Victoria Atkins MP
Ref: AJ/HE/1713
Minister for Crime, Safeguarding and Vulnerability
Home Office
2 Marsham Street
London SW1P 4DF

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Dear Minister

STATEMENT ON 'REDUCING OPIOID-RELATED DEATHS IN THE UK REPORT – FURTHER RESPONSE REGARDING DRUG CONSUMPTION ROOMS'

In your recent response to the ACMD's recommendation, you expressed concerns about "the challenges that DCRs place on law enforcement agencies"[i]. As democratically elected Police and Crime Commissioners, responsible for the strategic direction of our respective police forces, we are well-placed to address the anticipated issues you raised. However, we are deeply concerned about the government's continued opposition to the introduction of DCRs.

Evidence, including reports you have cited, highlight the success of DCRs in other countries

In your letter to the ACMD you state that The Home Office's International Comparators report "concluded that DCRS have often been legally problematic, pose ethical issues for medical professionals and difficulties for law enforcement". However the same report found that DCRs "increase access to social, health and drug treatment services", "target difficult, hard-to-reach drug users"', and "provide a safer injecting environment".

The International comparators report also states that "DCRs in other countries have most often been established as a response to the acute social and public health issues that arise when drug misuse is concentrated in a small area." It is clear that "acute social and public health issues" are relevant to the current context in the UK, with drug related deaths at an all-time high and the added risk that fentanyl has the potential to be introduced into the heroin market. If the Home Office does not take action we could see a crisis developing as is the case in the USA and Canada.

International evidence also shows that DCRs "do not result in higher rates of local drug-related crime" and instead can reduce "street disorder and encounters with the police"[ii].

DCRs have been shown to reduce syringe sharing and litter[iii] which in turn reduces the risk of blood- borne virus infections, and they can reduce overdose fatalities and ambulance call-outs for overdose[iv], thereby reducing pressure on our emergency services. Evidence also suggests that DCRs "save more money than they cost"[v], with evidence from Vancouver that the DCR there saved over $18 million in health costs over a 10 year period.[vi]

In your letter you also state that the United Nations' International Narcotics Control Board

(INCB) shares your views that the creation of DCRs have the potential to condone organised crime. This in fact is not what the report says, the INCB Annual report of 2016 states: *With respect to "drug consumption rooms", the Board wishes to reiterate its frequently expressed concern that, in order for the operation of such facilities to be consistent with the international drug conventions, certain conditions must be fulfilled. Chief among those conditions is that the ultimate objective of these measures is to reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking. "Drug consumption rooms" must be operated within a framework that offers treatment and rehabilitation services as well as social reintegration measures, either directly or by active referral for access, and must not be a substitute for demand reduction programmes, in particular prevention and treatment activities.*

The position taken by the INCB was effectively a shift in its position to endorse DCRs subject to certain conditions. In its 2017 Annual report it stated:

The Board reiterates that in order for the operation of "drug consumption rooms" to be consistent with the international drug control conventions, certain conditions must be fulfilled. First among those conditions is that the ultimate objective of such facilities should be to reduce the adverse consequences of drug abuse without condoning or encouraging drug use and trafficking. " [vii]

The position of the INCB is therefore not aligned to that of the UK Government's.

Also, the issue you raise of the Danish experience and the presence of Swedish people attending the DCR is unique to that country. People from Sweden who use drugs – in particular heroin - have a long history of accessing harm reduction services in Denmark. This is a direct result of Sweden's punitive approach to drug use and lack of harm reduction interventions, such as needle syringe programmes and opiate substitute therapy. There is no reason to believe that the UK would experience anything similar considering the support for DCRs by the devolved governments and the fact Ireland will be establishing their own DCR this year and France has opened a number of these facilities in recent years.

There are clearly many strong arguments in favour of introducing DCRs in areas of need, as the ACMD has rightly recommended.[viii]

Clarification of some of the statistics and evidence contained in your letter

In your letter to the ACMD you state:

"Over half of all organised crime groups operate in the UK are involved drug-related crime"[ix]

These claims are accurate, but have little relevance to the subject at hand. While some European studies report "small-scale drug trafficking in the immediate vicinity of the [DCRs]"[x], there is no evidence that this is a consequence of the DCR itself; rather, that DCRs are often opened in areas where drugs are sold. The reality is that those accessing the DCR are already purchasing and consuming drugs such as heroin, but rather than injecting in a safe space they are injecting in our town and city centres – these are our current drug consumption facilities.

Arfon Jones, North Wales PCC and Ron Hogg, Durham PCC, recently visited Geneva, to see first-hand the delivery and the impact of a Drug Consumption Room, Quai 9, and received input from the police. Law enforcement cooperated with the centre, and senior police officers from the Criminal Investigation Department attended the steering committee. Police officers in Geneva said that in the last 2 years there was no serious crime amongst drug addicts who use such facilities. Safety and security measures were introduced around the centre and they operated targeted interventions and controls of the dealers near the centre. It has been estimated that the 10% of the heaviest users of heroin in Switzerland consumed around 50% of all the illicit heroin imported. As a result, getting these users engaged in harm reduction services via a Drug Consumption Room has the potential to reduce the consumption of illicit heroin, which could substantially reduce the scale of the illicit heroin market, depriving organised criminals of resources.

> **"Around 45% of all acquisitive crime is committed by regular users of heroin and/or crack cocaine, and that these crimes cost society approximately £6 billion a year"** [xi]

Again, this is not relevant to DCRs, as there is no evidence that DCRs increase acquisitive crime.[xii] Evidence from Sydney found that the presence of the DCR had no reported effect on thefts or robberies around the facility.[xiii] Another study from Vancouver concluded that the presence of the DCR was not linked to an increase in drug trafficking, assaults or robbery.[xiv]

However, the paper that you cite that estimates £6 billion lost due to acquisitive crime also shows that drug-related deaths and NHS treatment for people who inject drugs cost society approximately £4 billion a year[xv] - a cost which could be significantly reduced by introducing DCRs[xvi].

> **"The Government spends an estimated £1.6 billion in 2014/15 on law enforcement activity aimed at tackling the criminal activity linked to the trade in illicit drugs"**

This figure is from the Home Office's evaluation of the Drug Strategy 2010, which also notes that "activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability". This enforcement also has many "potential unintended consequences", the report describes, including drug market violence, "health harms from varying purity of drugs", and the "negative impact of involvement with the criminal justice system".[xvii] Our call for new approaches such as Drug Consumption Rooms is a natural response to the Home Office's

own research, which recognises that the current approach is not working.

Drug treatment services already manage many of the legal risks associated with a DCR

In your letter you state that DCRS are 'legally problematic' however many of the activities that would be illegal under the Misuse of Drugs 1971 Act are already managed by drug services, especially needle syringe programmes ('NSPs'). For example, it is widely accepted that people accessing NSPs for sterile equipment will be in possession of a controlled drug. Even the Crown Prosecution Service accepts this position, stating in its guidance for charging standards for drug offences:

These schemes [NSPs] need police and CPS co-operation because those who run and use them will necessarily commit offences under the Act. It is therefore not normally in the public interest to prosecute:

- *a drug user retaining used needles;*
- *a drug user possessing sterile needles;*
- *bona fide operators of schemes.*

Simple possession cases that are based on police surveillance at or near exchange centres should not normally be prosecuted. The need to prevent the spread of serious infections outweighs the normal requirement for prosecution.

Furthermore, services ensure they have policies in place to limit section 8 MDA 1971 liability (activities related to premises). The International Comparators report highlights the risk of a potential offence under the Serious Crime Act 2007, by 'encouraging or assisting' a crime, however some harm reduction advice provided at NSPs may be considered to fall within this offence, especially in the absence of significant case law for this specific provision where the aim is in the public interest i.e. to reduce drug related deaths, blood b0orne viruses and public nuisance.

The international evidence shows that DCRs are not problematic for police, who will have historically had to manage potential drug specific crimes in relation to the provision of harm reduction services, such as NSPs. This learning is applied to the location and surrounding area of the DCR, where, like NSPs, drug dealing is not permitted. We can assure you that the police in the UK have similar experiences and would have the requisite knowledge and skills to manage law enforcement to tackle drug dealing and to tolerate drug possession offences to allow the DCR to operate properly – as we do with current harm reduction centres.

We therefore ask that you review your decision to prevent the introduction of DCRs as an example of the government's commitment to "exploring alternative options available,

within [the] legislative framework". If the Government was to allow a pilot site, based on a local needs assessment, to operate in the UK, we would be able to demonstrate what works locally. We are sure, like us, you want to see a reduction in drug related deaths, a reduction in health risks, fewer open drug scenes, improved cleanliness, reduced public insecurity related to drug use and an increase in services that support some of the most marginalised and vulnerable in society.

Kind Regards
Arfon Jones North Wales Police and Crime Commissioner
David Jamieson West Midlands Police and Crime Commissioner
Ron Hogg Durham Police and Crime Commissioner

Victoria Atkins Response
References

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xiv Ibid
xv Because of the significant increase in drug-related deaths across the UK, the cost to society of drug-related deaths is likely much higher than it was estimated to be in 2010/11. According to the method used in this report, drug misuse deaths (registered in 2016 across the UK) alone cost society approximately £5.4 billion a year. The costs of NHS treatment will also be underestimated because these estimates exclude the cost of treatment for Hepatitis B, C and bacterial infections from injection.
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