

ACMD

Advisory Council on the Misuse of Drugs

Consideration of the use of foil, as an intervention, to reduce the harms of injecting heroin.

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ACMD

Advisory Council on the Misuse of Drugs

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10th November 2010

Dear Home Secretary and Secretary of State for Health,

The use of foil as a harm reduction intervention

I have pleasure in enclosing the Advisory Council on the Misuse of Drugs' report 'The consideration of the use of foil, as an intervention, to reduce the harms of injecting heroin. The provision of foil for the purposes of smoking controlled substances, generally heroin and crack cocaine, is illegal under section 9A of the Misuse of Drugs Act 1971. The ACMD has been considering the evidence on this issue, specifically the position of foil under Section 9A of the Misuse of Drugs Act 1971.

The Advisory Council on the Misuse of Drugs (ACMD) wrote to your predecessor on the 22 October 2009 concerning the ACMD evidence gathering and considering the use of foil as a harm reduction intervention.

In the attached report the ACMD has fully considered the available evidence regarding the use of foil as a harm reduction intervention. The ACMD considers that the balance of benefit favours exempting foil from Section 9A of the Misuse of Drugs Act 1971.

The evidence of the benefits of the provision of foil, in controlled settings, to promote smoking over injecting are several: evidence for a reduction in injecting behaviour (with potential for associated reduction in blood borne viruses); greater contact between users and treatment services; reduced systemic infections; reduced soft tissue and venal damage; lower risk of overdose and reduced litter. The dis-benefits of foil provision, in controlled settings, are largely theoretical e.g. further individuals being recruited to the user population (by way of foil being a route to the use of heroin). The ACMD finds that there is evidence of the benefits of foil provision, but can find no evidence of the dis-benefits.

The ACMD would welcome discussing further with you or your officials and being part of any on-going discussions.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Les Iversen', written in a cursive style.

Professor Les Iversen

Interim Chair of the Advisory Council on the Misuse of Drugs

1. Introduction and Background

- 1.1. The provision of foil for the purposes of smoking controlled substances, generally heroin and crack cocaine, is illegal under section 9A of the Misuse of Drugs Act 1971. However, some drug services provide foil to heroin users as a cited harm reduction measure. Evidence has been provided to the ACMD that some drug intervention agencies supply specialist foil to drug users to encourage smoking as a safer alternative to the practice of injecting. The foil generally comes with a specified health warning¹.
- 1.2. In most cases foil is provided in packs, in ready cut sheets. It is noted that, for the user, kitchen foil is not discreet to carry and is often coated with vegetable oil that is generally burned off before use.
- 1.3. The ACMD began its consideration of the issue of the use of foil as a harm reduction measure in July 2008 after a growing body of evidence of its potential benefits and also its distribution from drug services.
- 1.4. Evidence has been presented to the ACMD that the legislation (Section 9A of the Misuse of Drugs Act 1971) is broadly un-enforced; with respect to drug services providing foil in apparent contravention of the Misuse of Drugs Act 1971. The ACMD understands that there are various reasons for this: 1) it is a low policing priority; rather than expend effort collecting evidence and preparing a file for the Crown Prosecution Service (CPS) they would take a crime prevention approach and inform those services that were providing foil that they should stop; 2) it is reported that some forces are 'supportive' of the provision of foil as a harm reduction initiative and have, upon request, supplied 'letters of comfort' which clarifies that they will not produce a report to the CPS for prosecution.
- 1.5. According to the Health Protection Agency (2009), there is some uncertainty about the extent of injecting drug use in the United Kingdom. It may be as high as 217,000 in England and Wales alone. What is certain is that people who inject drugs are especially vulnerable to a wide range of infections. These include viruses such as hepatitis C (HCV) and HIV and also bacteria such as group A *streptococci* or *Clostridium botulinum*. High rates of mortality and illness arise from these infections so public health and protective behaviour interventions among injecting drug users (IDU) are important.
- 1.6. In its 2009 report *The primary prevention of hepatitis C among injecting drug users*, the ACMD estimated that:

¹ Details can be found at:

http://www.exchangesupplies.org/needle_exchange_supplies/foil/foil_intro.html

“There are 120,000 to 300,000 (mid estimate 190,000) people that have been infected with HCV in England and Wales, and about 50,000 in Scotland. 85% became infected through injecting drug use.”

The report concluded that “Ultimately we need to stop injecting to reduce the risk of HCV”.

2. Background to the evidence underpinning ACMD's previous considerations and recommendations regarding paraphernalia [under section 9A of the Misuse of Drugs Act 1971]

- 2.1. The ACMD first considered sterile water for injecting (WFI) in 1991 and other drug paraphernalia in 1995. The issue was raised again at an ACMD meeting in November 1998. Concern had been expressed that drugs workers were putting themselves at risk of prosecution when supplying paraphernalia in breach of the law.
- 2.2. A number of reports and studies were discussed at the November 2000 ACMD Technical Committee meeting:
 - 2.2.1. A report by the Royal Pharmaceutical Society of Great Britain (RPSGB) had recommended that section 9A should be amended to permit the supply of injecting paraphernalia by pharmacists to drug misusers.
 - 2.2.2. A report of the Police Foundation's Inquiry into the Misuse of Drugs Act 1971 (Police Foundation, 2000) had also recommended that section 9A should be repealed.
 - 2.2.3. A paper by Sheridan *et al.* (2000) examined the supply of syringes and other injecting equipment by needle exchange schemes in South-East England. The researchers collected data from approximately 400 community pharmacists and needle exchanges; the responses had indicated that 83% of needle exchanges supplied swabs and 6% supplied filters.
 - 2.2.4. Research by Crofts *et al.* (2000) found detectable levels of hepatitis C virus on injecting equipment other than needles or syringes – which suggested that infection could be transferred to syringes (and individuals) through sharing paraphernalia. The virus had been detected on 70% of syringes, 67% of swabs, 40% of filters, 25% of spoons and 33% of water samples.
- 2.3. The ACMD considered a paper on the supply of drugs paraphernalia at its meeting in November 2000. The ACMD considered drug paraphernalia and WFI at its meeting in May 2001 and subsequently the use of filters in May 2003.

2.4. In May 2001, the ACMD made its recommendation to amend the misuse of drugs legislation to permit the supply of swabs, bowls, spoons, stericups, citric acid and WFI. In May 2003, the ACMD recommended the inclusion of generic filters in the legislation. These recommendations were accepted by government.

3. Current legal position and background

- 3.1. Section 9A(1) of the Misuse of Drugs Act 1971, below, makes it an offence to supply any article used for administering a controlled drug unlawfully (i.e. without a doctor's prescription).

“A person who supplies or offers to supply any article which may be used or adapted to be used (whether by itself or in combination with another article or other articles) in the administration by any person of a controlled drug to himself or another, believing that the article (or the article as adapted) is to be so used in circumstances where the administration is unlawful, is guilty of an offence.”

- 3.2. Section 9A was inserted in the 1971 Act by the Drug Trafficking Act 1986.

The purpose was to outlaw the supply of cocaine kits (razor blades, *foil* and lemon juice) that were being marketed in the mid-1980s. An exception was made for sterile syringes and needles to permit the supply of clean injecting equipment to drug users because of their significant harm reducing benefits, including reducing the spread of HIV, hepatitis B and hepatitis C and other water and blood-borne diseases.

- 3.3. The ACMD was previously asked to consider whether the supply of additional items of paraphernalia should be lawful. (It had become clear that some pharmacists and drug workers in needle exchanges were supplying such other items contrary to Section 9A in the belief that they were effective in reducing the harms associated with injecting drug use). In May 2001, the ACMD concluded that certain items had significant harm reducing benefits and recommended that the supply of swabs, utensils for the preparation (spoons, bowls, cups and dishes), citric acid and ampoules of water for injection (when supplied in accordance with the Medicines Act 1968) should be lawful, but only if medical practitioners, pharmacists and persons employed in the lawful provision of drug treatment services supplied them and, from 2005 onwards, a supplementary prescriber. Whilst rejecting them in 2001, the ACMD subsequently recommended that the supply of filters should be lawful in similar circumstances. Cross Government agreement was sought by the Home Office and changes were made by secondary legislation – Regulation 6A of the 2001 Regulations – in August 2003. (The ACMD rejected the inclusion of tourniquets, concluding that the risks outweighed the benefits). Following evidence that users injecting crack or freebase cocaine tend to use ascorbic rather than citric acid and following the ACMD's recommendation, the 2001 Regulations were further changed in 2005 to incorporate ascorbic acid.

- 3.4. In accordance with section 9A, the supply of any *other* article is prohibited where the supplier *believes* that it will be “used in circumstances where the administration [of a controlled drug] is unlawful”, but not otherwise. It is a matter for the police and the crown prosecution service respectively to assess what policing priority should be given and whether prosecution is in the public interest where a drugs worker supplies articles in contravention of section 9A.
- 3.5. Despite the current legislation 15%² of UK services have for some time contravened section 9A by providing foil. Yet there are no cases of a service being charged with an offence (Pizzey and Hunt, 2008).
- 3.6. The ACMD considers that any advice provided to ministers regarding changes in respect of the Misuse of Drugs Act 1971 would need to fulfil two criteria:
- for there to be evidence that the intervention reduced drug related harm; and,
 - the intervention would not encourage use of illegal drugs, especially heroin.

² According to the findings of an online survey conducted by the National Needle Exchange Forum (NNEF) between October and November 2008.

4. Evidence presented to ACMD regarding the use of foil as a harm reduction intervention

- 4.1. Two key studies provided evidence of how the provision of foil might reduce harm among injecting drug misusers in the UK. A published study (Pizzey and Hunt, 2008), provided an evaluation of results from an intervention in South West England using foil packs to promote a transition away from heroin injecting to inhalation. The study analysed data from four needle and syringe programmes (NSPs) and interviews with injecting drug users (IDUs) in one NSP. A Turning Point report (Boid and Waldock, 2008) described a trial scheme entailing the introduction of aluminium foil to Sydney Street needle exchange and Sharp Action needle exchange in Sheffield.
- 4.2. The report by Pizzey and Hunt (2008) showed that foil packs were taken when available (out of 320 attendees, 54% took the foil packs). Over the period of the evaluation, NSP transactions increased by 32.5% from 1,672 to 2,216.
- 4.3. The findings from the Pizzey and Hunt (2008) study suggested that distributing foil packs could be a useful means of engaging needle and syringe programme (NSP) attendees in discussions about ways of reducing injecting risks – thereby reducing harms to users and providing a mechanism of engagement to reduce overall use. It could also reduce injecting in settings where there was a pre-existing culture of heroin chasing.
- 4.4. The study called for further research, to evaluate whether the study findings (Pizzey and Hunt, 2008) could be reproduced in other cultural contexts and evaluate whether the observed behavioural changes were sustained and led to reductions in harm including blood-borne infections and overdose.
- 4.5. The Turning Point report (Boid and Waldock, 2008) details a trial scheme, with feedback, where foil was provided at both a site based needle exchange (423 packs provided) and an action van (304 packs provided). Whilst the feedback received was not analysed it was apparent, from self reported results, that the provision of foil reduced injecting behaviour and promoted less risky alternatives.

- 4.6. The National Needle Exchange Forum (NNEF) undertook an online questionnaire between October and November 2008, the results of which were analysed by Liverpool John Moores University. The questionnaire produced 445 responses from across the UK, these included responses from managers, commissioners, service users and workers. The results of the NNEF questionnaire (Chandler *et al.*, 2009) found that 15% of services provided foil while 67% of services had no provision due to the current legal status. 92% of respondents felt that foil would help reduce harms and 81% felt that foil would encourage drug users not to inject. Overall the questionnaire indicated that respondents were supportive of foil being supplied through needle exchange programmes. The NNEF recommended that Aluminium Foil should be added to the current list of exemptions in Section 9A of the Misuse of Drugs Act. The NNEF further requested a more detailed assessment and review of Section 9A.
- 4.7. In February 2009 the Association of Chief Police Officers (ACPO) Drugs Committee wrote to the ACMD to highlight that ACPO Drugs Committee members had been aware that, during the last few years, a number of local service providers had taken part in harm reduction initiatives and had supplied foil to intravenous drug users in order to encourage a change in their consumption habits. The ACPO Drugs Committee cited a scheme operating in Somerset Drug and Alcohol Action Team (DAAT) which had received prominence following its evaluation in 2008.
- 4.8. The ACPO Drugs Committee requested clarification of the legislative framework provided to all parties involved in these schemes so that local health professionals and police do not expose themselves to breaches of the law. This is a difficult area since the ACMD is aware that on a local level individual forces are providing 'letters of comfort', where requested, to needle exchanges and services. These letters do not have any legal standing, but are a statement that effectively turns a blind eye to the provision of foil by services.
- 4.9. Release provided a submission to the ACMD in March 2009 that supported an amendment to section 9A to include foil in the exempted paraphernalia list. Release recommended that:
- There should be an immediate review of section 9A and how it impacted on the development of harm reduction initiatives;
 - Consideration to be given to a new system led by medical opinion whereby those working in this area could dispense equipment if it could be shown to have an effective impact in reducing harm and/or acting as a tool for engagement.

- 4.10. A study by Exley (2008) tested the hypothesis that aluminium foil could be a significant source of aluminium in users of heroin who were 'chasing the dragon'. These experiments used the same 'batch' of street heroin. While there was evidence of an increase in bio-available aluminium from heroin vaporised off aluminium foil this would not account for the elevated urinary excretion of aluminium in heroin users. According to a case study aluminium had been found as a contaminant of heroin; e.g. 42 – 2280 μg aluminium g^{-1} heroin (Bora *et al.*, 2002). The study also measured the aluminium content of 'street' heroin and found; 48.0 ± 19.6 μg aluminium g^{-1} heroin (n=9). In comparison the aluminium content of tobacco has been found to be; 600-3700 μg g^{-1} (Exley *et al.*, 2006) the aluminium content of heroin is generally too low to account for the high urinary excretion of aluminium from heroin users.
- 4.11. A presentation on the Dutch experience (Kools, 2009) provided an overview of the supply of foil in the Netherlands. The Dutch aim was to promote a move away from drug administration by injecting towards less risky methods, a practice known as 'route transition'. It described autonomous trends among opiate and stimulant users from injecting towards non-injecting drug consumption in the early 1990s. This trend in the drug using community was initially recorded in 1992 and became the basis for a range of health interventions to promote a shift away from injecting.
- 4.12. In the Netherlands, the provision of a combination of a full range of health interventions (Opiate Substitution Therapy - OST), NSPs, consumption rooms, community outreach, peer support, social marketing etc.) led to significant individual and public health benefits.
- 4.13. Currently within the Netherlands foil is available in all needle and syringe exchange programmes (NSEP) and consumption rooms (CR). It was highlighted that a success recorded from the intervention had been a significant reduction of blood-borne viruses (BBVs) (Kools, 2009). In Amsterdam during the last decade "HIV prevalence had fallen from 8.5 per cent to virtually zero, and the number of fatal overdoses had also drastically decreased" (Kools, 2010).
- 4.14. The ACMD heard that provision of aluminum foil within NSEPs and CR had not encouraged new users to take up illicit drugs.
- 4.15. In Scotland, Glasgow Addiction Services have proposed a foil exchange pilot scheme. This followed encouraging results from a recent service user evaluation. In October 2009 an anonymous service user questionnaire was developed and distributed to service users to evaluate the service and establish their views on foil provision. The key findings regarding foil were that 83% of service users said they would like foil to be offered as part of the service and 59% said the provision of foil would encourage them to consider smoking rather than injecting.

5. Consideration of the evidence

- 5.1. In all studies the benefits ascribed to the use of foil and the aims of providing the foil were multi faceted. They included:
- To reduce injecting related harms (blood borne viruses, infections, vein collapse);
 - To reduce the risks of overdose;
 - To reduce injecting drug use;
 - To engage users to discuss options with a view to reduce harms, injecting and ultimately drug use;
 - To reduce drug related litter; and,
 - To reduce drug related crime.
- 5.2. However, from the present studies it is difficult to specifically quantify the reduction in injecting related harms since studies are not constructed to measure this. Most of the studies to date have been qualitative in nature and have been self-reported.
- 5.3. In the ACMD's report on the primary prevention of hepatitis C (ACMD, 2009) it was noted that there was only weak evidence for the effectiveness of many interventions in reducing HCV among IDUs. The key finding was that there is emerging epidemiological evidence (supported by preliminary studies in the UK) that the *combination* of opiate substitution therapy (OST) and NSP is the most effective way of reducing HCV (and HIV) incidence among active IDUs (NSP or OST alone may not be sufficient to prevent HCV). Transposing the findings of the ACMD report (2009) it is likely that the provision of foil alone, unless a total substitute for injecting behaviour, would not make any significant impact on the incidence of blood borne viral infections. Nonetheless, foil provision may have an important role within a programme of interventions (like other paraphernalia) if it can be used to enforce harm reduction messages on the dangers of injection.
- 5.4. The National Institute for Health and Clinical Excellence (NICE) Public Health Guidance 18 *Needle and syringe programmes: providing people who inject drugs with injecting equipment* recognises the importance of NSPs in providing a gateway for IDUs to commence OST as a mechanism for reducing harm. In this report it was also noted that from fieldwork findings of participants who worked at Needle and Syringe Programmes:

'They were disappointed that the draft guidance did not address the need to provide foils and crack pipes to help people who inject to stop.'

5.5. There is evidence from around the world which demonstrates that different routes of drug administration are used, and that route transitions³ are a common phenomenon. A key example where a successful wide scale change of drug 'route transition' from injecting to smoking took place was the Netherlands. From initial health promotion activities in 1992 about the technique of smoking heroin or 'chasing' and the provision of aluminum foil, to full promotion campaigns to switch to non-injecting a few years later. It seems evident that such interventions significantly contributed to a major shift away from injecting within the drug using population and the availability of aluminum foil seems to have played a significant role in the transition process.

*'By the end of the 1990s the development seemed to be complete. Within a couple of years an entire generation of drug users in Holland changed their rituals and habits and moved away from injecting'*⁴

5.6. The Dutch experience does indicate that the provision of foil can provide a platform – when coupled with harm reduction messages and appropriate service provision – for the transition from injecting behaviour. Indeed the ACMD considers that the evidence from the Netherlands is compelling when it comes to making decisions around the provision of foil in the United Kingdom.

5.7. The conclusion from the service user evaluation undertaken in Scotland (Glasgow Addiction Services, 2010) was that the results supported the provision of foil and demonstrated that foil provision could encourage 'route transition' in injectors. Many of the service users questioned felt that foil provision would be both less damaging to people's health and save money. Some also commented on the ability to choose their method of administering drugs if given the choice of needles and foil. The anecdotal feedback suggested that injecting episodes would be reduced and the chances of abstinence increased.

*The more services available to people the better chance they will have of coming off drugs.*⁵

5.8. The ACMD considered the use of foil and the risk of bioavailable⁶ aluminium. However, the evidence provided to date does not indicate that the levels of aluminium derived from the use of foil constitute a risk to the individual.

³ A 'route transition' is said to occur when a person changes the method of drug administration that they predominantly use.

⁴ John Peter Kools, *Consultant on Drug Use, HIV and Harm Reduction, Amsterdam, Netherlands (2009)*

⁵ Anonymous respondent, *Glasgow Addiction Services, October 2009 Service User Questionnaire.*

⁶ uptake into the body.

The ACMD considered the evidence of effectiveness to determine:

Whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgment:

The evidence base has not been well developed; borne in part out of the current legal restrictions on the provision of foil which means that the intervention has not been properly trialled. Further pilot studies are needed to be able to draw firm conclusions. However, the available evidence, the ACMD believe, is sufficient to enable an informed judgment. The evidence suggests that the introduction of foil would bring positive benefits. Foremost of these is the greater contact between users and treatment services. This allows for greater impact to be made on user behaviours and increases the opportunity to provide public health messages.

Whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether it is equivocal:

As outlined above (Section 5) there is evidence of actual and potential benefits. However, what is more difficult to elucidate, from the presently available evidence, are any potential dis-benefits - such as further individuals being recruited to the using population (by way of foil being a route to the use of heroin). The results from the Amsterdam Cohort Study 1986-1998 (van Ameijden and Coutinho, 2001) which followed nearly a thousand drug users, showed that injecting initiation linearly decreased (4.1% to 0.7% per visit) following the introduction of harm reduction policies which included the provision of foil. The study concluded that a harm reduction approach did not lead to an increase in injecting drug use.

Where there is an effect, the typical size of effect:

Although the evidence is limited, what is available suggests an impact could be made on user behaviour. The Pizzey and Hunt study (2008) showed a take up rate of more than half of service users. The Glasgow survey results appear to support that figure. In Amsterdam HIV prevalence had been reduced to almost zero.

6. Conclusion and Recommendations

6.1. Having considered the evidence regarding the provision of foil as exempt under the Misuse of Drugs Act 1971, the ACMD concluded that there were three possible options as follows:

1. No change to current legal status
2. Implementation of a pilot scheme for foil provision
3. Recommendation that foil be exempted under Section 9A of the Misuse of Drugs Act 1971

6.2. The ACMD considers that on the current balance of evidence foil is exempted under Section 9A of the Misuse of Drugs Act 1971. The ACMD concludes that there is:

- a) No evidence of harmful effect of the provision of foil.
 - Previous studies have indicated that the intervention does not encourage the use of illegal drugs
- b) The potential benefits include:
 - Potential for a decrease in blood borne viruses;
 - Increased contact and engagement with drug service workers;
 - Reduced systemic infections;
 - Reduced soft tissue and venal damage;
 - Lower risk of overdose; and,
 - Reduced litter.

The ACMD would note that the recommendation of foil is different from that on other paraphernalia as it is not directly associated with injecting practice. Rather, the use of foil is specifically designed to move individuals away from injecting practice and the associated high risks of blood borne viruses and overdose. In this context the standard of evidence of proof, for the exemption of foil from Section 9A of the Misuse of Drugs Act 1971, may therefore be intuitively higher than for other paraphernalia. However, the ACMD believes that this report demonstrates a weight of evidence in favour of exempting foil as a harm reduction intervention⁷.

⁷ The ACMD noted the findings of the National Institute for health and Clinical Excellence (NICE) evaluation on NSP overall that while there were sizeable gaps in the evidence base for effectiveness they could support the continued or extended provision. This reflected the positive balance of probabilities approach.

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8. Presenters

James Bridge	National Needle Exchange Forum
Chris Exely	Keele University
Neil Hunt	London School of Hygiene and Tropical Medicine
Peter-John Kools	Consultant on Drug Use, HIV and Harm Reduction, Amsterdam, Netherlands.
Rachael Pizzey	Turning Point Somerset
Helen Wilks	National Needle Exchange Forum

9. Members of the Advisory Council on the Misuse of Drugs

Member	Sector
Professor Leslie Iversen (ACMD Chair)	Professor of Pharmacology, Oxford University
Dr Dima Abdulrahim	Briefings Manager, National Treatment Association
Lord Victor Adebowale	Chief Executive, Turning Point
Dr Jason Aldiss	Veterinary Medicine and Public Health - Managing Director of Eville & Jones Ltd
Mrs Gillian Arr-Jones	Chief Pharmacist for the Care Quality Commission
Mr Martin Barnes	Chief Executive, Drugscope
Dr Margaret Birtwistle	Specialist General Practitioner, Senior Tutor – Education and Training Unit, St George’s Hospital and Forensic Medical Examiner
Commander Simon Bray	Commander, Metropolitan Police
Dr Roger Brimblecombe	Pharmaceutical Industry - pharmacologist
Ms Carmel Clancy	Principal Lecturer for Mental Health and Addiction, Middlesex University
Professor Ilana Crome	Professor of Addiction Psychiatry, Keele University
Ms Robyn Doran	Mental Health Nurse and Director of Operations, North-West London Mental Health Trust
Professor Simon Gibbons	Professor of Phytochemistry (natural product chemistry), School of Pharmacy, University of London
Mr Patrick Hargreaves	Advisor for Drugs and Alcohol, Durham County Council Education Department
Ms Caroline Healy	Children's Strategic Adviser

Professor Raymond Hill	Professor of Pharmacology, Imperial College London
Mr David Liddell	Director, Scottish Drugs Forum
Mr Hew Mathewson CBE	Dentist and former President and Chair of the General Dental Council (2002 to 2009)
Dr Fiona Measham	Senior Lecturer in Criminology, University of Lancaster
Mr Graham Parsons	Pharmacist
Mr Trevor Pearce	Director of Enforcement, Serious Organised Crime Agency
District Judge Justin Phillips	District Judge, Drugs Court London
Mr Richard Phillips	Independent Consultant in Substance Misuse
DCC Howard Roberts	Deputy Chief Constable, Nottinghamshire Police
Dr Mary Rowlands	Consultant Psychiatrist in Substance Misuse, Exeter
Ms Monique Tomlinson	Freelance Consultant in Drugs Misuse
Mr Arthur Wing	Assistant Chief Officer – Sussex Probation Area

10. Conflicts of Interest

Two members of the ACMD declared conflicts of interest and therefore were not involved in decision making discussions regarding the report.

Lord Adebawale is Chief Executive of Turning Point who was involved in some of the National Needle Exchange Forum research.

Monique Tomlinson is a freelance consultant who works with the company, Exchange Supplies, that produce foil specifically for smoking heroin.