have got no support from their parents, are growing up around drugs then of course they're going to struggle to get that start in life and go to turn towards crime or drugs. So I think it's more of a broad sense in that education, education for life rather than just passing your GCSEs or passing your A Levels.

S3: Can I say something? I think it isn't just skills though. It is also resources. So you can have all the skills in the world but if you haven't got the resources and you haven't got the money, it's the same problem. So I'm about to try and do a trial in Bradford with young adults on a universal basic income, some of them will get money every week. Some of them will get money plus life skills training. Some of them will get life skills training and then we'll have a controlled group. We just want to see, test the feasibility of this and see what the outcomes are. The outcomes that I'm interested in there are not are they in employment, education, entrepreneurship, whatever, because sure they're more likely to be if they've got more money and more skills. I'm interested in whether or not society is investing in them and cares about them and they have the self-efficacy to move forward.

 But we're supposed to be in what's called equipoise in academia, we're going to try something we're not supposed to have any faith in which way it's going to turn out. But I just can't do that. So I think if you get the life skills and the money, you're better off.

F: Yes, I totally agree but I think...

S3: How do we mainstream that, scale it up?

F: I mean it's more than just a drug policy. It's like an education policy. More needs to be done in schools in general. Kids are coming out with pointless GCSEs that are not fit for them in real life.

S6: But the number of children that we've got that have had traumatic experiences and their ability to access mental health support is almost nonexistent. If you've got kids who have been hooked up at an early age and they listen to case studies, there will be time and time again experiences that are just so horrific. We've talked about it...

S5: I think I would broaden it because obviously we've got lots of stories of people with really horrific maltreatment but it's also about education, about much more subtle methods of adversity and the effect on individual's psychology so that they get to the point, when they are using drugs recreationally, that it has a particular fit with them. There's lots of pathways into just feeling not okay with yourself and feeling anxious and not feeling like you fit in or feeling good enough and lots of other things that aren't just about physical and sexual abuse. The way our society is structured at the moment, you've got parents who are doing two or three jobs, they're doing to do their best but their attention is elsewhere that event their kids are going to suffer as a result of that. Bullying and the way that kids talk about each other or use social media about it, there's all sorts of ways that are going to leave more and more people feeling vulnerable.

S3: You don't get that happen without all the things you're talking about.

S5: To the effects of drugs, most of us can use drugs without problems so let's have a bit more compassion for the folks who find them so useful that they want to remain in that space. There are all sorts of pathways into that. It's not just the horrific stories that I've heard. There's many more pathways to that kind of vulnerability.

S2: I think about the language we use because as a society there is this normal which doesn't exist which I guess is modelled out there by politicians. They talk about us trying to bring society to a normal but actually we've all had different experiences. When I talk about mental health, considering there is one in four people experience a mental health challenge, I'd say one in one actually do. You're at different points, clearly, on a line but the same with trauma. If we say across society, we've all had different experiences. A lot of what people are doing is clearly self-medicating. It's at that place of where it's safe and not safe. Therefore I think we've got to start trying to normalise vulnerability in our society and say, "Actually we all experience different levels of vulnerability in different ways." Clearly in a hierarchical society, that then exhibits itself in a very different way but then we can start looking at causation more as well and trying to de-escalate in different ways.

 But I think if we say actually the fact that something will have a glass of wine after a stressful day or somebody experiences more severe dependency on substances, it's all on a spectrum. I think instead of just saying, "You're in a box," and somebody else is in a different box, I think we've got to talk about how we normalise some of the challenges that we all face in different circumstances. You've been waiting such a long time.

F: I did want to go back to what you were saying about front end services. I just think that... I've worked in drug treatment for fifteen years and one of the people that was made redundant because of the changes in the reduction in funding in the York area. I just think that it shouldn't be so subjective to what a commissioner believes and what York think because York's believe is in recovery, which is wonderful and I don't want to take anything from the recovery element of it because recovery is so important. I do believe that everyone has the ability to recover should there be the funding to provide that but there isn't the funding. So York's commissioner has gone down a recovery focused way when the rest of the country seems to be waking up to a harm reduction way. I just wish that the policy was that it shouldn't be down to a commissioner in a town, a city saying...

S4: Or an ideology. (unclear 01:21:52) with the experts and the evidence, shouldn't it? That's where it needs to sit. All of the media and the political stuff around it, that's a nonsense. It's got to be about the evidence. That's what isn't coming forward. The media have got a lot to answer to as well because it's so influential. The media are so influential. That's one of the reasons it makes it difficult to get the evidence through and why the question for politicians is so difficult when they're asked, "Have you taken drugs before?" that's because of the media. They could be honest. They're not dishonest people by nature, I'd like to think. It's the media that is determining that.

S2: Okay, you're next.

M: I like what I've heard from this panel tonight. I'm a young person. I'm 25. All these substances that are causing harm in society, cannabis is causing zero effect. Peanuts kill more people yearly than cannabis has ever. It's the most popular illicit substance on the legal black market and the government is giving away hundreds of millions, even billion pounds of a market to criminal gangs. These gangs are recruiting young people. It's creating a need for more firearms and knives to be on the streets, for these gang members to protect themselves from other rivals because the market is just continually growing. It's causing slavery up and down the country with Vietnamese immigrants being held in grow operations. Another thing about all the substances is that the only identification a young person needs to buy any of these substances on the streets is just (unclear 01:23:46). We obviously really need to focus on harm reduction.

 At the same time, with cannabis, the medical establishment is just... Hancock has made promises to families of sick kids with a campaign called End Our Pain to give sick, epileptic children medicinal cannabis but their medicine is being confiscated on the border still. He's made these false promises. This is giving cannabis the same chemicals that are in the streets that are offered to kids. There is a complete stigma that the media and the government are trying to push. We really need policy change. The Lib Dems offered it on their 2016 manifesto that they were going to legalise cannabis which (unclear 01:24:29). So I think we just need to finally step up as the Labour Party and say that we need to stop this war on drugs and legalise cannabis once and for all because it's not going to get any more dangerous once it's legal than it is now. All these drugs are in the most dangerous forms on our streets.

S2: James, I'm going to go to you next.

S4: I agree pretty much with what you've said. I suppose legalising control and regulating not just cannabis but all drugs but obviously cannabis. It's pretty clear at some point in the pretty near future we're going to move to some kind of legal market. I think the discussions and conversations we need to have as a society, what our market looks like, how it's going to operate and how we're going to safeguard people who are vulnerable because most people who use cannabis don't have problems but there are people. I've met people who, for them, cannabis isn't working. It causes them as many problems as lots of other, much more serious drugs. Cannabis isn't always totally harmless. I think that's an important part of the conversation to have. We've got to give a nuance to discussions around cannabis because it's easy to fall into it doesn't cause people problems but it does. We're seeing more presentations to mental health service, we're seeing more presentations to treatment services.

 There are lots of reasons around that but obviously a legal and controlled market will prevent young people accessing it, maybe introduce some kind of controls around some of the newer forms of cannabis like extracts, which are really high in strength, or be able to access them with appropriate regulation and control. But yes, Labour absolutely should be supporting a legal, controlled and regulated market. But yes, how are we going to make sure that people who might have problems don't access it or get the right support and education to make an informed choice if they do.

F: I just want to go back to when we were talking about the need for evidence based policy, which is obviously really important. I think I want to take that back to drug treatment. I think there needs to be a recommendation, a review of the evidence that we are working towards as drug treatment providers because certainly in our service there is intervention being done. Not only is there a massive variation of what could happen between each worker but there's a massive lack of evidence based interventions that we're doing. Initially I was going to say we need a review of the evidence base but actually, when I look at the academic work that's going on, that is existing. It's what you were saying Kate. It's not filtering down properly from academia into frontline practice so there needs to be a better system of working where we're working together with that. It might be happening in other areas of the country but I know it's not happening in the service we're at.

 It needs to be that we're seeing these trials actually in real life practice and we're working together with that. I mean obviously there needs to be more funding with that but a more stable funding so that it can happen throughout the country, not just in one pocket where a service has more money and then York sees a bigger cut and we're not seeing that happen. So I think it needs to be...

S3: It's a culture shift. We're sitting in the Alan Maynard lecture. For those of you who don't know, Alan Maynard was a professor here at the University of York, professor of health economics who died last year. I remember going to York City Council with Alan to the health and wellbeing board where I was obviously good cop and he was playing bad cop. He gave them a really, really hard time. He said, "Local authorities are constantly experimenting on the public. They put a policy in place or they put an intervention in place, they start something going. They've don't evaluate it properly so they don't know if it's effective. They certainly don't know if it's cost effective. Then the money runs out and they stop doing it or the money doesn't run out and they keep doing it and it wasn't effective." He said that was unethical and they should stop doing it.

 Of course he's right but that needs collaboration between researchers, practitioners, policy makers, politicians but it needs a culture shift where actually those who make policy, those who commission, those who are political, know how to understand evidence. We have got a long way to go. There are pockets where it works.

S5: Drug treatment has moved to a machine of targets. It's totally target driven which moves away from common sense evidence based work. The evidence is all there. We know how to work in a psychosocial way with an individual. The structure type of social interventions are longstanding, evidence based, the same with the pharmaco therapies. For those that need that, it should be an adjunct. It shouldn't be what drug treatment is all about but it should be there for some that need that. But people don't get the training in these interventions. They don't get the supervision. They don't get the support. Management haven't even heard of them. So the tick boxes they've got to tick have nothing really to do with sitting in front of people and really listening to their lives and understanding the case and getting the right support for them and doing these frontline type of social interventions. It just doesn't happen.

S6: But the problem with target based approaches is it's who is setting the target. When it's the funders and they're saying, "We need to find 10% across the health and adult social care budget," they just say, "Top slice, 10% of every area," or, "20% off every area." They don't work on risk. They don't work on where the need is.

S5: The outcomes are harmful though as well because the targets are often drug free exits which can be really harmful for a cohort of people. The commissioners themselves, and they say it to me, "Matt, I need to hear from you because you're the expert." They say things like that to me because they don't know what the quality markers might be. It's all about the outcome that they're looking for, the recovered drug user who has been rushed through Methadone treatment and all the rest of it. I mean everywhere it's a nonsense but the evidence is there as to how we should do it. It's all there.

S2: I'm going to just take some comments and then we can have some more feedback. So I have got one, two, three, four at the back, five and then we'll see how we're going.

M: I was going to make another point that I just wanted to say on that, it kind of sounds quite similar to what is happening in universities with ( unclear 01:31:18) how we run things like the REF and the (unclear 01:31:22) and everything is based on metrics that don't actually mean very much when it comes down to the actual teaching and learning. My point was going to be more on if Labour were to commit to ending the war on drugs, whether we should start to really refrain the kind of dialogue around drugs, not always frame drugs in terms of their potential harm but sometimes in terms of their potential medical and psychological benefits because there is research going on now where Robin Carhart-Harris of Imperial College of London is looking into psychedelics and a guy Ben Sessa...

S5: Treatment of PTSD with amphetamine with depression, you could go on.

M: I wonder whether we could expand because obviously the drug treatment is probably the main issue here (unclear 01:32:15) but once we go beyond the war on drugs, whether we could really start to introduce (unclear 01:32:22).

S2: That has really been well demonstrated with cannabis and obviously the cannabis oil debate at the moment as well. It's segregated as a separate substance. At the back?

M: I have enjoyed what everyone has been saying. I was looking at the graph thing, so Portugal stands out as an inequality place, one of the lowest index drug use. That, as far as I know, is about the only place that's decriminalised. If you are a repeat offender or if you get repeatedly found with things, you get a choice towards recovery. So you're right, drugs are drugs. Drugs are not the problem. It's how people use them. For myself, I think addiction is a fear based illness. It expresses all the things that you've been talking about. I go to prisons. I see recovery wards and things like that. People come out and do belly flop. Treatment houses, wonderful places but people come out and, like the lady was saying about the Rat Palace, you go out there...

S5: Rat Park.

M: I've also heard it called palace but I meant park. You put people out into society where they're absolutely alienated. They're going to go back to the last thing they managed their feelings with.

S5: Social dislocation is at the heart of a lot of people's problems. It's connecting and integrating people, relationships, meaningful relationships, employment, a house over your head. All of these things are the crucial building blocks to help people start to think that they've got a future and be more optimistic. All the fundamentals are not there.

S3: Bruce Alexander who did Rat Park, he called it poverty of spirit. That's what underpins addiction. What this chart shows is that poverty of spirit is not confined to the poor. You won't see that UK statistic if it was only the poor that tended to use more drugs. It's a more unequal society, everybody is affected. We all have more poverty of spirit when we live with inequality. That underpins all kinds of health consequences, mental health, physical health, addictive behaviour, all kinds of other things.

M: What I find sad about all this is that, I'm not the brightest person in the room, this is not news. This is not news to any of you and we've got to this situation.

S5: I was in Portugal earlier in the year and obviously they used to have the highest drug related deaths in Europe, they had the highest HIV rates, they decriminalised drug use and now have the lowest drug related deaths and I think the lowest HIV rates. I spent some time at what's called the dissuasion committee, which is where you get sent if you're caught with drugs. One of the interesting things about that is that most of the people they see have been using cannabis, which I didn't know until I went. I was really surprised that that's the biggest chunk of people they see, cannabis smokers go to the dissuasion committee and then have to sign up to a variety of different kinds of undertakings as a way of not getting a criminal sanction. But absolutely, the decriminalising substances has worked in Portugal.

 The society hasn't fallen apart. It still functions. Everybody gets on with it. If you're caught with drugs, you go and see the social workers and the dissuading committee, you talk about it and they give you some support or they've got apprenticeships that they signpost people. If they're problem drug users, there's all kinds of investment in good quality treatment and support as well.

M: My name's Phil. I'm actually the service manager for all the drug services in York. It's interesting what you have to say. I think the stuff you talked about at the beginning, it was very briefly about the funding element. We've talked loads about the policies around what intervention should happen for people using drugs. What's not talked about is actually do people need to do those interventions? So the skill set and the staff, I work with amazing staff, we're now eleven or twelve staff, less than we were ten months ago because of the cuts. I've had to manage the whole service while the cuts were going through which is okay but for the policy to work, what we need is longer commissioning, longer than seven years because to manage a service and embed a new service and to make it work and to get the evidence based approaches and to train staff on them, it has to be much, much longer than that as well as more secure and, for staff training, very much a significant use of that.

 When we talk about the evidence based interventions and that being fed back down to staff and having a core element to what should be a base line for staff to have, it's really important that it comes down and there is a call for that. Some people (unclear 01:37:45) the core for the training... I'm old. I'm sixteen years in service now, that's a long time so it's coming through that. But for it all to work, there needs to be a really strong base at the bottom. Unfortunately, that is the staff who have to deliver that intervention. For that to happen, we need to have really secure funding that isn't going to be taken away halfway through, that isn't going to be possibly reduced or even increased. It's useful to know how much you've got and how much you can actually do with the service and what you actually can do with it and the length and longevity of that funding at the same time. When we're talking longevity, people say ten years is too (unclear 01:38:28) because what you said before, you can't hire another psychotherapist or a psychologist because funding is so insecure.

 For me to get a really good staff and to train staff and to have them engaged and develop pathways, so we talk about pathways and we talk about engaging with mental health services and making a wrap around service in the city of York. You can't do that because when you've done that, the funding goes and suddenly those pathways have disappeared. So what you need to have is a really, really good bottom line to ensure that everything you put in place that's supporting people coming through services will remain there and improve over a long period of time.

S4: So just very quickly, in 2015 after a few rounds of competitive tendering where we got slashed more and more in Leeds, in 2015 my NHS service took a 50% cut, 50% and that's staff. That was people with decades of experience and knowledge built up, really bright, brilliant people, a year later another 10%. We were in a brand new contract for five years and then we took a 10% after that as well.

M: Where is that? We lost a period of money but like Michael said, we're now in a position where we maybe need some more money. It's about how we gate that.

S4: The massive brain train that's gone out of this treatment and the staff who are doing it on the frontline need that extra, extra support to help them.

M: And security.

S4: But as (unclear 01:39:59) they get to having a cut, they then have to make decisions based on that cut. The fact that six months later the cut gets reversed for this year, doesn't mean to say, "Fantastic. We can have all those staff back," because they've gone. Things have changed. You can't then plan to develop a new service or a new programme because next year you've still got the prospect of another £200,000 cut. That's the reality of how sensitive the long term clear funding pathways are for services that are so crucial to such a wide proportion of the society.

M: I just want to add, and I empathise with the people I've seen leave the services in the nearly five years that I've engage with drug and alcohol treatment in York and mental health treatment. But there is a slight oversight always when we're collating all this information to present to people in government. It's the service users that it affects the most. I feel sorry for the people that have had to face redundancies. I'm really empathetic to all that but the message gets lost somehow. It's the actual service user...

S3: It's the professional relationship and the fact that you build up your trust and you have confidence in that person.

M: I think that's a key point that gets shoved...

S5: Very quickly, one of the common threads that arises from childhood all the way through is a lack of power that people have. They don't have power. Power is taken away. Power is in the hands of other people. Then they go into services and again, they don't have the voice. They don't have the power. So that narrative needs to completely change as well.

S2: I've seen a hand here and a hand there. Is there anyone who hasn't spoken who would like to make a contribution?

S1: I just wanted to say, I think we're going to have to start wrapping up soon. It is 8:30pm so maybe just...

S2: Absolutely. Okay, you just got in on time so off you go.

F: Hi, I'm Helen. I'm the GP so bear with me, at the York Drug and Alcohol Service. So what I wanted to say is we've spoken a lot about education and I think what's sadly lacking is there is no medical education around substance misuse cure environments. You can go and do a five or six year degree and never have any formal education in working with patients, similarly in the nursing profession but less so because mental health nurses tend to get more exposure. It's very difficult to introduce to medical schools the concept that this might even be a good idea. I'm forever trying with Hull York to try and get them to at least send someone along just for a day. I recently did have some work experience students, so 16, 17 year olds from a widening participation programme so wouldn't normally get into medicine. They ended up with me because we were doing that as a favour and they loved it. Do you know what? The feedback was fantastic.

 I think we need to do something because it will be brilliant if we can upskill the profession in substance misuse but we really need to upskill our colleagues in the hospitals, in general practice, where we know that our service users are discriminated against. That poor guy in housing, why was he allowed to discharge? There is an issue there, isn't there? So I think yes, there is lots to do but there is easier fixes as well with the colleagues that we've got already.

S5: I do lots of training work all over the place, training people in all kinds of settings, housing workers, mental health workers. All that knowledge around substances, around just basic knowledge around drugs for a lot of people just isn't there. What you get instead is stuff they've read on Facebook or something they've read in the paper or what their mates have told them. You just think, "This is the starting point." These are people who have worked in contact with people who use drugs and you're often faced with just a lot of stigma around it. It's cutting through that to get people to think these people who need treatment, that's where we've got to get to and that's going to take some doing.

S2: If people on the panel have got further thoughts, can you just hold them for one minute wrap up.

F: I'm a student at the University of Leeds and I think it's been a really good talk so thank you all for coming. I think there is a point to make about taking it back to the normalisation of the conversation. I think it starts from such a young age, I mean Year 5, Year 6 in school given an education on drugs but it's fear mongering tactics. I mean the discussion of gateway drugs is important but it drills in this idea of guilt surrounding drugs. That means that when it maybe goes beyond say recreational use, these young people don't feel like they can discuss it with their peers, perhaps with their parents if they've got parental support. That again, obviously it's been discussed the idea of treatment will disappear. So I think any policy that goes forward really needs to go hand in hand with the Department of Education implementing it into the education system, the idea of safe recreational use or it goes beyond that, what we can do to tackle it. I think experts like you, you guys into school to discuss it with these children would be really good rather than... it's almost something we could do.

 We do have a sexual health talk. We talk about contraception and safe sex and embed that conversation into drugs. I think it's another way, whereas when you're 10 or 11, that's one of the most important years of learning. If that's what's being drilled into you, I think that's what you're going to take with you in the future.

F: I've been an ED nurse for the last year and I've lost count of the number of patients who discharged, really sadly, because they couldn't get the Methadone or they couldn't get the Subutex. Most of them have mental health problems, some of them have physical needs. Actually where I worked, which was down near Leicester but I can't imagine it's that different across the country, we had really good links with Turning Point but it was, "We can get your Methadone but it's going to be five hours from the pharmacy," or with Subutex, "Yes, it will be another four hours," and then they self-discharge and you think, "Well." So I think actually as a policy, you're going to need tie-in from the NHS with things like that. That's a really simple thing. That's in ED, someone that you know often coming with things like really serious, been found trying to commit suicide with a rope. You think, "Actually, that person is an incredibly high risk individual," but if they've got a community Methadone script and they're going, "That's due now," and this nurse is telling me and they're doing their very best.

 They've found out how much this person is on, they've got it prescribed, they've ordered it from the pharmacy but they physically cannot get it in less than four hours, that person is going to self-discharge quite likely. They may be a really high risk, very suicidal individual with a plan and an intent and they may not come back for a mental health assessment. So I think getting that... I don't know what the practical solution to that is but obviously needing a policy to have that practical.

S5: Really quickly because I know I'm not supposed to speak.

S2: If you just wait a moment, Matt. Have you finished?

F: Yes. That was my point.

S2: I'll bring everybody in so Matt, you can go first.

S5: Just to say, there is an answer to it. Just for example in Leeds I've got a team of specialist nurses who are inside the hospitals. They take every alcohol and drug related admission. They'll see them into the admission, into the hospital if they're admitted into the hospital and they'll link with the drug treatment service as well so that there is no drop in their Methadone or whatever else that they need. So there are models out there that will deal with the problem.

F: I mean I've been in, well through my (unclear 01:48:32), I've been in about eight hospitals and I have lost count of the number of patients who have self-discharged for this reason. I know it's happening in Leeds but it's certainly not happening everywhere.

S2: Michael, any final thoughts?

S6: No. Just that I've been absolutely blown away by all of your experiences, all of your input and certainly from the panel, I've learnt so much. It's just made me realise how little I actually know. But you've just got to keep the weight on.

S2: Right, one minute, we could look at that chart for physical health, mental health, bullying in schools, educational outcomes, social mobility, etc., etc., all the health and social problems that are so prevalent in the UK are connected to this root cause of inequality. So yes, the Labour Party needs drug policy reform but it needs to tackle that root cause, all these different branches of dysfunction that come from that. So basic Labour policy needs to be so strongly focused on reducing inequality and then a lot of the things that we're seeing as problems will become less of a problem and therefore easier to tackle but we do of course need the treatment kind of policies as well. James.

S4: So I was in Denmark last week which obviously is over this side and I spent some time in the drug consumption rooms there just looking at how they worked. I guess it's about dignity, it's about where there's that different kind of society and different view of people who use drugs. Actually you've got a massive drug consumption room next to a restaurant and they're quite happy with it, no complaints. The police don't arrest people. People come and use their drugs or smoke crack there, no overdoses. It all seems to work okay. So another world is possible, that's what I think.

S2: That's brilliant. It's great obviously learning about what's happening elsewhere in the world particularly in places like Portugal where we see such success and in such a short amount of time as well, which just says what a difference can be made. I just really, from the position of chair, want to thank everybody from the panel but also across through the room. It's just been such a rich discussion. It's such valuable evidence obviously for what we're trying to do in really shifting this agenda. I want to continue the conversation here in York so I think it would be important to do so. Obviously if you haven't been able to get things in today and you're one of my constituents, please write to me. I'm happy to meet at my surgery or come out and meet with you at Changing Lives or elsewhere as well, come and visit again and have further discussions about how we're taking this forward. I'll be really pleased to do that. I'm going to bring in Lola to sum things up.

P1: Yes. So I just want to say thank you so much for all your contributions. I mean we could have gone on all night I think. It's a shame that it's already past 8:30pm. It was a really lively discussion. I think everyone learnt a lot. I definitely learnt a lot. I think really we can all agree it's such a complex issue. That's one of the things that you can take from tonight. It is so complex. There is treatment, there's education and the bottom line is what's going on right now isn't working. These conversations that really need to be had, we spoke a lot about (unclear 01:52:21), they can't be had. The narrative is what we need to conduct a war against drugs because who's the victim? Who are we fighting against? You made a point about the industry. If this so called war we're trying to fight against the drug industry, well that's not working because it's just growing and it's worth so, so much money.

 The people that are victims, the people we've talked about today who lose out when fundings are cut for services or can't even access funding at all. But yes, I mean I'm going on now. So all I really want to say is thank you so much for coming. The things you've said tonight are going to go to an expert working group. Policy description is going to be based on this and then that's going to go to the front bench. This is actually going to be listened to. Hopefully this can go in some way to making change. I think Labour has already (unclear 01:53:14) with the Royal Commission and support for Public Health approach. So thank you so much. I'd also like to thank (unclear 01:53:33) and we wouldn't have all been able to have such a rich discussion so thanks (unclear 01:53:41).

**[End of Recording]**