Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
12 November 2014

Meeting time:
09.30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

1 Introductions, apologies and substitutions (09.30)

2 Inquiry into new psychoactive substances ("legal highs"): Evidence session 5 (09.30 - 10.15) (Pages 1 - 34)

Detective Chief Inspector Gary Phillips, TARIAN, the Southern Wales Regional Organised Crime Unit

Detective Inspector Richie Jones, Police Federation of England & Wales

3 Inquiry into new psychoactive substances ("legal highs"): Evidence session 6 (10.15 - 11.00) (Pages 35 - 41)

Paul Roberts, Her Majesty's Inspectorate of Prisons

4 Papers to note (11.00)

Welsh Government Draft Budget 2015-16: Follow up from 16 October 2014 (Pages 42 - 48)

5 Motion under Standing Orders 17.42(ix) and (vi) to resolve to exclude the public from the remainder of the meeting and for item 1 of the meeting on 20 November 2014 (11.00)

6 Inquiry into new psychoactive substances ("legal highs"): Consideration of evidence received (11.00 - 11.15)

7 Inquiry into alcohol and substance misuse: consultation arrangements (11.15 - 11.30) (Pages 49 - 51)

8 Inquiry into access to medical technologies in Wales: consideration of draft report (11.30 - 12.15) (Pages 52 - 117)

Agenda Item 2

Document is Restricted

ROCU
Problem Profile

Profile of Mephedrone and New Psychoactive Substance Use & Supply in Wales

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Date:	September 2014

Contents

Introduction

Intelligence suggests that the use of Mephedrone and New Psychoactive Substances (NPS) is an ongoing issue within the South and Mid Wales Region. The purpose of this document is to help gain a better understanding of the Mephedrone and NPS markets within the southern Wales region.

Scope

The profile will concentrate on the period between 2012 and 2014 with an analysis of offences, availability of Mephedrone/NPS and Mephedrone/NPS related deaths. The report uses recorded drugs offences and intelligence reports relating to Mephedrone from the Dyfed Powys, South Wales and Gwent Police Forces.

Key Findings

- A year on year comparison of drug-related crime data across Dyfed Powys, South Wales & Gwent shows a general reduction in Mephedrone-related arrests and seizures for 2013/14 when compared to recent years.
- A report produced by Fiona Brookman and published by the University of South Wales in April 2014 gives an invaluable insight into the harmful side-effects of long-term Mephedrone use on the users, both physical and mental.
- Despite a reduction in reported cases of Mephedrone-related drugs offences, there continues to be supply and demand for Mephedrone and other closely related substances in southern Wales
- The Welsh Emerging Drugs & Identification of Novel Substances Project (WEDINOS) continues to evidence the varied & ever-changing nature of New Psychoactive Substances (NPS) available in Wales
- Over 77% of all branded NPS products tested by WEDINOS were shown to contain two or more substances in varying levels
- WEDINOS findings show that a brand name for any given NPS is no guarantee of consistency in the chemical content of the product, presenting the real risk of unwitting poly-drug use

Definitions

Description of Mephedrone

Mephedrone (meph, m-cat, miaow miaow) is derived from cathinone – a stimulant found in the plant Catha edulis. Mephedrone is available in several forms including powder, pills and capsules, and is also water soluble allowing users to inject the drug. The drug can also be snorted, swallowed and bombed (ground up, wrapped in paper and swallowed) but cannot be smoked. Mephedrone has a uniquely unpleasant odour that has variously been described as resembling stale urine, vanilla and bleach, and electric circuit boards. It can be cut with other substances so sometimes appears discoloured.

Description of NPS

New Psychoactive Substances are mainly synthetic drugs manufactured to mimic the effects of already controlled drugs and are used mainly as recreational drugs. The majority of NPS are sold in mixtures. NPS come in the form of white, off white and other coloured powders, various shaped and coloured pills, pellets, liquids and smoking blends. The only way that anyone can be certain of their content is when they are examined by the relevant scientific analysis equipment.

Effects of use

Mephedrone

In summary users report the positive effects to be somewhere between MDMA and Cocaine with euphoria, enhanced music appreciation, elevated mood, increased energy, sociability, mental stimulation and sexual stamina commonly mentioned. Loss of appetite and weight loss are also cited as positive effects.

However, Mephedrone can over stimulate the heart, circulation and nervous system therefore causing a risk of fits. The psychological impact of the drug can have an effect very quickly and cause side effects, including psychosis, paranoia, depression, self-harm and suicidal thoughts. Mephedrone is twice as corrosive as Cocaine on the membrane/septum when snorted and collapses the vein three times faster than Heroin when injected (SWP Intelligence Bulletin 83/12).

There is strong anecdotal evidence that users can become addicted to Mephedrone. Users report a desire to re-dose and craving the drug, often to overcome the ‘come down’ or ‘hangover’ associated with its use. Users report that they quickly develop a tolerance to Mephedrone and have to increase the frequency and dosage to maintain the positive effects. This is often reported to quickly progress to uncontrolled binging behaviour called ‘Fiending’. The desire to offset the effect of comedown and to return to the highly pleasurable effects of Mephedrone leads to this ‘fiending’. In one survey over 60% of users reported using the drug for longer and in larger amounts than originally intended when they began (Wood, 2013).

Standard risks associated with frequently injecting controlled drugs apply to Mephedrone also. Very little is known about the long-term effects of the drug.

NPS

Little evidence currently exists as to the harms that these substances may be able to cause (ACPO, 2011). Products sold under a ‘branded name’ often contain completely different substances and therefore, the effects of NPS cannot be known (NCA, July 2014).

In general, the most commonly reported adverse effects appear to be losing consciousness and vomiting. While these are both a cause for concern in isolation, it is important to note that the threat they pose is significantly increased when occurring *simultaneously*, due to the risk of potentially fatal asphyxiation.

Legislation

Mephedrone

Mephedrone became classified as a Class B illegal substance in April 2010 under the Misuse of Drugs Act 1971.

NPS

NPS/'legal highs' are substances which produce the same, or similar effects, to illegal stimulant drugs such as Cocaine and ecstasy, but are not controlled under legislation. It is however considered illegal under current medicines legislation to sell, supply or advertise for "human consumption". To get round this sellers refer to them as research chemicals, plant food, bath crystals or pond cleaner. A number of NPS have been controlled under the Misuse of Drugs Act 1971 often using a generic definition enabling the Government to legislate for the 'family' of related drugs as far as possible.

Forensic Early Warning System (FEWS)

FEWS was developed in January 2011 in response to the emergence of NPS. FEWS helps to identify NPS quicker by bringing together expertise from forensic laboratories, chemical suppliers, law enforcement agencies and experts in the field in a coordinated approach to the analysis of law enforcement seizures and test purchases.

Substances are collected by forces and sent to their usual Forensic Provider (using a special FEWS Label) for examination, when collection plans are in place. The Forensic Provider will examine these substances as part of the FEWS project, at no cost to the submitting force.

Emerging NPS

New and previously unseen NPS are being identified throughout Europe and the United Kingdom on a regular basis.

FEWS (Forensic Early Warning System) has identified a number of NPS including:

- AKB-48
- 25-B-NBOMe
- 4-MeO-PCP
- Critical Haze
- Sparklee
- Black Mamba

The most commonly mentioned legal highs in 2013 and 2014 were "Exodus" followed by "Pandora's Box" and "Black Mamba".

In 2013, 81 new psychoactive substances were notified to the EU Early Warning System, compared to 74 in 2012, 49 in 2011 and 41 in 2010. This brings the number of substances monitored to more than 350.

During 2013-2014, two new NPS (down from 10 in 2012) have been identified under FEWS which have not been previously encountered in the UK or Europe. These are mephtetramine and LY2183240. Two new substances have been identified at UK level only, which are BB-22 and dichloromethylphenidate.

The EMCDDA report noted particular concern at EU level around synthetic opioids such as AH-7921, MT-45, carfentanil and ocfentanil which have been widely reported in the past two years. The ACMD has recommended the control of the synthetic opiod AH-7921 ('legal Heroin') as a Class A drug. A number of tryptamines are already controlled under UK legislation but the ACMD is recommending the definition is widened to include hallucinogenic drugs in the same group including AMT (similar effects to LSD) and 5-MeO-DALT ('rockstar'/'green beans'/'jungles').

Enquiries reveal "Jeffrey" refers to either the stimulant NPS "Posh" mixed with Mephedrone *or* oxidised, illicit Ephedrine. For example limited intelligence from South Wales indicates some Western BCU dealers are adding NPS to Cannabis, though it is unclear if this is the addition of chemical stimulants, hallucinogens and/or Synthetic Cannabinoids (Wilson and Holmstrom, 2014).

There is limited intelligence to suggest NPS are being used as cutting agents, although the full extent remains unknown.

User profile

Mephedrone

The majority of Mephedrone users are in the age range 18-24 and are predominantly male (RIUW, 2012). Richards (2012) states that young people are most vulnerable to Mephedrone use because they are more exposed to drugs in pubs and nightclubs. Mephedrone has been ranked as the fourth most popular drug in the 16-24 age group on the British Crime Survey.

According to the British Crime Survey 2013 – 2014 around 10.9% of respondents who had been to a nightclub four or more times in the last month were frequent drug users. This compares with 2.3% of respondents who had not visited a nightclub in the past month. Furthermore, youths are a particular high-risk group in that they are more likely than other age groups to try an unknown drug/white powder.

NPS

The profile of the most significant number of users is broadly similar to the profile of club drug users; both NPS and club drug users are generally young males, well educated, and socially functional (ACPO, 2011). The NPS user demographic is generally seen to differ from other drugs. Those that present to health services tend to have stable jobs, relationships and accommodation and appear more likely to make the most of treatment (NCA, July 2014).

The report for the National Treatment Agency for Substance Misuse (NTASM, 2012) stated that individuals who sought treatment for NPS in 2012 were relatively young, with 56% of all adults in treatment aged 18-24. Despite the fact that the sale of such substances to minors is prohibited, the

intelligence logs have shown the use of NPS to be strongly linked to those under the age of 18. Street dealers have no qualms about supplying NPS to minors.

There are incidents of former high-harm drug users diverting to NPS, potentially due to the low purity of controlled drugs in their area (ACPO, 2011). There is some evidence to suggest that NPS are being injected by users; generally existing drug injectors as a substitute for opiates during a periods of low opiate availability/affordability (NCA, July 2014).

Vulnerable groups

Children & Young People – influenced most by the image of Mephedrone, more likely to experiment with unknown 'white powers' and being actively targeted by dealers (offering tasters to school children for under £1).

Problematic Drug Users – intravenous Heroin users are at increased risk due to the image of Mephedrone as an aid to coming off Heroin and reducing withdrawal symptoms.

Existing Mental Health Issues - those already suffering with poor mental health may also be at increased risk as Mephedrone seems to exacerbate existing conditions and has been linked to a disproportionate number of suicides than other stimulants.

Not in Education Employment or Training (NEETs) - unemployed males and females aged 16-24 years may be most at risk of becoming Mephedrone dealers given the current state of the jobs market in many areas of Wales, particularly if they are already recreationally using drugs.

A large proportion of people using Mephedrone and NPS are not using these substances in isolation but take them alongside other controlled substances namely Valium, Cocaine, Heroin, Ketamine and Amphetamine.

Sources

<u>Mephedrone</u>

Research suggests that Mephedrone was originally sold as a party drug in Israel in the early 2000's and then distributed and used in the western world (Nutt, 2012). Mephedrone can be bought via the internet or through street dealers. Prior to being classified in 2010 it was also widely available from 'head shops' on the high street. However, even following the classification of Mephedrone as a Class B drug it can be easily purchased online.

Europol (2011) reported that the most common method of sourcing Mephedrone in urban areas is from friends and dealers. Even following classification of the drug it can easily be purchased online but McElrath and O'Neill (2010) reported that very few people purchased Mephedrone from online suppliers. Similarly, Brookman's (2014) study also revealed little evidence of internet-based purchases.

'Silk Road', is an underground website (sometimes referred to as the 'Amazon.com' for illegal drugs) which provides buyers with anonymity when browsing and making online drug purchases. The site was shut down in 2013 but now apparently operates again as Silk Road 2.0.

Suppliers appear to order large quantities of Mephedrone online (mainly from China and India) which then arrive through post and parcel services (SOCA, 2012). Intelligence suggests that it is unlikely that Mephedrone is being produced in South Wales. However, the vast majority of

Mephedrone dealers appear to have a localised impact, obtaining smaller amounts frequently (rather than kilo quantities) and dealing to a network of local users.

Mephedrone suppliers often use legitimate businesses as a method to conceal their dealing activities. Pub owners, particularly in the Western Valleys of South Wales, are known to sell controlled substances including Mephedrone over the counter to their customers. Similarly, delivery drivers are known to carry and distribute drugs alongside takeaway food.

NPS

The earliest reported form of new psychoactive substance was Ketamine in America at the start of the 1980's (EMCDDA, 2002).

NPS can be bought via the internet, at festivals, through street dealers or 'head shops' on the high street. Those selling NPS through the internet and head shops will often brand them as 'legal' or 'herbal highs' or attempt to conceal their true purpose by miss-describing them, for example as 'plant food', 'pond cleaner', 'bath salts' or 'research chemicals'. However, analysis of test purchases demonstrates they often contain Mephedrone or a wide range of other controlled drugs.

The majority of NPS are produced in China, and sometimes India, and traded via the internet. Whilst the internet is an important retail agent, particularly for larger amounts, available data suggests that at 'user' level most consumers purchase NPS through friends or traditional 'dealing' networks (NCA, July 2014).

It has been reported that students have created websites to supply legal highs nationally and through local markets (ACMD, 2011).

Price

Mephedrone

The price of Mephedrone at street level is very similar across southern Wales, on average between £10-20 for a deal (approx. 1 gram). Frequently 2-3 gram bags can be purchased at lower prices, often £25-30. In some areas the price can be as high as £40 per gram, but it is likely that at this price the Mephedrone will be mixed with other drugs such as Cocaine or Benzocaine. Ounces can be bought across South Wales for on average £150-300 but limited information is known about the larger quantities such as kilos.

Price comparison with other problematic drugs

Cocaine	£30-50 **Gram**	£800-1000 **Ounce**	£50,000-55,000 **Kilo**
Heroin	£40-50	£650-900	£15,000-17,000
Mephedrone	**£10-20**	**£200-300**	**£4,000**

Mephedrone is significantly cheaper than Heroin or Cocaine at all levels of the supply chain. Rough estimations of profitability suggest that selling Mephedrone at street level is more profitable than dealing Cocaine with the added attraction of a significantly lower initial outlay.

Intelligence suggests drugs markets are becoming increasingly "business-like" with some Mephedrone dealers charging a £20 "delivery charge". Street dealers are known to drive around in vehicles delivering the substances to their customers.

Mephedrone and NPS are also widely available to drug users in prison. It is said that a single line of Mephedrone will 'cost' one box of Amber Leaf tobacco.

NPS

NPS products online range from £4 to £150 depending on dosage and item, in certain shops legal highs can be purchased for between £10 and £200. Some customers are known to come in and 'stock up' on a large quantity of drugs, presumably with the intention of trading the products at a higher price. Young buyers have been seen selling newly purchased drugs just two streets away from the head shop in which they were bought. Due to the age restrictions that prohibit the sale of NPS to minors, there is some suggestion of an emerging trend for nominals to make multiple legitimate purchases from head shops that they then "deal" to under age users.

Overall, prices of NPS products are very similar to prices of Mephedrone. In much the same way as Mephedrone, NPS can be bought as a gram/bag (£10) or several grams/3 bags at a reduced rate (£25).

There is data available that shows that some significantly lower priced items sold online contained the same NPS as the more expensive samples. It is possible that vendors expect customers to make the assumption that high price equals high quality, thereby enabling maximum profit.

Prevalence

Mephedrone

Areas of high prevalence in 2012 and 2013 were Llanelli, Swansea, Bridgend, Cardiff and Newport. Police records do not show that this problem has began to impact on North Wales (Chadd, 2013).

Mephedrone use was first recorded in the British Crime Survey England and Wales in 2010-2011. Mephedrone usage decreased in 2012-2013. 0.5% of adults reported using Mephedrone compared to 2011-2012 when an estimated 1.1% used it.

The British Crime Survey 2013 – 2014 revealed that 1.9% of people (aged 16-24) have admitted to using Mephedrone at least once in their lives. This is a slight increase compared to 1.6% of people in 2012 – 2013.

Including Mephedrone, the proportion of adults (aged 16 to 59) taking any illicit drug in the last year was 8.8% in 2013/14 i.e. no different to the proportion when excluding Mephedrone (Home Office, 2014) which suggests that Mephedrone popularity is decreasing dramatically.

The British Crime Survey 2013 – 2014 revealed that less than 10% of adults (aged 16 to 59) used Mephedrone more than once a month compared to over 80% of young adults used the drug less than once a month.

Between April 2014 and June 2014 the Welsh Emerging Drugs & Identification of Novel Substances Project (WEDINOS) received 641 samples of NPS (this represented a 15% increase from the last quarter). 77% of all branded psychoactive products were found to contain at least two substances following analysis; with 34% containing at least three substances. Out of the 7 welsh health boards the Anuerin Bevan locality (Blaenau Gwent, Newport, Caerphilly, Torfaen and Monmouthshire) provided the most samples. Mephedrone was the seventh most commonly identified substance amongst the samples.

Despite the prevalence of Mephedrone in Western, Northern and Central BCU's in South Wales, in the main little is known in relation to the supply structure above that of end-users and their immediate suppliers.

NPS

Within the UK data relating to the use of NPS is relatively new, with Ketamine and Mephedrone only being included for the first time on the 2010 – 2011 British Crime Survey and the 2012 report for the National Treatment Agency for Substance Misuse (NTASM, 2012).

In 2011 The European Commission interviewed 12,000 randomly sampled young people from EU member states and it was found that 5% of the whole young person sample had used NPS. In relation to the UK, it was found that 8% of the young people had used NPS compared to 0.8% in Italy, 1% in Finland and 1.6% in Greece.

19.2% of NPS samples collected by FEWS in 2013-14 contained controlled drugs. In some cases more than one substance was identified in each sample. Some samples contained cutting agents such as caffeine, lidocaine and benzocaine. Of the samples analysed that contained NPS, about 91% were identified as mixtures of either two (61%) or three (30%) different active components.

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Seizures of Mephedrone & Related Arrests

Dyfed Powys

Crime data reveals that the total amount of Mephedrone seized within the Dyfed Powys force area during the period 1 April 2014 to 1 August 2014 has decreased from approximately 1.39kgs to 0.5.kg when compared to the same period last year. 84% (472g) of the Mephedrone seized during the reporting period has been in Carmarthenshire, the remaining being seized from Powys (59 grams) and Pembrokeshire (13 grams).

Area	Apr '13 to Aug '13	Apr '14 to Aug '14	% Change
EASTERN	107	50	-53.27%
Carmarthenshire	90	37	-58.89%
Powys	17	13	-23.53%
WESTERN	15	13	-13.33%
Ceredigion	1	4	300.00%
Pembrokeshire	14	9	-35.71%
Grand Total	244	126	-48.36%

Data supplied in the Dyfed Powys Mephedrone profile from August 2014 shows a reduction of 48.36% in the number of Mephedrone related drug offences when comparing like periods for 2013 and 2014. All but one area showed a reduction in offences, with the largest reduction being in Carmarthenshire.

South Wales

Occurrence data reveals that the total amount of Mephedrone seized within the South Wales force between the period August 2013 and July 2014 decreased by 34% compared to the same period in 2012 and 2013.

BCU's	Aug 12 to Jul 13	Aug 13 to Jul 14	% Change
Central	111	82	-26.13%
Eastern	45	23	-48.89%
Northern	111	93	-16.22%
Western	163	84	-48.47%
Grand Total	430	282	-34.42%

Seizures in Eastern and Western BCU's decreased by nearly half in 2013-2014 compared to 2012-2013. Northern and Western BCU's also show a decline regarding the recorded seizures. Northern BCU demonstrates the smallest percentage decrease of seizures year on year.

Overall, much like Dyfed Powys Police Force, the occurrence data reveals that the seizures related to Mephedrone in the South Wales force area have decreased dramatically in 2013 – 2014 compared to 2012 – 2013.

Gwent

Data obtained for Gwent Police shows that there was a 63% reduction in the amount of Mephedrone seized in Gwent when comparing the data for 2012/13 with that of 2013/14. There were 58% fewer items seized in 2013/14 compared to 2012/13 and the amount seized reduced from 1.54kg down to 569g in total.

LPU	Apr '12 to Mar '13	Apr '13 to Mar '14	% Change
Blaenau Gwent	57	3	-94.74%
Caerphilly	62	37	-40.32%
Monmouthshire	41	19	-53.66%
Newport	101	72	-28.71%
Torfaen	27	23	-14.81%
Grand Total	288	154	-46.53%

Overall results for Gwent show a 46.53% reduction overall in the number of arrests relating to Mephedrone. Reductions were noted across all of the LPUs, with the most significant occurring in Blaenau Gwent and Monmouthshire.

Offending

Mephedrone

In 2011 – 2012 drug related offences involving Mephedrone increased by 83% in Wales (289 to 530). In 2012 – 2013 a further sharp increase of 165% was noted (Chadd, 2013).

Whilst there are numerous anecdotal accounts of Mephedrone-induced aggression and violence (Daly, 2012) the empirical research base is sparse. Van Hout and Bingham (2012) studied the patterns of use and perceived consequences of Mephedrone based head shop products in Ireland. The study analysed 11 Mephedrone users who all had a history of injecting and poly drug use. Mephedrone users stated that Mephedrone heightened the sense of paranoia that in turn, led to elevated levels of violence and participation in criminal acts. Mephedrone users also reported acting violently when they were trying to secure further supplies of the drug for the next dose (Van Hout and Bingham, 2012).

Increased aggression and violent behaviour has also been reported on numerous occasions often linked to the 'come down' rather than the 'high' (Brookman, 2014). Over half of those interviewed in Brookman's (2014) survey, which covered an area that took in both South Wales and Gwent Pilce Force areas, had become involved in acquisitive crime (including shoplifting, burglary, vehicle theft and street robbery). Intelligence logs from South Wales and Gwent Police Forces over the last 12 months support this information. Three-quarters of those interviewed had committed acts of violence connected in some way to their use of Mephedrone. Four somewhat distinct violence-Mephedrone links were discerned: (i) violence when 'high'; (ii) violence associated with comedown; (iii) economic compulsion and violence and (iv) violence associated with purchasing and dealing Mephedrone. Importantly, regarding the first two categories, interviewees were very clear in their own minds that Mephedrone had a direct and significant influence on them becoming involved in acts of violence. This, they reasoned, must be the case as they were either not usually violent or, would not normally have been violent in relation to such trivial triggers.

Key findings from expert practitioners who work with users in many regards mirrored and confirmed the findings from the users (Brookman, 2014). Many practitioners had been on the receiving-end of aggressive and violent behaviour by Mephedrone-using clients, most of whom had not exhibited such tendencies in the past. Many had been verbally threatened and several had been physically assaulted. Practitioners also reported a range of acquisitive crimes committed by their clients specifically linked to their abuse of Mephedrone and the necessity to fund their increased use of this highly addictive drug.

All Southern Wales forces report incidents of domestic disturbances or assaults mainly involving youths who were Mephedrone users. A number of assaults across the region can be linked to Mephedrone use, often in combination with alcohol or the night-time economy. In several cases the offenders have had no previous history of violence (Chadd, 2013).

Users who had injected or snorted Mephedrone were prone to being more aggressive and violent, compared to users who swallowed or bombed the drug (Daly, 2012).

NPS

NPS markets encompass a large number of users across almost all demographics of society. The impact of NPS usage therefore also poses a significant threat to the Force area; Anti-Social Behaviour (particularly linked to younger users), the often blatant dealing and using of these drugs and the associated risks to mental and physical health all have a profound effect on communities. (Wilson and Holmstrom, 2014).

At this time, there are no known Organised Crime Groups concerned in the supply of NPS in the South Wales area (Wilson and Holmstrom, 2014). The rise in popularity of NPS, particularly Synthetic Cannabinoids, is undoubtedly an issue within the SWP force area. The existing widespread and established drugs market and the supply chains, the low risk of penalties, the inability to identify usage via drug testing, the ease at which they can purchased at low cost and the misguided belief that they are "safe", all make NPS appealing to many demographics within society and relatively easy to get hold of.

Whilst much NPS trade is in small amounts, trafficking and supply sometimes also involves organised crime. Criminals involved in NPS activity specifically are often relatively unknown to UK low enforcement, score low on OCGM and receive limited attention (NCA, July 2014).

High risk areas

Areas of higher prevalence of Mephedrone offences appear to correlate primarily with rural areas or urban areas of higher depravation. It is possible that Mephedrone is more popular in rural areas simply due to a lack of an established class A market. In more deprived urban areas (e.g. some areas of Swansea, Bridgend or the Valleys) the drug is likely to be more attractive to both recreational and problematic drug users as it is cheaper and better quality than available Cocaine and Heroin. The British Crime Survey 2013 – 2014 showed that 4.5% of adults who lived in very deprived areas were more frequent drug users compared with those who lived in the least deprived areas (2.3%).

Mephedrone can be easily sourced via the internet/postal systems, so normal Class A drugs supply networks are not needed to source the drugs. In more deprived urban areas (e.g. some areas of Swansea) the drug is likely to be more attractive to both recreational and problematic drug users as it is cheaper and better quality than available class A drugs such as Cocaine and Heroin.

Hubs feeding Wales

Bristol, Liverpool, Manchester, Cardiff, Newport & Swansea are the principal hubs identified for supply throughout southern Wales.

Even with limited intelligence the hubs tend to reflect the established Class A hubs. Dealers are likely to be picking up other Class A drugs alongside Mephedrone from these hubs.

Related deaths

<u>Mephedrone</u>

In the UK between September 2009 and August 2011 there were a total of 60 confirmed and 125 suspected Mephedrone-associated fatalities identified. Two of these deaths occurred in Wales. 13 of the confirmed deaths resulted from suicide by hanging, which is significantly higher than with other stimulant drugs.

On 2 July 2013 Sarah Mayhew, a teacher from Newport, died after taking a cocktail of drugs, including Mephedrone and became the first recorded Mephedrone death in Gwent.

On 30 December 2013 Rhys Trimby from Crumlin died after taking Mephedrone with alcohol.

NPS

Since 2005, NPS have been attributed to 70 deaths in the UK (NPS conference, 2014).

The number of deaths related to Mephedrone and NPS is extremely difficult to ascertain as there is a significant delay between a death occurring and the coroner's findings being released. Previous research surrounding Mephedrone/NPS related deaths shows us that deaths have occurred due to poly drug use.

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National Assembly for Wales
Health and Social Care Committee
Inquiry into new psychoactive substances ("legal highs")
Evidence from The Police Federation of England and Wales - LH 05

Influence. Represent. Negotiate

To: HSCCommittee@wales.gov.uk

National Assembly for Wales
Health and Social Care Committee
Inquiry into New Psychoactive Substances (NPS)

1. The Police Federation

1.1. The Police Federation of England & Wales ('The Federation') was formed in 1919 by an Act of Parliament and, in Wales, it represents 6,780 police officers, of all uniformed and CID ranks from Constable to Chief Inspector. The Federation's membership comes from each of Wales' four police forces.

1.2. The Federation was established to protect and promote the 'welfare & efficiency' of police officers and in its discharge of functions as laid down by statute.

1.3. The Police have a duty of care to the public. The sworn and attested duties are discharging their duty 'to protect life' and to 'enforce the law'. The Police Federation's principal representatives, are all serving police officers who are elected to their respective roles.

2. Evidence

2.1. The Police Federation will restrict this submission to the impact that NPS' are having upon the role that officers play in combating such emerging drug and associated crime. *We make a recommendation in this submission at paragraph 3.1.*

2.2. It is important to recognise that the criminal elements that make up NPS are simply to *generate profit through organised crime via the production and selling of drugs*. Such organised crime is not concerned with the wake it creates in regard to anti-social behaviour, the negative impact upon people's lives, their families or their health, or indeed - save for making criminal profit - the overall chain-reaction it generates through more serious crime such as to fund the further purchase of the drugs. The negative impact generated by NPS includes also violent and sexual crimes for those taking such drugs.

2.3 Policing in the front line to combat NPS is conducted exactly the same as it is in dealing with those drugs commonly known in classes A and B. Examples of Class A drugs being cocaine, heroin, LSD, and ecstasy and Class B drugs such as amphetamines, barbiturates, cannabis, mephedrone and synthetic cannabinoids which remain illegal.

2.4 To effect quality policing requires a combination of source-led intelligence. Such operations come from information gathered from the streets and elsewhere, but ultimately such a police resource that can effectively deal with the intelligence, arrest and associated processes, requires a physical presence of police officers. In Wales, since 2010 police numbers have reduced by circa 800 officers; effectively since that time, Wales' resilience to police the streets has reduced, we stand by these remarks irrespective of what political messages are given out on crime.

2.5 The collating of information of such drug usage is down to Wales' four individual police forces, each will have witnessed an increase in the prevalence of NPS and where necessary the recording of such use. This is apparent even with the known 'amnesty drop boxes' that are found outside night clubs etc. However, not all NPS usage is at public bars and clubs. The outcome of this is that this leaves communities vulnerable, especially so when the number of retailing outlets for these drugs (termed 'head shops') are actually not known.

2.6 Police may arrest a suspect on producing, selling or using such NPS. However, to secure a charge and conviction it's chemical make-up has to be analysed and currently this is being conducted by Kings College London and latterly in Wales by Wedinos; this takes time and finance. Many of the branded products that are analysed contain more than one substance, in fact 77% of all branded psychoactive products contain at least two substances with 34% containing at least three substances. Around 19% of products sold do contain controlled drugs. Users do not know what they are taking – either for image/steroid enhancement, but also for psychoactive mind altering properties - producers do not know the exact chemical make-up of the NPS other than they are actually synthetically produced in cocktails (often from overseas) and for home-produced drugs this is extant also for hydroponic production across the UK.

2.7 Police can arrest any suspect under current police powers; we believe that those 'powers of arrest' are sufficient. However, the alteration of NPS compounds (i.e. their actual chemical make-up) can be rapid, as those engaged in 'organised crime' need to evade detection. Albeit The Misuse of Drugs Act 1971 has been amended to allow Temporary Class Drug Orders to be made - and that this goes some way to alleviate the issue, in reality it does not (with the exception of the possession offence) keep up-to-speed or in-step with the 'changing science' of NPS production. Such synthetic production has considerable momentum driven by criminal profit and 'social acceptance' across many age ranges.

2.8 It is not uncommon for 'head-shops' to obscure their identity of multiple outlets, or for 'online sales' not to comply with and to flout product safety. Indeed regularly, retail outlets cite that they are unaware of what the contents actually are within the products (often in pre-sealed packages) that they sell; despite what it 'says-on-the-tin'. So, to combat the increase of usage of NPS requires a multi-agency approach from not only the police, but trading standards, local authority, education and health boards.

2.9 The police of course provide training and awareness amongst its own officers and share this throughout police forces and indeed collaborate on intelligence; such collaboration is nothing new. However where a gap does exist is in the provision of training and awareness through community partnerships and this may prove of significant value, especially so as the authorities will be seen to be acting through various out-reach-groups and via diverse communities that are at risk right across Wales. This is an area, that other stakeholders may identify to you in detail.

3. Recommendation

3.1 We are concerned with application and enforcement of the law and so from a policing perspective, we believe that Trading Standards/Local Authorities need the continued resources to deal with the authorised opening of 'head-shops', but moreso, that the NAfW could examine examples from overseas 'licensing' in as much as in Eire, their *The Criminal Justice (Psychoactive Substances) Act 2010* became law that empowered the Garda to seek court orders to close head shops suspected of selling drug-like products, with the onus on the owners to prove they are not doing so. Let us stress we are not advocating the licensing or legalisation of drugs, but an enhancement to current powers that could be enacted quickly, with a Court Order - pending retrospective investigation of Chemical compounds therein - of such articles found. This power would need territorial enactment across both Wales and England jointly in legislative competence and effect.

We therefore recommend that jointly the Welsh and UK Government examine how best to progress legislation that allows a Court Order to be issued that allows the police and Welsh local authorities to close outlets suspected of selling illegal drug-like products, that would be categorised as NPS.

3.2 The result is that head-shops and any other shops would have the onus placed upon them to ensure that what they are selling is not 'illegal', such a power would extend to any other shops that sell products that are, or can be used for NPS. We accept that umbrella bodies such as retail consortiums etc., may also have a view upon this, but our sworn attested duties are both to enforce the law and to protect public life and property; we believe that such a power will go some way towards that service to the public.

3.3 We accept that such a legislative route will not fully curtail the selling of 'wraps' or 'poly bags' on the streets for personal consumption (or further illegal sale), or indeed online sales, however, not withstanding police resources, our current powers in this respect would be sufficient to stop, search and if necessary impound suspect goods and arrest a suspect. That current power extends also to S23 of the MDA that allows the police, with a warrant, to search premises when grounds exist that controlled substances are held.

4. Conclusion

4.1 What is abundantly clear, is that the current position on NPS is somewhat disjointed and albeit each 'stakeholder' is engaging, there is a lack of police powers and/or local authority powers to act decisively and to work with intelligence.

4.2 We cannot continue on such an *ad hoc* basis with no 'messages' being conveyed concisely to the public (or sellers) about the illegality of such drugs. Despite the valiant efforts with the Welsh Government's *DAN 24/7 Helpline* which has an important and integral part to play in education, help and support of the public, from our perspective, we are concerned with law enforcement, and we believe that our recommendations go some way further in ensuring safer communities and to help lower crime.

4.3 None of the information in this submission is classified as 'Restricted' and The Police Federation are happy that this submission is placed in the public domain. Additionally, we are happy to make available officers with considerable operational knowledge in this subject to give oral evidence to the Health & Social Care Committee or be called forward in respect of advice should a legislative route be progressed in due course.

Steve White
Chair etc

Andy Fittes
General Secretary etc

National Assembly for Wales
Health and Social Care Committee
Inquiry into new psychoactive substances ("legal highs")
Evidence from HM Inspectorate of Prisons - LH 18

Agenda Item 3

RESPONSE TO National Assembly for Wales - Health and Social Care Committee: Inquiry into new psychoactive substances

RESPONSE TO National Assembly for Wales - Health and Social Care Committee: Inquiry into new psychoactive substances

by Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit a response to the inquiry into new psychoactive substances (NPS).

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons, young offender institutions (YOIs) and immigration detention facilities. HMI Prisons also inspects court custody, police custody and customs custody (jointly with HM Inspectorate of Constabulary), and secure training centres (with Ofsted).

3. HMI Prisons coordinates, and is a member of, the UK's National Preventive Mechanism (NPM) the body established in compliance with the UK government's obligations arising from its status as a party to the UN Optional Protocol to the Convention Against Torture (OPCAT). The NPM's primary focus is the prevention of torture and ill treatment in all places of detention. Article 19 (c) of the Protocol sets out the NPM's powers to submit proposals concerning existing or draft legislation.

4. All inspections are carried out against our *Expectations* - independent criteria based on relevant international human rights standards and norms.

5. In response to the serious threats that drugs and alcohol pose to health and safety in prisons, HMI Prisons has on its staff three specialist substance use inspectors. They have wide ranging backgrounds in substance use nursing, addiction rehabilitation and service management within prisons and the community. They also bring experience in substance use treatment programme design and evaluation, both in the UK and internationally. Inspectors' on-going involvement with substance misuse research in prisons adds to the specialist knowledge base. Working as part of the HMI Prisons healthcare team, they inspect clinical and psychosocial aspects of in-prison substance use treatment and associated education and awareness programmes. Substance use inspectors also work closely with security inspectors to determine the effectiveness of prisons' drug supply reduction initiatives including drug testing programmes.

6. As part of HMI Prisons' statutory duty to report on conditions for and treatment of those in prisons, YOIs and immigration detention facilities, we have monitored and reported on the rise of NPS use and availability in prisons in England and Wales. The following response is based on evidence from HMI Prisons' most recent inspections of Welsh prisons, as follows:

    - HMP Swansea: unannounced inspection, 29 September – 10 October 2014 (*report not yet published)*

    - HMYOI Parc Juvenile Unit: unannounced inspection, 28 April – 9 May 2014

- Arolygiad dirybudd Carchar EM / Sefydliad Troseddwyr Ifanc y Parc (9-19 Gorffennaf 2013) –/– HMP/YOI Parc: unannounced inspection, 9 – 19 July 2013

- Adroddiad ar arolygiad heb ei gyhoeddi ymlaen llaw o CEM Brynbuga a CEM/STI Prescoed (22 Ebrill – 3 Mai 2013) –/– HMP Usk and HMP/YOI Prescoed: unannounced inspection, 22 April – 3 May 2013

- Arolygiad lle rhoddwyd rhybudd o Garchar Ei Mawrhydi Caerdydd (18–22 Mawrth 2013) –/– HMP Cardiff: announced inspection, 18 – 22 March 2013

Summary

- Drugs get into prisons through five main routes.
- HMI Prisons inspections of Welsh prisons over the last two years have shown new psychoactive substances (NPS) to be less of a problem than in English prisons. This may change in the near future.
- Spice and Black Mamba have been an increasing problem in English prisons since autumn 2013.
- Areas of good practice are beginning to emerge, from which lessons can be learned.
- Current drug testing programmes in prisons are not equipped to deal with NPS.
- Under the current legislative framework, prisoners find NPS an attractive alternative to more traditional drugs for a number of reasons related to the lack of detectability and reduced risks of penalties.
- Inspection findings over the last year have pointed to increased safety concerns in prisons. The rise of NPS misuse is one such factor that may also partly be a result of the other factors that contribute to prisoners feeling less safe, given that people who feel under stress will often take drugs in an attempt to relieve that stress.

HMI Prisons response

7. In order to reflect the sole focus of HMIP on places of detention, this evidence focuses specifically on the inquiry's terms of reference that fit with the unique circumstances of prison environments. We have therefore left the remaining three areas more effectively to be evidenced by community-based service users and providers.

How to raise awareness of the harms associated with the use of legal highs among the public and those working in the relevant public services.

8. The wider awareness of drug problems in prisons at a strategic level, includes an understanding of how drugs get into prisons. In 2008, David Blakey produced a report entitled 'Disrupting the supply of illicit drugs into prisons.' That report cited five routes that are still widely used:

    - *With visitors* – normally passed to prisoners during a visit
    - *'Over the wall'* – people on the outside use various devices to throw drugs over prison walls for prisoners to retrieve from exercise yards and walkways. Small packets or even single coins holding a single tablet are commonly found especially in inner-city prisons. Coins are used to provide weight and velocity sufficient to ensure passage through nets that are sometimes erected to prevent throw overs.
    - *In post and parcels* – even confidential letters from legal representatives have been used to get drugs into prisons.

- *Brought in by prisoners* – drugs are often secreted in body cavities – a practice known as 'packing' or 'plugging'. As well as opportunistic attempts by individual prisoners, a new trend is emerging in this area. Intelligence from some areas of the UK points to organised gangs directing individuals released on licence to commit minor offences that ensure a short return custody. This enables drugs to be taken into local prisons regularly and in relatively large quantities.
- *Through corrupt staff* – Blakey said *"Most staff are not corrupt and have a clear integrity. They are let down by a minority of staff who are corrupt. That corruption will extend, in some cases, to receiving large amounts of money for carrying in phones or drugs."*

9. When we inspected HMP Cardiff in March 2013, whilst the diversion of prescribed medication was an issue, there was no evidence of NPS availability or use. Similarly, at HMP/YOI Parc four months later in July 2013 and at the inspection of the Parc Juvenile unit in May 2014, there was no evidence of an emerging NPS problem. Most recently, at our inspection of HMP Swansea in early October, (report not yet published), staff and prisoners told us there was little or no evidence that NPS were becoming and issue within the prison.

10. Nevertheless, prison staff and prisoners alike often say that drug trends within prisons follow those in the community. As NPS gain momentum in Welsh communities, it can be predicted with some confidence that Welsh prisons should expect a rise in the incidence of NPS misuse – as is certainly the case in England.

11. On 28 October 2014, the WalesOnLine website reported the Chief Inspector's warnings for the proposed new prison in North Wales. Stating legal highs had a "prison value" 10 times that of the "street value," he stressed the health dangers and warned: "[They] are a cause of debt and debt is a cause of violence. What we found is that on the whole in Welsh prisons, actually, they don't have the problem yet to the same extent as English prisons..."But I think it will [arrive] and therefore those Welsh prisons need to be ready for this to hit them and on the whole I think the system has been too slow to react."

International evidence on approaches taken to legal highs in other countries.

12. In the autumn of 2013 we reported the beginnings of the availability and use of NPS in prisons with our report on the Category D establishment, HMP Blantyre House (Kent, England), inspected 9 – 20 September 2013. We made the following comments:

> *The number of violent incidents had increased since the last inspection and there had been two recent serious assaults. Although the level was still low, more prisoners reported victimisation than at the last inspection and at similar establishments. This appeared, at least in part, to be due to the availability of 'Spice' – a synthetic cannabinoid – and associated debt and bullying. Current testing methods did not detect Spice, so the very low positive drug testing rate did not give an accurate picture of the availability of drugs in the prison. The prison's response to the issue was inadequate.*

13. In our report on the Category C establishment, HMP Ranby (Nottinghamshire, England), inspected 10 – 21 March 2014, we raised the following concern:

> *There were high levels of illicit drug and alcohol availability. More than half of the population said that it was easy to get illegal drugs and a quarter that it was easy to get alcohol. The number of finds was high. Most intelligence and finds related to undetectable diverted medication and new psychoactive substances (especially 'Mamba')... In the previous six months substance misuse and health services staff had responded to 25 acute medical situations which were thought to have resulted from prisoners taking such substances...The prison had taken some reactive measures but there was no coordinated action plan to reduce supply and demand.*

14. To address the above concern we made the following recommendation to HMP Ranby:

> *An action plan to address drug and alcohol supply reduction and demand should be implemented and should address the specific issue of new psychoactive substances and diverted medication.*

15. HM Chief Inspector reported on inspection findings across prisons in England and Wales in his Annual Report 2013-14, specifying:

> *NPS, specifically 'Spice' and 'Black Mamba', were cited as causes for concern at 14 (37%) of the adult male establishments inspected, particularly local and category D jails. Although many prisons had taken steps to promote awareness of this problem, we highlighted the need for some to give prisoners and staff accurate and up-to-date information on the acute health dangers associated with NPS.*

16. Drugs education and treatment programmes in prisons in England and Wales have experienced huge changes in recent years. The previous nationally-based and prison service-run CARAT (counselling, assessment, referral, advice and throughcare) service, has been replaced by locally commissioned, civilian-based services. Much time and effort has been, in our opinion rightly, devoted by these newer services to the development of integrated clinical and psychosocial opiate treatment programmes (e.g. heroin and its substitutes). Whilst this has been in response to previously assessed levels of need, the demographics of drug use are constantly changing. Services in England, where NPS is becoming a problem have had to devise awareness and education programmes quickly and with minimal resources.

17. Staff training, in some prisons where NPS is a problem, has been difficult to organise. Overall shortages in staff have reduced opportunities to take staff away from operational duties for training.

18. Nevertheless, as well as pointing out areas for improvement, the HMI Prisons inspection process is a useful way of identifying good practice. In recent months we have found good practice that has begun to address NPS in some prisons in England has included the following components: (due to this information being recent, reports are not yet published):

- Adaptations of drugs strategies and action plans that specifically address supply reduction, demand reduction and harm reduction relating to NPS.
- Up-to-date, accurate information on the appearance and effects of NPS – given to both staff and prisoners.
- Extra training given to discipline staff and primary healthcare staff that better equips them to recognise and deal with acute health situations caused by prisoners' use of NPS.
- Extra training given to drug workers to enable delivery of NPS-specific demand reduction and harm reduction initiatives.
- Exploration of initiatives to reduce the supply of NPS including:
- The training of drug dogs to recognise 'Spice' and other synthetic cannabinoid receptor agonists (SCRAs)
- The development of accurate tests to detect SCRAs

The possible legislative approaches to tackling the issue of legal highs, at both Welsh Government and UK Government level.

19. Powers to require prisoners to provide a sample for drug testing purposes were introduced as part of the Criminal Justice and Public Order Act 1994 (Appendix 1). The initial powers for testing prisoners for drugs were added under the aegis of Section 16A the Prison Act 1952, and came into force on 9 January 1995.

20. HMI Prisons has noted that while there has been a general decline in the positive rates resulting from the mandatory drug testing (MDT) of prisoners – both in random testing and that carried out under 'reasonable suspicion' – this trend does not mean that prisoners' illicit drug use has reduced. While MDT rates provide an indicator, they do not reliably measure drug availability in establishments – nor does testing necessarily deter prisoners' use of illicit drugs. In our survey, 31% said that illegal drugs were easy or very easy to obtain in their prison, and 7% told us they had developed a problem with illegal drugs and 7% with diverted medications since coming to prison. HMI Prisons considers that the main reason for this is that the current MDT does not detect new psychoactive substances (NPS) and most diverted prescribed medications.

21. It is important to consider that the wide range of drugs that fall into the 'NPS' (which includes stimulants like Mephedrone, to depressant hallucinogenics like Spice and other SCRAs) makes the development of tests a complex issue involving many drugs, the precise ingredients of which are constantly changing.

22. The current absence of a usable test for any NPS makes such drugs attractive to some prisoners who might otherwise be deterred by the risk of being caught through drugs testing programmes.

23. The previous two points notwithstanding, the types of drugs used in a prison environment tend not to include stimulants. The majority of prisoners will prefer to use drugs that depress levels of awareness of surroundings, reduce anxiety and produce a sedative effect. Such effects are brought on by depressant drugs. NPS that fall into this category are the SCRAs.

24. NPS, and specifically SCRAs are also attractive to prisoners for the following reasons:
    - These substances have little odour when mixed and smoked with tobacco.
    - The penalties for a prisoner caught with NPS will be limited to 'possession of an unauthorised article', rather than 'possession of a controlled drug'. The former will lead to a temporary loss of privileges whilst the later can be adjudicated by an Independent Adjudicator (a judge) and lead to the greater penalty of added days to the sentence.
    - This is because each sample, if found in the possession of a prisoner, would have to be forensically tested to determine whether or not it fell within current definitions of drugs controlled under the Misuse of Drugs Act (1971). Such analysis is expensive and unlikely to be given funding. Also, given the constantly changing nature of NPS at a molecular level, the manufacturers of NPS are often able to keep ahead of the drugs covered by statute.
    - We have spoken to many prisoners who say they enjoy the risks associated with taking new drugs, the effects of which are unpredictable.

25. In conclusion, the emergence of NPS in English prisons is likely to be mirrored in Welsh prisons in the near future. Lessons that can be learned include the need for a strategically co-ordinated, 'whole prison' approach to tackling the new threats posed by NPS.

26. A 'whole prison' approach to drugs is a strategy that recognises a simple principle: Drugs have the potential to affect virtually all areas of prison life. It therefore follows that an effective strategic response will address all relevant issues in all those same areas of prison life. The 'whole prison' approach will have at its core, strategies that tackle three areas:
    - Supply reduction: stopping drugs getting into the prison – security is everyone's business.
    - Demand reduction: treatment for drug users - but importantly not just that. This area also involves all areas that reduce demand. Some examples:
        - Where prisoners feel safer in custody they experience lower levels of stress and therefore will be likely to have reduced self-medication needs.

- Time out of cell and purposeful activity reduce boredom and stress, facilitating healthy sleep that prisoners otherwise may feel the need to induce with drugs.
- Good healthcare and effective pain management reduces demand for self-medication.

- Harm reduction: up-to-date, accurate and effective drugs awareness and education that equips staff and prisoners to deal with situations and make informed choices in their own behaviour. Good harm reduction supports demand reduction by recognising that some users of illicit recreational and diverted prescription drugs in prisons are not regular drug users in the community. Simply put, any prisoner who feels unsafe, unfulfilled and unhealthy may be more likely to want to take mind-altering substances.

Closing remarks

27. I hope that you find this information useful and should you require anything further, please do not hesitate to contact me. I look forward to attending the Committee hearing on 12 November 2014.

Paul Roberts
Specialist Substance Use Inspector
HM Inspectorate of Prisons

On behalf of
Nick Hardwick
HM Chief Inspector of Prisons

28 October 2014

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/MD/3154/14

David Rees AM
Chair of the Health and Social Care Committee
National Assembly for Wales
Ty Hywel
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4 November 2014

Dear David.

I refer to your letter of 25th October, outlining the key issues you identified during your scrutiny of the Welsh Government's 2015-16 draft budget. You have commented on a number of important issues and have asked for further information in a number of cases.

I also note that you attached a letter from the Chair of the Children, Young People and Education Committee, which refers to issues raised by them and you have also asked for a response to the questions they have raised.

I am happy to provide the further information you have sought and have also included below my responses to the questions raised by the Children, Young People and Education Committee.

1. Additional revenue allocation for NHS services in 2015-16

The Committee would welcome further information from the Welsh Government on how it will monitor and ensure that the additional revenue funding for the 2014-15 and 2015-16 financial years delivers meaningful reform to services and positive outcomes for patients rather than being used by health boards to address end of year deficits resulting from unchanged models of care.

As emphasised within the Nuffield report the majority of the new funding is primarily required to maintain current service levels and the continuation of the provision of high quality safe services. However it is acknowledged that even with additional funding we cannot continue to provide the services in the same way as we have historically. We will need to be more innovative and continue to identify new models of service delivery.

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The planning process will be key to identifying how we will deliver this change and the funding will be targeted to meet the challenges outlined in the integrated medium term service plans. Through the continued development of the NHS's integrated service plans we will ensure we achieve the right service models and the right patient outcomes.

We monitor progress against the integrated plans and oversee the performance of the NHS through a number of vehicles, including: Monthly Chief Executive meetings, monthly quality and delivery meeting, detailed submission of monthly financial monitoring returns, joint executive team meetings etc. We also have a recognised escalation and intervention process which has been developed in conjunction with HIW and the WAO. This involves sharing and reporting on the performance and progress on NHS organisations between each other.

2. Resource allocation formula and distribution of additional funding.

The Committee would welcome further detail on the distribution of this additional funding once made, to include information about how the integrated medium term plans of health boards have influenced decisions.

I will provide the Committee with an update on the total revenue allocation made to each health board for 2015-16 once final decisions are made.

3. Intermediate Care Fund

In the short term the Committee would welcome further information from the Minister on how he will monitor and ensure that the positive steps made as a consequence of the funds existence will be maintained once its funding stops at the end of 2014-15.

Although the intermediate care fund was funded initially on a one year basis, we hope to be able to build on some of the key successes it has helped to develop either by mainstreaming some of this work within the primary care and community focus; through the joint working and collaboration we are building and funding through the three year planning approach or by calibrating an element of the additional revenue resources that are being provided to Health and Social Care in 2015/16. We are considering how the additional funding for health can be used to drive forward and mainstream the beneficial impacts made by the Fund.

Furthermore an additional £10 million has been made available to social services, some of which can be used to invest in and reform services to focus on prevention and early intervention which are key elements of the Intermediate Care Fund.

Where additional capital may be required we are also reviewing our capital priorities to develop additional community initiatives and we are looking at how this could be funded through innovative finance solutions built on partnerships across public, private sector and third sector arrangements

In terms of monitoring, each region is required to provide a formal quarterly update on progress in relation to the work being taken forward and officials are also meeting with regions on a quarterly basis to review progress. There is also a requirement for formal evaluation by each region. This will enable us to identify the good practice and interventions which deliver the greatest impact and benefits and which should be sustained and mainstreamed longer term.

4. Capital

The Committee is concerned by the overall reduction in capital funding and would welcome further information about how the new capital prioritisation exercise will work in practice.

The Welsh Government shares the Committee's concerns at the reduction in capital funding for public services in Wales.

The capital prioritisation exercise in my department has focused on identifying capital schemes that will meet and deliver objectives around investment to support service change with clear benefits, including revenue savings and the provision of sustainable services. An expert panel has been set up from within the Welsh Government to undertake this work. The panel includes senior representation from across the organisation including, medical, workforce, planning, finance and information technology leads.

Local Health Boards were asked to prioritise and submit proposals to the panel, based on key investment criteria, linked to health gain, affordability, clinical and skills sustainability, equity and value for money. All schemes within the forward Programme from 2015-16 onwards, including those that have already commenced the business case process but have not yet received Full Business Case approval were included.

The expert panel is in the process of evaluating and further prioritising the submissions received. As part of its remit, it is considering the affordability envelope and the potential impacts on the forward work programmes linked to the pipeline identified. The findings and recommendations of the group will be submitted to me in due course.

5. Mental health services and the ring fence

The Committee would welcome further detail about the allocation of funds to mental health as information appears to have been presented in a different format in this year's draft budget documentation. Furthermore, the Committee would welcome clarification of whether the ring-fenced allocation for mental health services has grown with inflation since its inception.

The evidence paper provided to the Committee refers to £529m which relates to the primary element of Mental Health funding that is identified within the NHS protected and ring-fenced allocation for 2014-15. In addition to this there are also elements within prescribing and general medical services allocations which form part of the overall total of protected funded for Mental Health of £587m.

The mental health ring fence represents a floor below which expenditure on core Mental Health Services should not fall. The LHBs have consistently exceeded the ring fenced level of expenditure as demand has increased for Mental Health services. Since 2010-11 there has been additional funding added into the ring fence for specific areas like the Mental Health Measure, CAMHS and Advocacy.

The ring fence level is currently under review and consideration will be given to adjusting it for the 2015-16 NHS budget allocation process.

For clarity the evidence paper provided to the Committee also refers to expenditure on Mental Health of £618m. This is included within the Programme Budgeting chart relating to the 2012-13 financial year. For the Committee's information this figure represents a retrospective analysis of fully absorbed reference costs allocated to the Mental Health Programme Budget Category. This would include all of the following:

- The ring fenced funding mentioned above;
- Any further funding directed by each HB from their Discretionary budget; and,
- Overhead costs that are apportioned across the specialties and points of delivery as part of the process that the Health Boards go through when compiling their annual reference costs, which are then mapped to their programme budgeting returns.

6. Litigation and the Risk Pool

The Committee looks forward to receiving further analysis relating to the quantity and level of in-year settlements made against the risk pool in recent years, as requested during the meeting.

In addition to providing the further analysis requested by the Committee, it may also be helpful briefly to explain the accounting conventions associated with the administration of the Risk Pool.

The Welsh Risk Pool reimburses losses over £25,000 incurred by Welsh NHS bodies arising out of negligence and other eligible claims and is funded through the NHS Wales healthcare budget. The annual funding for the Welsh Risk Pool consists of:

- Annually Managed Expenditure resource for movements in the balance sheet provision held in respect of future liabilities and settlements.

- Revenue Departmental Expenditure Limit (RDEL) resource for payments made in a financial year to reimburse Local Health Boards and NHS Trusts for claims settlements made.

In accordance with statutory accounts requirements, a provision is maintained for the future liabilities of the Welsh Risk Pool. This provision is shown in the consolidated Welsh Government statutory accounts annually.

The provision consists of two major elements:

- provision for the future reimbursement by the Welsh Risk Pool to NHS Wales Local Health Boards and NHS Trusts, for approved Clinical Negligence and Personal Injury claims greater than the agreed excess (currently £25,000) and considered to have a probable outcome (greater than 50% likelihood) in favour of the claimant; and,

- provision for periodical payment orders awarded to claimants, managed by the Welsh Risk Pool on behalf of the relevant NHS Wales Local Health Boards and NHS Trusts. (Periodical payment orders are an arrangement whereby a claimant agrees to resolve a claim by receiving periodic payments on an agreed schedule rather than as a lump sum).

  The provision in the Welsh Government Accounts for the last two financial years is as follows:

	31 March 2013	31 March 2014
Welsh Risk Pool Provision	£521m	£594m
Periodical Payment Order	£183m	£214m

element of the above		

The movement in this provision annually is funded from the Annually Managed Expenditure budget.

The Revenue DEL resource utilised for in year claim settlements in the the last three financial years is as follows:

	2012-13	2013-14	Forecast 2014-15
Welsh Risk Pool claims settlements	£60.8m	£69.1m	£75.0m

Comment on the general trend of claims
In recent years and in common with other nations NHS Wales has experienced a growth in the number of legal claims, for example in 2013/14 the NHS Litigation Authority in England reported a 17.9% increase in clinical negligence claims from 2012/13 and a growth in their total claims provision of 13.7% compared to the 14% increase in the Welsh Risk Pool provision. Individual claims can take several years before a full settlement is reached, and the timing of such claim settlements is determined by the legal and court processes.

The reasons for the increase in claims are multifactorial and it is not possible to say with any certainty what the primary driver for the increase is. There has been a general upward trend in claims over recent years both in terms of number and value. Recent changes to funding rules for legal claims which came into effect on 1st April 2013 are considered to have had an impact on the registration of claims before this date, and therefore upon the subsequent submitted case volumes being experienced in 2013/14. It is also considered that increased public awareness of clinical redress options is contributing to claim volumes.

The cost of claims has also increased, especially for settlements involving long term care packages. The reason for this increase is that care needs are becoming more complex and it is necessary to ensure that any care packages are fully compliant with applicable legislation such as Health and Safety and Working Time Directives.

NHS Wales takes a pro-active approach to learning from claims to reduce the risk of recurrence. Before reimbursement is made by the Welsh Risk Pool, Health Boards and Trusts are required to outline the key weaknesses which gave rise to the claim and outline the steps taken to reduce the risk of recurrence. Claims are reviewed internally within the Welsh Risk Pool for efficacy of action and then considered by an All Wales Executive Level multidisciplinary group with representation from Medical Directors, Directors of Nursing, Chief Executives, Directors of Finance, Chair of a Health Board, Directors of Governance and the Welsh Government. Where there is evidence of risks which may be relevant to other NHS bodies, or evidence of good practice, a more detailed claim review can be requested.

Where all Wales issues are evident from claims, the Welsh Risk Pool undertakes themed work. This involves the clinical assessment of high risk areas including those of maternity, emergency departments and the surgical pathway. The findings of the

reviews are shared with the individual Health Boards with a composite report being shared with the Welsh Government and Chief Executives.

Children, Young People and Education Committee

7. Additional £10 million for Social Services
What mechanism has the Welsh Government put in place to ensure that an appropriate proportion is spent on Children

The Government has worked hard to find extra resources for Social Services and schools in the draft Budget. This means local authorities in Wales no longer on average face the 4.5% reduction we feared earlier this year.

An additional £10 million has been added to the settlement in recognition of the importance of strong local social services to the long-term success of the health service in Wales, and we will continue to protect school funding in line with our commitment to provide an increase in resources at 1% above the overall change in the Welsh Budget.

The local government settlement is unhypothecated to provide flexibility for Authorities to determine local spending priorities. It is for local authorities to set their budget priorities and ensure they meet their statutory responsibilities. This includes the safeguarding and provision of services for children, and the legal duty to take account of the rights of the child in developing and delivering services.

8. Transfer of £4.6 million for the Integrated Family Support Services to RSG
What safeguards have been put in place to ensure local authorities make a continued investment in this new programme over time.

The vast majority of social services are delivered and funded by local government. Where the Welsh Government invests in these areas it is primarily for development and start up costs. Our main focus is on the outcomes achieved across social services, but we will be tracking activity and expenditure in these areas through regular meetings with statutory directors of social services.

For the Integrated Family Support Services (IFSS), there are regulations in place setting out the requirements for provision and delivery of these services by local authorities and their partners. This includes the requirement for an IFSS Board, which receives and reviews quarterly monitoring reports from the IFSS team. The reports include information on activity and outcomes, workforce and finance (income and expenditure). The Board must notify the local authority and the local health board of any financial or other resource issues which are likely to affect the ability to fulfil its functions.

There is also a requirement for the Board to submit an Annual Report to Welsh Government. This will be used to ensure that the Integrated Family Support Services are being delivered in line with the requirements set out in regulations and statutory guidance.

9. £3 million for Social Services Act implementation:
What mechanism has the Welsh Government put in place to ensure the appropriate proportion is spent on the legislation as it affects children and young people.

Our financial support for the implementation of the Social Services and Well-being (Wales) Act is not hypothecated for particular groups of service users, but it supports local authorities and partner organisations in preparing and delivering their own regional implementation plans. The Act, very deliberately, an all-age 'people's Act'. The Act introduces a requirement for local authorities and local health boards to develop population needs assessments, which will include the needs of children that will be used to shape and prioritise their services.

10. Funding arrangements for LHBs:
Given that funding arrangements are at the discretion of the LHB and have no age related hypothecation: How does the Welsh Government assess the impact of LHB spending decisions on children's health and wellbeing; What assessment has the Welsh Government undertaken of the potential impact on children's health arising from the LHB resource review.

Local Health Boards are responsible for the provision of healthcare to all of their resident populations and it is for health boards to determine the best use of this funding across all their areas of responsibility, informed by an assessment of the health and wellbeing needs of their local populations. A range of national policies exist which focus on the need for effective investment in services for children and young people.

The Welsh Government has a number of mechanisms in place to monitor and review the performance of the NHS against their service plans and the impact of spending decisions against the policies associated with the healthcare needs of children and young people is reviewed through this process.

The committee will be aware that the basis of revenue resource allocation is being updated to include the impact of the latest data sets which will include, for example, the age profile of the population.

Best wishes,

Mark

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Agenda Item 7

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