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Q1a. Are these the right aims for the new drugs strategy?
Yes they are but we feel that there needs to be a focus on changing outdated cureent drugs legislation - eg the Misuse of Drugs Act 1971 needs a major overhaul. We would also like to see: A focus on providing treatment to the most vulnerable. The strategy identifies sub-categories of young people who are specially vulnerable, but does not do the same with adults. We would identify them as the homelss, rough sleepers, people with complex needs, many of them the adults who have come from the childhoods described with reference to the vulnerable young people. They are also often the most visible users, with chaotic street-based lifestyles and usage patterns, and disproportionately involved in antisocial behaviour. Simply targeting them through DIp schemes is not effective; the police frequently do not bother to charge or record interventions with eg rough sleepers, and though many are PPO's in practice they are not recorded as such. A focus on devising and funding better treatment. Although there has been success in increasing the numbers who engae with and are retained by treatment services, the outcomes are still often woeful, with fewer than half those entering treatment remaining 'clean' after two years neing considered not unusual. We need outcome rather than output measurement to determine effectiveness, and more longer term interventions. There is a wealth of evidence that the longer the intervention, the more positive longterm outcomes are achieved: rehabilitative treatments of 1 - 2 years are far more likely to achieve 'clean' results after 10 years. No London boroughs will fund more than six months rehab. This inefficiency in treatment commissioning leads to a significant level of wastage in the necessarily limited resources devoted to treatment.

Q1b. Which are the most important and why?
They are all very important but the following are more closely related to the work that St Mungo's carries out: - Reducing the impact of drugs on local communities - reducing drug related crime and associated anti-social behaviour - Reducing the harms that drugs cause to the health and well-being of individuals and families. If we had to choose one, we would say reducing the harms that drugs cause to the health and well-being of individuals and families, because individuals and families are the base of society and community and if harms are tackled at this level, then social harms will be reduced. This is why we think that the Government should seriously focus provision on the most vulnerable in society, both young and adult.

Q2. What is the most effective way to keep children off and away from drugs?
The most important of all is to strengthen parenting skills, and families - securely attached, happy children do not become problem drug users. Education is highly important - interactive information and discussions with ex-users also seems to be highly effective with young people. Focussing on the skills and abilities of drug using parents to keep their drugs away from their own children is important - individual, electronic safes should be given to all drug-using parents as a matter of course to store both prescription and illicit drugs in as a saftey precaution. Peer education is important as young people pick up a lot of what they think to be true about drugs from their friends and peers - if peer educators are trained up within a community group, school or college then the correct information is more likely to be passed around. peer educators have a credibility that 'official' sources can never enjoy. We are also clear that many young people do use drugs recreationally and go on to lead happy, fulfilled lives despite their drug experimentation - there needs to be an equal focus on both stopping young people accessing drugs and an emphasis on safer use if they do start to use. Roles portrayed by those seen as role models - people from the worlds of television, music, film etc - are undoubtedly influential: if these are of drug-taking, violent, sexist, homophobic gangsters, for example, the impact is likely to be negative. 'Drugs are naff' would be a

very powerful message if it were delivered by seriously cool people.

Q3. How should parents, guardians and carers be supported to protect children from using drugs?
Training and education programmes for them are also important - bit size literature that will actually be used, maybe posters and leaflets - access to resources such as FRANK as well for parents, guardians and carers. Being able to openly discuss the costs and potential benefits of drug use with their wards ie "it may make you feel good to begin with and you may seem cool with your firends but ....dependency issues, financial issues, health implications etc.". It's important that children's carers know at least as much as the children they care for, and preferably more, and that they are prepared to be honest. If they say "If you take ecstasy you will die", and the child knows six friends who have taken ecstasy and had a great time, then there's a credibility gap that it's hard to recover from. If they say, for example, "There's a risk you could die, and if you think about it is it really worth taking that risk for one night out, which you're going to enjoy a lot anyway even if you don't do that...", then it's realistic, respectful and opens a dialogue.

Q4. What needs to happen to achieve more effective joint work between children's services and drug services in support of young people?
An increase in training and education for generic or other specialist staff around substance use - ie social workers, nurses, housing officers, teachers etc to be able to recognise an issue and to support young people to access appropriate support within a framework of their duty of care. Drug services need to be where the children are, and easily accessible, and discreet at the same time, which can be more easily achieved by them being part of other children's services, which in turn will enhance joint working.

Q5. What might an effective local system look like that identifies problems early, provides integrated prevention services and ensures that other specialist services are available when required?
St Mungo's does not work with young people, we only work with adults over the age of 18 years old. Any local system needs to have robust care pathways, information sharing protocols, a care co-ordination system, a flexible structure to ensure emergency support in a crisis is available. A school, community group and web-based education system will also support the prevention of young people using drugs. Prevention is usually better than cure, so services targeted at the most vulnerable - children from broken families, those who truant, etc - before they develop drug issues are likely to prove cost-effective in the longterm. What will prevent children from developing problematic drug use is emotional resilience and strength: targeting psychotherapeutic support on vulnerable young people before they develop serious problems would be more effective and cheaper than lots of professional interventions afterwards.

Q6. What needs to happen to ensure that children's and adult services work together effectively to safeguard and improve the well-being of children and young people affected by substance misuse?
Specialist staff who understand the needs of young people and those of adults, using a pedagogic approach as practised by some other European countries. Transitional support is particularly important including 'hand holding' and joint care management between adult and child services.

Q7a. What role should education in schools and other settings play in reducing the harms caused by drugs?
As discussed - myth dispelling, giving correct info about harms and risks. Use of ex- or current users to discuss their issues and to make the negative side of drug use "real" to young people. School-based counselling should also be available and easily accessible, to enable children to find ways of managing difficult life situations and emotional stresses other than turning to drugs or alcohol.

Q7b. What should drug education aim to achieve, when should it start and how might it be improved?
We feel that it should start at Year 6 so that children are educated about drug use prior to starting at Senior School as this is an environment with much older children and exponentially greater risks. It should definitely involve current or ex-users and look at the following areas: * What Drugs Look like - so children can recognise them * How drugs are ingested - shock tactics can be quite powerful around injecting. * What drugs feel like initially and over time - tolerance, withdrwal, dependency etc * Risks - both directly and indirectly related to drug use. Some messaging content as well - "Only sad people use drugs".

Q8. What role should drug information campaigns play, what should they aim to achieve and how could

this be measured?
For current users, targeted campaigns around different elements of drug use - prevention - overdose - safer using - harm minimisation - relapse prevention - dangerous batches of eg contaminated heroin, which produce disproportionate numbers of deaths - etc For non-users - messaging that drugs are out of date, boring, naff, uncool and generally as sexy as bedbugs - realistic information - warnings of dangers of mixing alcohol and drugs Use of web-based campaigns as well as leaflets, posters and tv adverts. Measured through reduction in drug related death, numbers on substitute prescribing, clients accessing treatment, reduction in drug related anti-social behaviour / ASBO's awarded.

Q9a. Should there be different approaches to information campaigns, such as harder messages on drugs (e.g. shock tactics or legal consequences)?
Diversity needs to be taken into account and different formats and languages must be used for those who do not have English as a (first) language or who have sight, learning difficulties or literacy problems. There is a need for culturally specific messaging, e.g. of some Muslim communities where drug and/or alcohol use may be denied, or some cultures where specific types of drug use may be seen as normal or even laudable. There is a place for shock tactics and and these can be quite powerful for both young people and adults. Pictures of physical drug related harm (including death) have a place in campaigns so long as they are not gratuitously used. It is also important not to wildly exaggerate, or state things which run too far counter to most people's experience, as this is counterproductive.

Q9b. Who is being missed out?
Some BME groups, and some religious groups,; those who are already socially excluded, from truanting children to single homeless to those with mental health problems. Single homeless people also need to be reached out to, both through outreach and hostel provision. Further training and support needs to be given in generic settings to enable tier 1 providers to either signpost clients to specialists or to provide some of the specialist interventions. St Mungo's has specialist substance use workers on site in our hostel provision which enables us to meet the needs more effectively of substance users, who will not access community based drug services - we currently provide low threshold methadone prescribing, needle exchange, Naloxone pilots, groupwork and structured keyworking sessions around substance use in our hostels.

Q10a. Should drugs and/or substance abuse campaigns be targeted at the under-11 age group?
Potentially in the year before going to senior school as previously discussed. We do not feel that under 11's should be targeted unless they are at high risk or already using.

Q10b. If so, at how young a group?
Generally 11+ or in final year at Junior school

Q11. How can information campaigns best help our children to keep away from drugs?
Education about risks and supporting young people to talk openly about their use or thoughts on use with knowledgable adults.

Q12. Is there a place for role models, including those drawn from peer groups, in drug Information campaigns?
Absolutely - there are so many high profile drug users in prominent positions in glamourous industries that it is important to have an equal presence of people who do not use, who have used and no longer do or who are willing to discuss issues around use.

Q13. Where is drug treatment succeeding and where are the gaps?
Successes: more clients are accessing treatment and being retained in treatment. However longterm (and sometimes even short-term) outcomes are still often poor. Gaps: A shortage in tying in "wrap around" services including housing, education/training,work, nutrition A greater range of accessible treament options eg heroin prescribing, flexible schemes and a move from supervised consumption to risk managed weekly dispensing More services for non-opiate users especially in crack or stimulant specific areas and for poly drug users so e.g. crack users can still access crack services if they are using heroin (which in some places is not happening) Higher priority and more resources for alcohol treatment More non-AA /12-step rehabilitation centres: though it's a good model for some people, it isn't for others but because of its predominance they are pushed into it if they want treatment An increase in female specific services

that provide an holistic approach. "Stabilising accommodation" where there is a gap between detox and rehab or after treatment Access to healthcare for drug related illnesses and injuries where clients are not stigmatised because of their use Greater access to detox and rehab for clients with mental health, dual diagnosis or complex needs. Treatment centres which cater for peole with challenging behaviours who are excluded from mainstream treatment (rather than sending them back to the beginning and wasting the work that has been done so far) Commissioning by outcomes rather than outputs: relapse is a failure of the treatment programme as much as of the patient. Longterm rehab (12 months +) for people who have been substance dependent for a long time. Specifically in homelessness, a recognition that it is often cheaper as well as more effective to keep someone in a therpaeutic rehabilitative community in the country than a front-line hostel in London. Recognition that effective and lasting teatment takes time.

Q14. How can drug treatment be made more cost-effective so that existing resources can go further?
Better screening of suitability for detox and rehab, designed to ensure better tailored services not - as is common now - to save on a tight budget. Increased funding through DAAT and PCT for pre-detox work carried out by specialist in a tier 1 setting eg St Mungo's substance use workers intensively preparing clients for detox in their hostel provision Assessment spread over more than one sessions so that the service users real motivation can be assessed, their true opinions know and a greater understanding of the client sought. Cease the monopoly supply of diamorphine and methadone and look for more creative alternatives, potentially redirect police reclaimed street heroin into purifying schemes to produce a cheaper supply of diamorphine Reclaimed drug supply money to be ring-fenced for treatment Diversion of some of the opiate funds to desperately needed stimulant and alcohol services. Greater emphasis on education and harm reduction schemes as well as treatment. Outcome-based commissioning, and longitudinal measurement of results. Longer rehab stays. More generic counselling/psychotherapy services so people can deal with the issues that make them return to substance use as a form of medication (paid for perhaps by a reduction in substance-specific counselling), therby reducing relapse and revolving door costs

Q15. There are many competing priorities within local areas. How should the provision of drug treatment be prioritised locally?
Comprehensive needs assessments are crucial to ensure that the needs of the service users and any consequent care plans are tightly targeted Social and psychological aspect of addiction and dependency co-ordinated as part of treatment services - they should be standard provision as opposed to existing only in a few areas of best practise. More flexibility in joint working between areas and boroughs for more transient populations More emphasis on aftercare and wraparound services. Locally in London should mean regionally - some services should be in all areas, and some in only a few but accessible to all the others (eg specialised unitsa for working with people with substance dependencies and personality disorders, or women wuith alcohol problems fleeing domestic violence).

Q16a. What can be done to help local partnerships meet the needs of drug users?
Greater consultation around development and delivery of services to include professionals and service user perspectives Greater communication between partners- information sharing protocols, jointly branded assessments and online shared packages (similar to PCT) Services set up with a clear understanding of the culture and ethnicity, gender, age, substance use, sexuality and disabilities of the local communities who may access them - Use Census information to gauge general population needs as well as drilling down into the demographics of substance users in the borough. Education about regional needs and why drugs require a regional response. Emphasis on targeting the most vulnerable, both young and adult A simple win is to target the single homeless and rough sleepers with more varied treatment options: St Mungo's has most of the wraparound services already in place so effectiveness can be maximised. It also tackles a group who are disproportionately visible and involved in visible antisocial behaviours such as begging.

Q16b. How could local accountability and performance management systems support this?
Funders to ensure that multi-agency partnerships are part of the services that are commissioned and that reporting on these are written into contracts and SLA's, and NDTMS data to report on partnership links. Outcome rather than output based commissioning. Use of expert patients from among local substance using populations. Longitudinal data on drug use post-treatment.

Q17a. How can the needs of under-18s with drug problems be met?
St Mungo's does not work with the under 18's so we have not focussed on this section. However, the

genral principles are the same - more outcome based commissioning; more focus on resolving the issues that lead people to abuse substances; more honesty and dialogue with clients and between professionals; more accessible and varied treatment pathways.

Q17b. What is the role of specialist drug services for young people and what should children's services do?
Specialist drug services should provide drug treatment and information; children's services should provide the wraparound element (which is actually core) - safe accommodation, psychotherapy, education/training.

Q18. What can be done to ensure that effective drug treatment is provided both to offenders in prison and in the community, ensuring continuity of care between the two?
Information sharing and client signing consent forms as standard practise on admission to prison so that Prison based specialist staff - DIP, CARAT or specialist prison officers - can give and receive information from community based services, and vice-versa. Provision of services to people on short sentences rather than sentences of over a certain length, even if this means their external service provider coming into the prison. Prison drug services to continue to work with clients post release. Accommodation for ex-offenders, large numbers of whom still leave prison NFA or become NFA whilst inside. there can be little or no successful treatment if large numbers of (especially short-term) offenders continue to be discharged without accommodation.

Q19a. What more should be done to facilitate better access for drug users to the mainstream services they need to help re-establish their lives (e.g. supported housing, employment, education, training and healthcare)?
Clarity around housing criteria when referring clients to housing including levels of drugs use or zero tolerance and ensuring the appropriate referrals are made. Open and shared information Training to generic tier 1 agencies around drug use and alcohol use. Enagagement and support contracts for new clients outlining their rights but also their responsibilities to maintain the tenancy. Trial license probation periods in order to gain a tenancy Flexibility is key - rolling programmes, visiting different settings, open days etc. - but so is the availability of housing, especially for short-term offenders. A good start would be the establishement of one or preferably several one-stop shops in London to which all London offenders are discharged, and where they pick up their discharge grants, housing referrals, jobseekers and other benefits applications, and are directed to hostels etc if necessary.

Q19b. Where are the main gaps?
Provision for people in pre and contemplative stages (ie not all for clients in the action stage) Preparing people for future treatment / changes around drug use. Not all work based at the initial stage Longer period of support into gaining work - salary and benefits in the short terms Treatment services for dually diagnosed clients and those with mental health issues and complesx needs. Greater availability of lonterm rehab. Greater availability of generic counselling/psychotherapy. A range of sepcialised projects, eg for women fleeing domestic violence who have alcohol problems, muslim women, people with personality disorders who medicate with poly-substance use, etc

Q20. What are the most effective ways of reducing drug-related crime and re-offending?
Changes in drug legislation and an increase in education. Flexible scripting options Continued development of DIP so that treatment options are real and in place Radical measures to change routes of supply Better access to services whilst in prison for persistent petty offenders. Accommodation for offenders on discharge, particularly for short-term offenders. Training and education, and support into employment. Treatment of the causes of dependency.

Q21. What is the best way of ensuring that all partners are engaged in dealing with drug-related crime?
Co-ordinated approach at regional, London-wide level More inclusion of voluntary agencies in borough and London-wide steering groups and policy and strategy bodies Greater service user involvement for eg DIP services, and the use of expert patients. Tasking and targeting meetings held in all boroughs / London-wide (replicate Camden's model) Re-offending targets for treatment providers Messaging that drug use is a community issue, not just an individual one

Q22. What is the best way to determine and agree local priorities and strategies?
National, regional and local DAAT subgroups including voluntary and statutory providers and service users. Real community, user and service provider input into strategies.

Q23. How can local communities better work together to tackle drug-related crime?
Anonymity around reporting of activities - people fear retribution for disclosure Forums to discuss local streetbased activity and crime eg tasking and targeting forums or community safety meetings. Local neighbourhood meetings with direct links to community safety - police to sit in on these meetings. Direct contact from drugs services and hostel providers to named police officers in relation to dealing. Family oriented support services.

Q24. Are existing funding and delivery structures effective or do changes need to be introduced (in order to truly embed programmes like DIP into 'business as usual')?
DIP needs to be further embeded and we feel that communication is a big part of this and is currently lacking between DIP and other providers, An increase in partnership and joint working will support this. Different strands of funding similar activities can be confusing in terms of duplication of work and care pathways eg SP, DAAT, PCT, JCG monies. A radical way of embedding DIP into business as usual is to abolish it as a separate programme - now that drug and medical services in prisons and criminal justice are mainstreamed through PCT's and voluntary sector providers, then there should be a common standard of service for drug users whether they come through a criminal justice route or not. Treat the individual not the symptoms.

Q25. How can commissioning and co-commissioning arrangements best be applied to the whole drug strategy, and what role should regional offender managers and other stakeholders (e.g. primary care trusts, local authorities and the Department for Work and Pensions) have in commissioning and co-commissioning drug treatment for offenders?
Cross organisational training and encouraging partnership work Structured joint action around commissioning of services, cross-referenced with local plans and service needs and requirements. Reduction of red-tape between London's boroughs, and mainly regional commissioning. Jointly agreed outcomes, and outcome based commissioning. Clear separation of commissioning and provider roles, so that eg the PCT or Probation is not commissioning itself.

Q26. Proposals to provide statutory provision on release for offenders with prison sentences of less than 12 months have been deferred. In their absence, are there arrangements - other than DIP - that could help to provide continuity of care on release for this group of drug-misusing offenders?
St Mungo's provides full wraparound services to short-term ex-offenders - floating support, specialised accommodation, specialised substance use, housing advice, tenancy rescue, and employment and training. We do this inside prisons and in the community, through programmes such as Housing Advice Centres, Exodus, Muslim odffender awareness progerammes etc. Sadly, we cannot offer this as a coordinated approach London-wide because there is no coordinated commissioning!

Q27a. How can police forces best build confidence that drug supply is being effectively tackled locally?
Reporting from local communities and services is important as well as feeding back any incidents that have occured, arrests made, hauls discovered etc. General information briefings at local forums as well as national releases about action plans that have been developed to tackle this issue. A real reduction in the amount of drugs on the streets, and their price; and a visible reduction in drug dealing and consumption.

Q27b. Do the police and local communities have all the powers they need to tackle anti-social behaviour related to drug dealing and use?
Yes, but there needs to be additional funding and training to support this. Ther are not enough police to go into all the places they need to and not enough police presence on the streets, or in clubs etc. to act as a real deterrent. When it comes down to it, anyone using (or even dealing in a small-time way) drugs is very unlikely to get caught: that can only change if there is an increase in police presence and community non-acceptance (cf drink driving). This is equally true of antisocial behaviour.

Q28. What role should communities play in tackling drug dealers and drug supply?
Confidential reporting where communities do not feel happy to give their names. Not turning a blind eye

to drug use and tackling drug use among the community. Not supporting begging.

Q29. Which organisations might be able to assist in assessing the impact of supply-side activities in communities?
Community based voluntary and statutory services, and service user groups. Also carer groups, treatment services etc.

Q30. To what extent and how should the UK tackle potential emerging threats (such as methamphetamine) as opposed to established drugs (such as heroin)? Methamphetamine is commonly referred to in the media as 'crystal meth'; it has many street names including 'ice'.
Education, education, education. Not allowing the media to describe it in unhelpful ways, and being wary of media hype adding to new drugs' status and popularity. We must learn from what has been done well in other countries to tackle this. We should focus on what is both a current problem in the drugs field and what could potentially become one.

Q31a. Do you think that there are ways in which the UK's broad approach to working with governments in priority drug producing, transit and consumer countries to tackle the causes and effects of drug problems and the harms caused to the UK can be developed and improved?
We are not in a position to comment on this in any detail. It would seem logical that any agreements with producer countries must include ensuring that there are ways of making a living that are at least as profitable for especially the farmers and smallholders who typically grow the crops that we are seeking to eradicate. The radical solution would be legalisation and control; failing that, replacement with equally economically rewarding endeavours seems the best bet. Poverty, and poverty of opportunity, are undoubtedly part of the reason drug-producing crops are grown. We would therefore suggest that Fair Trade is probably part of any solution.

Q31b. How might this be achieved?
Priority and possibly subsidised trade agreements with the erstwhile producers - so it would pay more to grow e.g. coffee than coca - or radical solutions like using heroin instead of methadone: why prescribe manufactured methadone instead of producing good quality heroin grown legally, thereby taking over the gangsters' own production lines? Fair Trade, as mentioned before. . This could be backed up by trade benefits - for example, and I'm sure too simplistically, 10% reduction on tariffs on Colombian exports if their drug production drops 10% .

Q32. How might we better measure the impact of supply and enforcement activity?
Cost and availability of drugs; percentage of population who have used drug x in previous 12 months.

Q33a. What are the most effective ways of preventing and reducing the harms caused to young people and families by drugs?
Education and information, limiting supply, meaningful occupation for people. Decent standards of housing and opportunities for realising potential, training schemes etc. , especially for some excluded population groups, eg second generation young men whose parents were of Caribbean descent. Strengthening of family links, and improving parenting skills; as we said before, happy and well-atytached children do not become problem drug users.

Q33b. Do young people's and adult services need to work more closely together?
Yes as the same person's drug use can affect both children and adults, and many young drug users become adult drug users.

Q34. How can we improve the effectiveness of specialist drug treatment services and help drug users to re-establish themselves in the community?
Service user involvement programmes and consultation More inclusion and less isolation - people going into their own flats too early or even at all for some people, creates risky situaions that semi-independent or community living could address. Appropriate aftercare must be put in place for "as long as the client needs it" rather than 3 / 6 months. Longer rehabs need to be available for those with long substance histories. More psychotherapy to help people work on the problems that led them to become substance dependent in the first place. Outcome based commissioning - it's not how many people complete your

treatment, but how many stay clean afterwards that matters. Accommodation and support to maintain it. Pre-vocational employemtn training - many homeless people, offenders etc need training to become employable, not just help to get jobs.

Q35. What more could be done to reduce the impact of drugs and associated crime on local communities?
Greater policing of no-go areas; more community involvement in policing; more representative police force. More community ownership of the problem.

Q36. How can we further reduce the supply of drugs and improve detection and the prevention of importation?
Ensure resident communities from drug-producing countries trust the authorities here and will inform on smugglers/dealers; big sentence-reduction offers to smugglers who grass on their paymasters; more international cooperation; concentration on tracing money movements.

Q37a. What could we do more efficiently?
Provide more effective treatment - in four key ways: 1. Specialised provision for some sub-groups of users, such as people with complex needs, and more treatment pathways, recovery-oriented and not just 12-steps. 2. Longer-term treatment for people with long histories of dependency 3. Psychotherpeutic treatment for people to work on the issues that led and lead them into dependency, so they no longer need to be dependent 4. Outcome-based commissioning The other thing that could be done more efficiently is policing: target more resources at community level, with more police on the street and the estates.

Q37b. Where is value for money not being delivered?
Treatment - huge resources, and high rates of relapse. Short-term offenders being discharged NFA. Keeping people longterm in hostels but being unwilling to fund longterm rehab.

Q38a. Have we got the right national, regional and local structures to ensure effective delivery of the drug strategy?
The DAAT's have been largely successful in coordinating drugs strategies; joint working between criminal justice and health services needs strengthening; the voluntary sector needs to be more involved in strategic planning and designing of services.

Q38b. How could these be improved?
As previous response.

Q39a. The Prime Minister announced on 18 July that he will ask the Advisory Council on the Misuse of Drugs to look at whether cannabis should be reclassified from a Class C drug to the more serious Class B. This is because of concern about stronger strains of the drug, particularly skunk and the potential mental health effects they can have. Do you think that cannabis should be reclassified and, if so, why?
Cannabis is a complex issue. Many people use it and suffer no ill affects, many clients report that using cannabis reduces their cravings and withdrawals form other drugs and helps them to be more focussed. On the other hand there is a clear association between particularly skuunk and mental ill health, including psychosis, an association which merits more publicity. As a housing provider we have to be very vigilant around cannabis use on our premises due to section 8 of the Misuse of Drugs Act in a way that does not necessarily promote useful interventions with cannabis users to prevent harm. When it comes down to it, few users probably think twice about whether cannabis is class B or C when they buy it or smoke it - the change therefore probably impacts most by suggesting that the Government and its experts aren't sure of their own views. There is already a lot of confusion around the clarssification of cannabis and many people will not know what it is currently classified as. Changing its classification again could further confuse this issue.

Q39b. Are there any other changes that you would wish to see and, if so, why?
Pilot safe injecting rooms.

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