

# Out of harm's way

Needle Exchange

Housing

Healthcare

Psychiatrist

Social Worker

Drug consumption rooms,  
benefits and challenges



west midlands  
police and crime  
commissioner

# Out of harm's way

## Introduction by David Jamieson



In February 2018 I published my eight recommendations for a new approach to drug policy. The recommendations were developed through extensive consultation. My ambition remains to provide an opportunity for open thinking and to create a space for sensible and mature discussion.

Despite the hard work of many, collectively our drug policy is failing. My office produced a hard-hitting 'cost of drugs' report in September 2017 which revealed that the estimated annual cost of substance misuse to the West Midlands region is £1.4 bn. This is the cost to society of drug-related crime, health service use, drug-related deaths and social care. At least half of all theft, burglary and robbery is committed by people who use heroin, crack cocaine or powder cocaine regularly. Every three days in the West Midlands, somebody dies of drug poisoning.

The seventh recommendation, published in February 2018, stated:

Consider the benefits of Supervised Drug Consumption Rooms to see if they would add value to current services in the West Midlands. Drug Consumption Rooms are clinical spaces in which people suffering from addiction can access clean equipment, medical support and drug treatment and other services. This support is typically targeted at hard to reach homeless people, improving their access to treatment while taking their injecting and needle litter off the streets.

I am grateful to Ernie Hendricks, independent member of my strategic policing and crime board, who has delivered on the recommendation by producing this in-depth report which assesses the academic evidence regarding Drug Consumption Rooms. Clearly, the evidence is strong and supportive of Drug Consumption Rooms as a way to reduce the harm caused, and the costs incurred, by drug use.

I will now work with partners to explore the two key recommendations to emerge from this report which could help to reduce needle litter, deaths from overdoses and help to engage individuals in drug treatment. This will not only reduce the harm to some of the most vulnerable in our society, but also reduce the cost to the taxpayer.

In the West Midlands, I, alongside many other residents, have been alarmed and disturbed by the significant increase in our homelessness and rough sleeping population. A Drug Consumption Room must be considered within this context and I will continue to work with leaders in the West Midlands to develop this thinking.

David Jamieson  
West Midlands Police and Crime Commissioner



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# Out of harm's way

## Explanation of terms

ARIMA	Autoregressive Integrated Moving Average*
ACMD	Advisory Council on the Misuse of Drugs
CGL	Change Grow Live
DCR	Supervised Drug Consumption Room
DRD	Drug Related Deaths
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EHRC	Enhanced Harm Reduction Centre
IAPT Service	Improving Access to Psychological Therapy
IDU	Intravenous Drug User
MDA	Misuse of Drugs Act (1971)
MSIC	Medically Supervised Injecting Centre
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NICE	National Institute for Health and Care Excellence
NSP	Needle and Syringe Programmes
ONS	Office of National Statistics
OPC	Overdose Prevention Centre
PHE	Public Health England
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RCT	Randomised Controlled Trial
RSS	Rough Sleeping Strategy (2018)
SCA	Serious Crime Act (2007)
SCF	Safer Consumption Facilities
SCS	Supervised Consumption Sites
SIC	Supervised Injection Centre
SIF	Supervised Injection Facility
SIAS	Solihull Integrated Addiction Services

\*An autoregressive integrated moving average is a statistical analysis model that uses time series data to either better understand the data set or to predict future trends.

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# Out of harm's way

## 1. Executive Summary

*“The use of supervised injection sites is often most effective for the hardest to reach homeless drug users providing a safe space for safe injecting practice, medical attention, prevention of overdose and engagement with health care service...[and their effectiveness to] maintain contact with and act as access points for housing and other social services for highly marginalised target populations has been widely documented. The EMCDDA fully supports the use of safer injecting sites to prevent overdose deaths.”*

UK Government’s Advisory Council on the Misuse of Drugs, June 2019

Under the current approach, the estimated annual cost associated with illegal drug use in the West Midlands is £1.4bn. The best available estimates are that, in the West Midlands force area in 2018/19, there were 230,000 adults who used an illegal drug (7.9%) and 72,912 reported using a class A drug (2.5%) – cocaine, crack, heroin and methamphetamine etc. This is mirrored by an all-time high of 521 drug related deaths recorded across the West Midlands in 2016-18, a hike of 11% from 469 in the period 2015-17. With an exception for the years 2015-17, where the numbers dipped by 5% on the previous years (2014-16), the trend has seen more lives lost in every reporting period, equivalent to an 82.7% increase over the last nine years.

This document has been written in response to one of eight recommendations in the West Midlands PCC’s Drugs Policy Report (2018), a report that adopts a new approach that is dictated by evidence and compassion and where the emphasis centres on harm reduction to help to lower crime, save money and support communities. This approach recognises the dangers of a solely recovery and abstinence-based agenda that fails to address the reality that many people who take drugs are not currently ready, or able, to stop because, as is often said in the drug treatment sector, people who are dead cannot recover.

**Recommendation 7:** Drug Consumption Rooms (DCRs): Consider the benefits of Drug Consumption Rooms to assess if they would add value to current services in the West Midlands.

### The Evidence

DCRs are clinical spaces where people dependent on drugs can take their own illegal drugs, using hygienic equipment, under the supervision of trained staff equipped to treat overdoses. They also provide wider medical support and access to drug treatment and other support services. They are targeted to reach certain groups including homeless people and those not currently engaged in treatment.

While there are limitations to the research reviewed in this report, and caution is required when making direct comparisons with other areas, the evidence available indicates the effectiveness of DCRs in achieving their primary health and public order objectives. This is particularly true when they are meshed with other harm reduction, housing and support services.

Perhaps most strikingly, despite many millions of injections in DCRs around the world, operating in different social and healthcare systems over several decades, no one has ever died from a heroin overdose in a DCR. While remaining opposed to DCRs, the UK Home Office has also acknowledged the evidence that they can reduce overdose deaths, improve health outcomes, reduce street injecting and discarded needles without increasing crime and disorder.

For example, the most recent research available (June 2019) concluded that overdose deaths would be more than twice as high in British Columbia in Canada (which has a population around double that of the West Midlands) without the scaling up of harm reduction measures including naloxone provision, Opioid Substitution Therapy and Supervised Drug Consumption Rooms. Developing a network of DCRs alone saved around 230 lives in a twenty-month period in the province.

From a policing perspective, the question is whether a custody block or a prison cell is the best place for someone with drug problems or whether such experiences – and a criminal record – present another obstacle on the journey to recovery and increase the likelihood of reoffending. In such circumstances, a DCR, delivering health interventions as part of a system focused on education, prevention and harm reduction, would offer a more holistic and cost-effective solution.

In summary, while recognising the excellent work delivered through existing treatment and support agencies, the findings in this report suggest that, if a DCR pilot was established in the West Midlands, it could add significant value by working in tandem and co-ordinating with existing services to:

- Reduce drug-related deaths locally and at city level if coverage is adequate
- Promote safer injecting practices and reduce risky behaviours including rushed injecting
- Reduce syringe sharing and the risk of blood-borne virus transmissions including HIV and hepatitis C
- Reduce the number of ambulance call outs
- Bring a population with complex needs into contact with detoxification and drug treatment services, potentially reducing drug use in the long term
- Improve access to primary healthcare, housing, welfare and other medical services to reduce adverse life circumstances
- Improve the amenity of city centres by reducing drug-related litter and street injecting
- Help tackle drug-related criminal activity and anti-social behaviour
- Save the taxpayer money because DCRs are cost-effective by preventing more complex health issues and costs associated with responding to crime
- Make a significant contribution to a drug alert framework

#### The arguments made against DCRs

A range of arguments have been made against DCRs which are not supported by the evidence.

- **DCRs would be difficult to police.** A number of PCCs, including the West Midlands PCC, have visited DCRs overseas, heard evidence from local police and concluded the challenges are manageable in the UK too.
- **DCRs encourage the use of drugs and support the illegal market.** These concerns are unfounded. DCRs do not increase the number of people using drugs or the frequency with which they inject. Instead of increasing drug use, by helping people engage with treatment, DCRs have the potential to reduce the scale of the drug market.
- **DCRs 'send the wrong message'.** There is no

evidence to support the premise that allowing DCRs would send a message that injecting heroin was not dangerous or that people would take more drugs as a result. In fact, as noted above, there is clear evidence that DCRs do not increase use.

- **DCRs act as a 'honey-pot' attracting people from other areas, increasing crime and street drug dealing.** DCRs are only located where there is an existing problem, which is reduced by taking street-use inside, and the vast majority of people with severe drug problems will not travel far.
- **Because some people using a DCR will die of an overdose outside of the facility at a later date instead, DCRs don't work.** DCRs provide an opportunity to make a life-saving medical intervention to reverse otherwise fatal overdoses. To further increase the number of lives they save, DCRs should be part of a wider strategy to reduce drug related deaths, including well-funded evidence-based treatment, naloxone provision and wrap-around social and other healthcare. The latest evidence shows those attending a DCR not only will not die in the facility itself but also that their risk of fatality outside it will be reduced as well.

#### Challenges with developing a DCR

There are currently no DCRs in the UK, despite support for opening them in several areas and, in the case of Glasgow, funding from the NHS being available. Their development has been stymied in part due to the nervousness of politicians at both local and national level and perhaps the wider, genuine concerns among some members of the general public.

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The main issue, however, relates to a legal framework which does little to provide comfort for clients, staff, regulatory agencies and law enforcement and, in particular, whether there could be a legal challenge based on contravention of the Misuse of Drugs Act 1971 or the Serious Crime Act 2007. This could be addressed through:

- In the short term, the Home Office issuing an explicit statement asserting that the operation of DCRs is a matter for local authorities and police forces, working together with the Crown Prosecution Service (CPS), health bodies and treatment groups.
- In the long term, the UK Parliament amending the relevant legislation to make operating DCRs explicitly legal.

### Wider strategy for the West Midlands

Should a pilot prove successful, the development of a network of DCRs would help to meet the WMPCC's primary objectives and aspirations published in two key documents – the West Midlands Police and Crime Plan 2016-2020 and the West Midlands Drug Policy Recommendations 2018 – by limiting the social and economic impacts of daily users by:

- a) Reducing acquisitive crime by helping people into treatment
- b) Reducing the harm that those suffering from addiction cause to themselves and to society
- c) Helping to reduce the estimated annual bill associated with substance misuse to the West Midlands of £1.4bn

Such a network would also support the delivery of a range of aspirations and goals in the Government's 2017 Drugs Strategy, the 2018 Rough Sleepers Strategy, the 2018 Serious Violence Strategy, the Domestic Abuse Strategy 2018-2023, the West Midlands Police Ambition Plan 2018-2020, the Housing First initiative and the West Midlands Combined Authority's 2017 report, Healthcare issues amongst the Homeless in Birmingham.

### Recommendations

- **Develop a business case through a multi-agency steering group for a drug consumption room in the West Midlands, based on the overwhelming evidence detailed within this report.**
- **Work with Government and the multi-agency steering group to support a DCR pilot site in the West Midlands.**



## 2. Context

**Recommendation 7: Drug Consumption Rooms (DCRs): Consider the benefits of Drug Consumption Rooms to assess if they would add value to current services in the West Midlands.** The West Midlands Police and Crime Commissioner's report,<sup>1</sup> *'Reducing Crime and Preventing Harm: West Midlands Drug Recommendations'*

This document has been written in response to the above, which is one of eight recommendations featured in the West Midlands PCC's Drugs Policy Report (2018), a report that adopts a new approach that is dictated by evidence and compassion, and avoids the political cynicism and hysteria that often shapes discourse around drugs.

Instead, the emphasis is on harm reduction to reduce crime, save money and support communities, and to adopt an approach that recognises the dangers of a solely recovery and abstinence-based agenda that fails to address the reality that many people who take drugs are not currently ready, or able, to stop.

All eight recommendations relate to the future of policing drugs and the proactive measures the PCC is taking to:

- a) Reduce acquisitive crime by helping people into treatment
- b) Reduce the harm that those suffering from addiction cause to themselves and to society
- c) Helping to reduce the estimated annual bill associated with substance misuse to the West Midlands of £1.4bn

To meet these ambitions, Drug Consumption Rooms (DCRs), also known as Overdose Prevention Centres (OPCs), Safer Consumption Facilities (SCFs), Safer Injection Facilities (SIFs), Medically Supervised Injection Centres (MSICs), Supervised Consumption Sites (SCSs) and Safe Injection Centres (SIC) amongst a number of

other terms, could have a role to play. For ease of reference, this report will use the generic term DCR but these are all spaces where illicit drugs can be injected using sterile injecting equipment under the supervision of professionally trained staff. Some also allow the inhalation of drugs in ventilated booths. Additional services provided can include a range of counselling and advice services before, during and after drug consumption, emergency care in the event of an overdose, primary medical care (for example wound care) and referrals to appropriate social, housing, healthcare and drug treatment services.<sup>2</sup>

This report draws on international evidence that suggests DCRs have been a worthwhile addition to the social and healthcare services of other countries, with particular benefits to people who are rough sleeping and using drugs. This includes people who inject and inhale on the streets, a cohort at particularly high-risk of drug-related death.

### 2.1 Drugs in the West Midlands

Establishing the scale of drug use is challenging. Assessments often rely on self-reporting of an illegal activity and household surveys (e.g. the Crime Survey for England and Wales) exclude key groups where use is particularly high, such as the homeless and prisoners. The best available estimates are that, in the West Midlands force area in 2018/19, 230,000 adults had used an illegal drug (7.9%) and 72,912 reported using a class A drug (2.5%), cocaine, crack, heroin and methamphetamine etc.<sup>3</sup>

While the most recent estimates show use of Class A drugs rising in England and Wales in recent years, the harm associated with drug use has increased even more rapidly. In the UK, drug related death rates (DRDs) are among the highest in Europe. 2016-2018 saw a 16% rise in England and Wales with 11,859 DRDs, reaching record levels for the last six years in a row and continue to increase.<sup>4</sup>

1. West Midlands Police and Crime Commissioner (2018). Reducing Crime and Preventing Harm: West Midlands Drug Recommendations. Birmingham: West Midlands Police and Crime Commissioner.

2. McCulloch, L. (2018) Back Yard: An Investigation into the Feasibility of Establishing Drug Consumption Rooms [online] (Volteface, 2018). Available at: <http://volteface.me/publications/back-yard/> [Accessed 3 Oct. 2018]

3. Office of National Statistics (2019). Crime Survey for England and Wales (Drug Misuse Statistics). London: Crown Copyright.

4. Office of National Statistics (2016,2017 & 2018). Deaths related to drug poisoning in England and Wales – Office for National Statistics. [online] Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/previousReleases>

# Out of harm's way

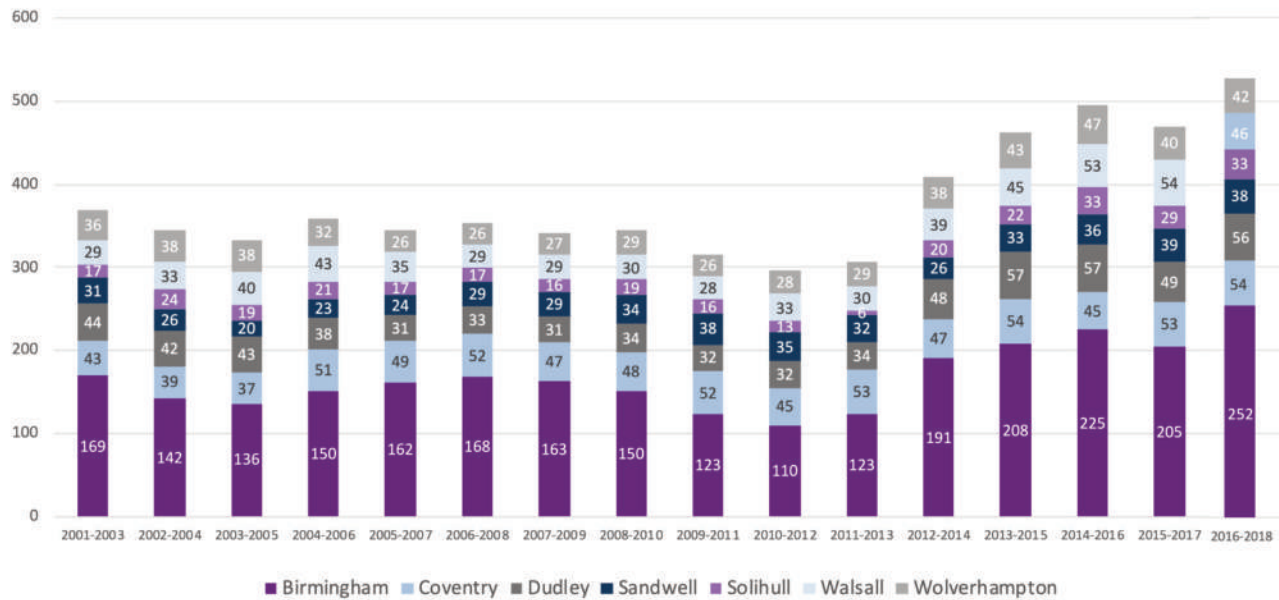
## 2. Context

Reporting across the region has seen an all-time high of 521 drug related deaths recorded across the West Midlands in 2016-18, a hike of 11% from 469 in the period 2015-17. With an exception in the years 2015-17, where there was a slight dip of 5% on the previous period, the trend is upward. With more lives lost in every reporting period equivalent to an 82.7% increase over the last nine years.

The Advisory Council on the Misuse of Drugs (ACMD) has voiced concern over more recent cuts to public health grants, suggesting that drug fatalities are the highest where cutbacks have been the deepest.<sup>6</sup>

On a local/city wide level, the data published in 2019 for DRDs shows the biggest increase across the region was Birmingham where there were 252 deaths in 2016-18, up from 205 in 2015-17, (+22.9%). There were also small rises for the period 2016-18 in Coventry (+1.8%), Dudley (+14%), Solihull (+13%) and Wolverhampton (+5%). The biggest decrease was in Walsall (-14%) with Sandwell reporting a slightly lower level (-2.5%).<sup>5</sup>

### Drug-Related Deaths in the West Midlands 2001-2018

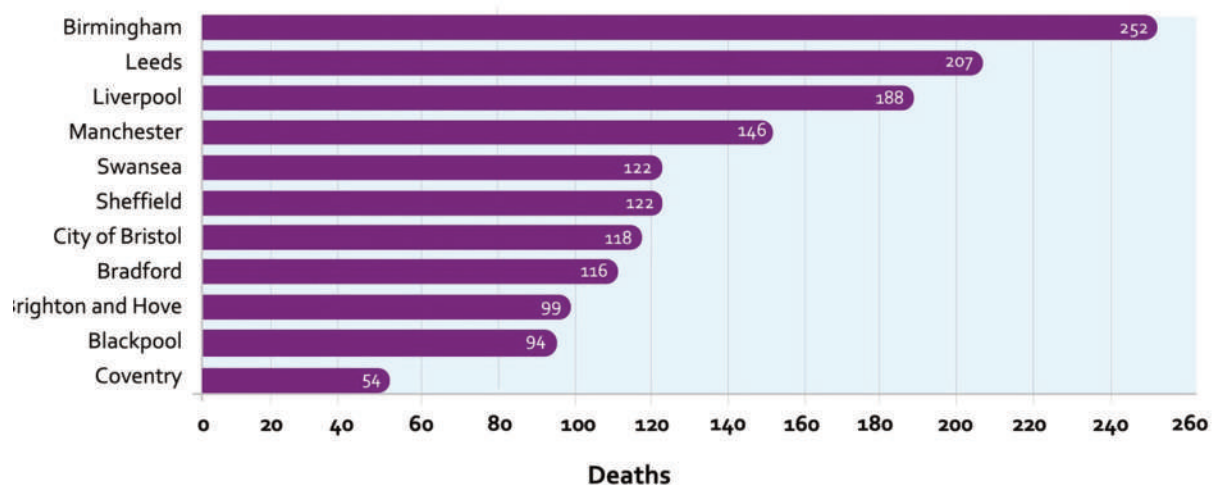


(Data: Office of National Statistics. Published 2019)

5. Ons.gov.uk. (2018). Drug-related deaths by local authority, England and Wales - Office for National Statistics. [online] Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority> [Accessed 19 Oct. 2018].

6. Edwards, M. (2017). Drug fatalities highest where treatment cutbacks deepest. [online] The Guardian. Available at: <https://www.theguardian.com/society/2017/oct/14/drug-overdoses-rise-most-treatment-cuts-are-deepest> [Accessed 13 Aug. 2019].

### Number of Drug Related Deaths 2016-2018 (by city)



(Data: Office of National Statistics. Published 2019)

## 2.2 Hepatitis C, HIV and other blood borne viruses

Transmission of hepatitis C is through blood and bodily fluids with prevalence most common in marginalised under-served groups, in particular people who inject drugs (PWID). The virus can cause liver failure and, in the worst cases, hepatocellular cancer which has a poor survival rate. According to Public Health England, injecting drug use continues to be the most important risk factor for hepatitis C (HCV) infection in the UK with around 113,000 citizens living with the infection across the UK.<sup>7</sup>

Data from UK surveys of people who inject drugs suggests that, in 2018, just over half tested positive for HCV antibodies, with around two-thirds unaware of the fact. 18% of people currently injecting psychoactive drugs reported direct sharing of needles and syringes. When including the sharing of spoons, mixing containers or filters as well as needles and syringes, the proportion of those reporting sharing was 39%. As a

result, 92% of hepatitis C infections diagnosed in 2016 were acquired through injecting drug use.<sup>8</sup> As far back as 2015, the Hepatitis C Trust estimated that over 5,000 people in Birmingham alone had hepatitis C, half of whom were undiagnosed.<sup>9</sup> The 2019 PHE report relates specifically to the West Midlands and contains data sets up to the year 2017. It suggests that prevalence remains high in PWID and injecting drug use continues to be one of the main drivers of hepatitis C. The population is a prime target for a Direct-acting Antiviral Agent or DAA roll-out. However, one of the biggest obstacles is in the entering of care pathways due to a lack of treatment settings that are suitable for PWID.<sup>10</sup> The chart below shows a decrease in the lab reporting of hepatitis C across the West Midlands of approximately 10% in 2017, with 1036 individuals testing positive. However, anecdotally early indications suggest an increase for the period 2020.

7. Public Health England (2018). Hepatitis C in England 2019: Working to eliminate hepatitis C as a major public health threat. [online] London: Crown Copyright. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/798270/HCV\\_in-England\\_2019.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/798270/HCV_in-England_2019.pdf) [Accessed 23 Dec. 2019].

8. Public Health England (2017). Shooting Up: Infections among people who inject drugs in the UK 2016. London: Crown Copyright. Available at: [http://www.hcvaction.org.uk/sites/default/files/resources/Shooting\\_Up\\_2017\\_report.pdf](http://www.hcvaction.org.uk/sites/default/files/resources/Shooting_Up_2017_report.pdf) [Accessed 23rd Dec. 2019].

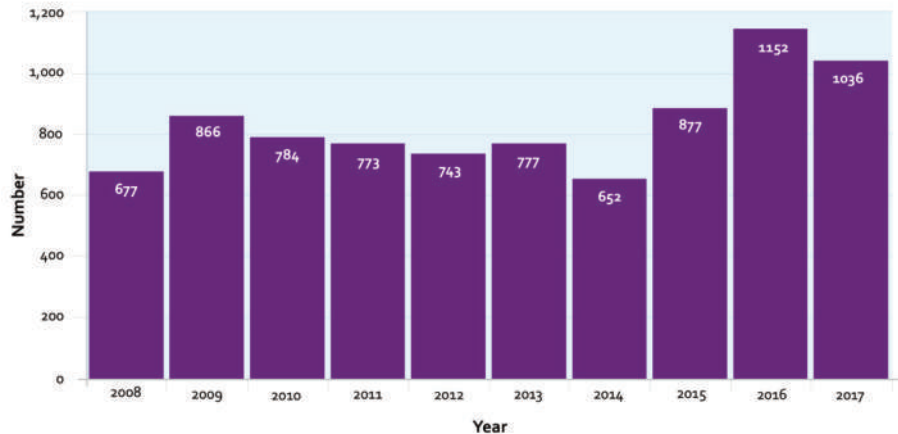
9. Hepatitis C Trust. (2019). Call for West Midlands to be hepatitis aware and 'get tested'. [online] Available at: <http://www.hepctrust.org.uk/blog/aug-2015/call-west-midlands-be-hepatitis-aware-and-'get-tested'> [Accessed 4 Jul. 2019].

10. Public Health England (2019). Hepatitis C in the West Midlands: 2017 data. [online] London: Crown Copyright. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/842672/Hepatitis\\_C\\_West\\_Midlands\\_Annual\\_report\\_2017.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/842672/Hepatitis_C_West_Midlands_Annual_report_2017.pdf) [Accessed 27th Dec. 2019].

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### Number of laboratory reports of hepatitis C, West Midlands Residents – 2008 to 2017



Data; Public Health England (2019)

The annual PHE Epidemiological Spotlight report published in March 2019 features HIV data sets up to the year 2017. While HIV is still a threat in the West Midlands, those newly diagnosed fell by 23% from 425 cases in 2016 to 329 in 2017. This mirrors a decline across the UK as a whole.<sup>11</sup> Yet, in November 2018, Public Health England advised of a small HIV outbreak amongst a Birmingham community of injecting drug users.<sup>12</sup> It is important to note that, within the West Midlands, six local authorities had a prevalence rate above the expanded HIV testing threshold. These were

Wolverhampton (3.41), Coventry (3.22), Sandwell (2.75), Birmingham (2.74), Walsall (2.18) and Stoke-on-Trent (2.13). The lowest prevalence rates were observed in Bromsgrove (0.49), Lichfield (0.53), Tamworth (0.61) and Staffordshire Moorlands (0.62)<sup>13</sup> (see table opposite)

The experience in Glasgow, which now has an out of control HIV epidemic among PWID, underlines the need for a precautionary approach.<sup>14</sup>

11. Public Health England (2019). Annual Epidemiological Spotlight on HIV in the West Midlands. [online] London: OGL Crown Copyright. Available at:

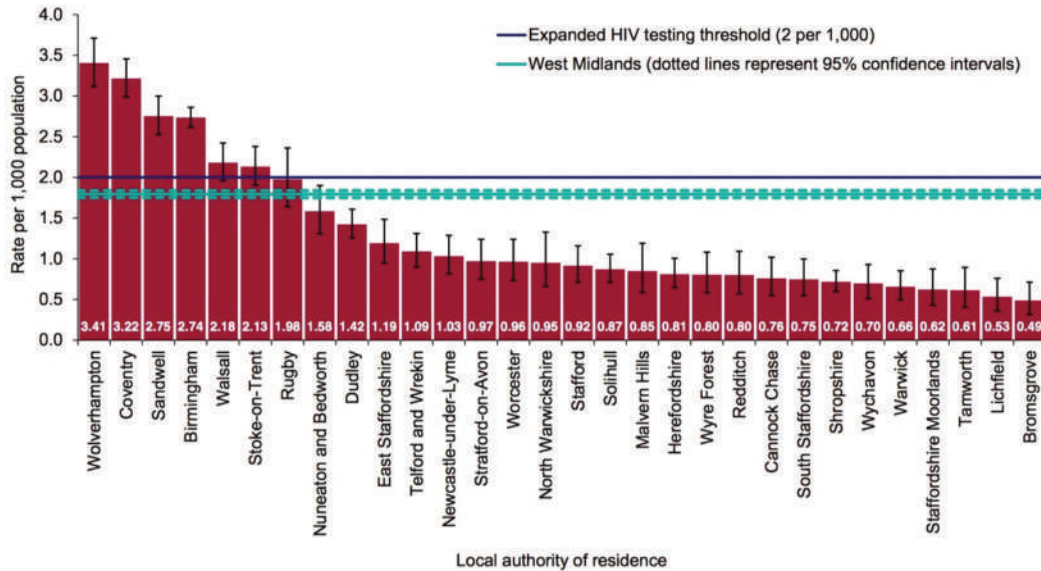
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/782279/annual\\_epidemiological\\_spotlight\\_on\\_hiv\\_west\\_midlands\\_2017\\_data.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/782279/annual_epidemiological_spotlight_on_hiv_west_midlands_2017_data.pdf) [Accessed 23 Dec. 2019].

12. BBC News. (2018). 'Worrying' increase in HIV cases. [online] Available at: <https://www.bbc.co.uk/news/uk-england-birmingham-46404138> [Accessed 17.12. 2019].

13. Ibid, p21. Public Health England (2019).

14. Smith, S. (2019). What can be done to halt Glasgow's HIV epidemic?. [online] BBC News. Available at: <https://www.bbc.co.uk/news/uk-scotland-scotland-politics-49207094> [Accessed 27 Dec. 2019].

**Diagnosed HIV prevalence in 15-59 year olds per 1,000 population by local authority, West Midlands residents, 2017. Data Public Health England (2019)**



### 2.3 Street injecting and discarded needles

A good indicator of the scale of the issue of substance misuse, and public injecting in particular, is the number of discarded needles found on our streets. Street injecting is dangerous for those forced to do it and unpleasant to witness. Discarded unsterile needles are also off-putting, pose the risk of needle-stick injuries to the public, including children, and carry a small risk of infection. The safety issues and potential reputational damage to cities from discarded needles and street injecting are not conducive to business investment or tourism. Needle litter is reported to local authorities with

six local councils recording 701 in 2016 (excluding Dudley, which does not record), Sandwell recording the numbers but not location and only Coventry recording needles found in the city centre. While major concentrations of needles appear common in city or urban centres, it is likely that needles reported to local councils are only a fraction of the total number to be found on our streets. Needles discarded on private property are not recorded at all, and many businesses and members of the public tend to clear these themselves, rather than wait for the local council to do so.

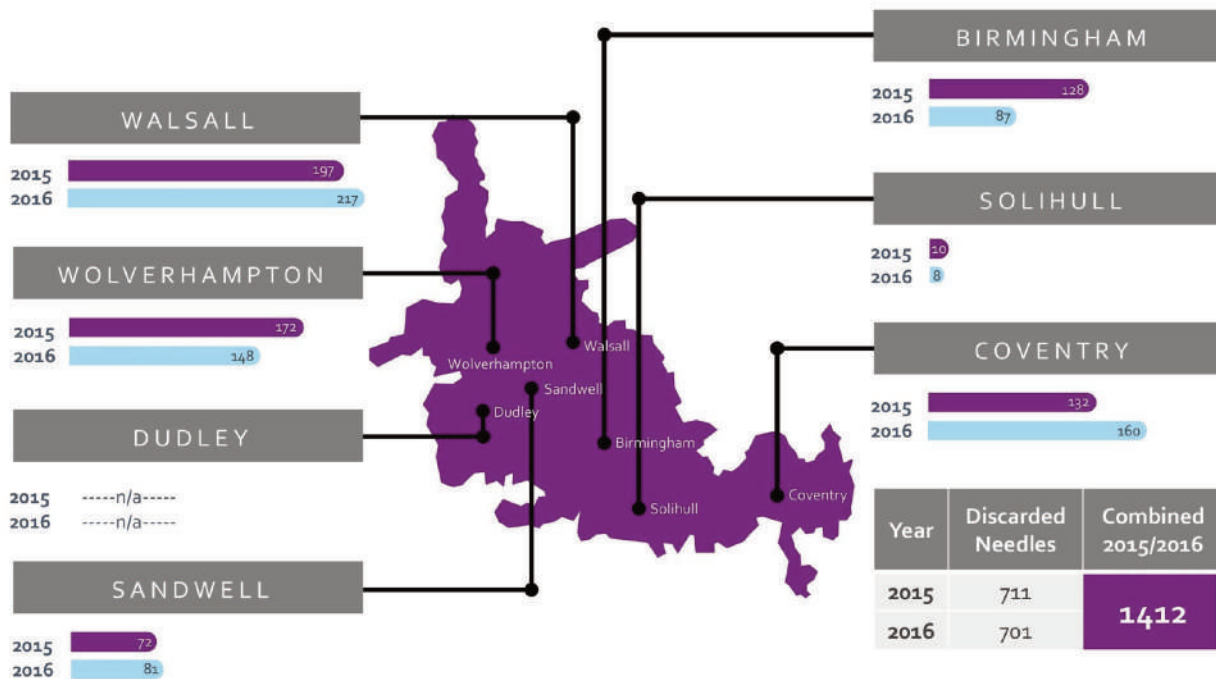
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## 2. Context

The map below shows the locations of discarded needles found across the West Midlands.

### Locations of discarded needles across the West Midlands (Data Analysis)

(Data: West Midlands Police and Crime Commissioner – 2017)



Needle maps are often represented by a solitary mark on a map and don't take account of a single site where hundreds of needles might have been collected as a result of an environmental clean-up, for example. To assess the problem with greater accuracy, a consistent approach to needle litter reporting and recording will need to be adopted across the West Midlands local authority areas where currently no uniform system exists.

### 2.4 Current service provision in the West Midlands

The delivery of drug and alcohol services is the responsibility of local authorities and services need to be designed to contribute to national and local priorities. It is vital that successful commissioning bids

also support the achievement of outcomes within the Public Health Outcomes Framework, national strategies and any local corporate plans, including strategic needs assessments.<sup>15</sup>

While each locality is different, with different needs and issues, the services put in place to support people who use drugs will share many similarities. In line with other regions, in the West Midlands one or two key providers are usually commissioned who respond to the needs of drug users. For example, the main substance misuse service provider in Coventry and Birmingham, two of the seven local authority councils in the West Midlands, is Change, Grow, Live (CGL). CGL is one of the biggest drug treatment charities in the UK, supporting 219,000 people with drug and alcohol dependency across more than 160 locations nationally.

15. Kilgallon, R. (2013). Drugs and Alcohol Needs Assessment 2013-14. [online] Birmingham: Birmingham City Council. Available at: [https://www.birmingham.gov.uk/downloads/file/7920/public\\_health\\_birmingham\\_drugs\\_and\\_alcohol\\_needs\\_assessment\\_2013\\_2014](https://www.birmingham.gov.uk/downloads/file/7920/public_health_birmingham_drugs_and_alcohol_needs_assessment_2013_2014) [Accessed 24 Oct. 2018].



CGL's 2019 annual report suggests it has helped 22,200 people beat their addiction.<sup>16</sup> The CGL care plans revolve around a recovery approach for those experiencing the harms associated with drug or alcohol misuse. In Birmingham, for example, CGL indicates that it offers treatment and care to just under 8,000 service users. Treatment and recovery is monitored and measured by the following outcomes framework:<sup>17</sup>

- Increased levels of employment
- Reductions in reoffending
- Improved housing
- Improved parenting
- Improvements in physical health

**Those in treatment - 12 month period (2019)**

(Data: Change Grow Live – 2020)

Service	All in treatment (in latest 12 months) OPIATES	All in treatment (in latest 12 months) ALCOHOL	All in treatment (in latest 12 months) NON OPIATES	All in treatment (in latest 12 months) NON OPIATES & ALCOHOL
Dudley Atlantic Recovery	880	505	173	168
Birmingham ROR (Combined)	4329	1010	396	380
Walsall The Beacon	966	427	120	134
Coventry	862	438	140	204
Warwickshire Adult	954	818	213	281
<b>West Midlands Combined</b>	<b>7991</b>	<b>3198</b>	<b>1042</b>	<b>1167</b>

\*In Structured Treatment

16. Moody, M. (2019). CGL Annual Report and Accounts (Year Ended 31st March 2019). [online] London: Change Grow Live. Available at: <https://www.changegrowlive.org/sites/default/files/2019-11/annual-report-2018-19.pdf> [Accessed 14 Jan. 2020].

17. Vaughan, M. and Beese, K. (2019). Change, Grow, Live (CGL) - Overview of Service. [online] Birmingham City Council: CGL, pp.67-142 (Birmingham Health and Wellbeing Board Agenda). Available at: <https://birmingham.cmis.uk.com/Birmingham/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=5QrLRD2ZaxuvWDKtJOeBKKEZJEDZUsRjcRzmelhf3yLSDfCT5CDFLQ%3d%3d&rUzwRPf%2bZ3zd4E7lkn8Lyw%3d%3d=pwRE6AGJFLDNih225F5QMaQWCtPHwdhUfCZ%2fLUQzgA2ul5jNRG4jdQ%3d%3d&mCTIbCubSFfxsDGW9IXnlg%3d%3d=jUgQCaU3L68%3d&kCx1AnS9%2fpWZQ40DXFvdEw%3d%3d=vf9TYtWuxig%3d&uJovDxwdjMPoYv%2bAJvYtyA%3d%3d=ctNJff55vVA%3d&FgPIIEJYlotS%2bYGoBi5oIA%3d%3d=NHdURQburHA%3d&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJff55vVA%3d&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJff55vVA%3d&WGewmoAfeNQ16B2MHuCPMRKZMwaG1PaO=ctNJff55vVA%3d> [Accessed 14 Jan. 2020].



# Out of harm's way

## 2. Context

There are a number of services that CGL delivers in light of the identified required outcomes of the commissioning process, some of these in partnership with other agencies but, essentially, there are two broad categories of drug treatment. These are:

1. Outpatient – the user attends a treatment facility during the day but returns home after the daily session
2. Residential treatment – the user is removed from their usual living environment for the duration of a programme

drawn nationally and considered as best practice for local service provision. Where they are present, CGL operate within the NICE framework. Treatment starts with identification and assessment criteria generated by the providers with referral pathways to keystone services; this leads to treatment options being delivered in line with the principles of care; that is, they are delivered by professionals and rely upon treatment plans that often involve wider family networks. Treatment pathways will often lead to some form of maintenance therapy in different settings and the journey toward detoxification could include the use of methadone or buprenorphine.

### Services typically offered by CGL (Data; CGL – 2017)<sup>18</sup>

Structured Treatment Interventions	Clinical Prescribing
Community Detoxifications	Acute Hospitals
Criminal Justice (Police Stations/Court & Probation)	Prison Release
GP Shared Care	Pharmacy & Needle Exchange
Employment Advice	Night Time Economy
Homeless Services	Outreach
Blood Bourne Virus	BME
Safeguarding	LGBT
Inpatient Detoxification and Aftercare	Residential Rehabilitation
Peer Mentor Volunteer Scheme	Housing Support
Domestic Abuse	Education and Training

Concerns have been raised by the ACMD (Advisory Council for the Misuse of Drugs) about the wider commissioning process. In their view, reduced funding has compromised the capacity of the treatment system to deliver effective drug services. The ACMD has made a number of observations including the protection of current levels of investment, better reporting of local treatment services, greater transparency around performance and the suggestion that the commissioning process should revolve around cycles of between five and ten years.<sup>20</sup>

Notwithstanding the comments above, there are a number of services and professionals working hard to offer a high standard of care to service users across the West Midlands. That said, the evidence review conducted by PHE noted that, “while treatment outcomes in the UK are comparable or sometimes better in comparison with other countries, there are opportunities for further reductions in the use of illicit opiates during treatment and drug related mortality”.<sup>21</sup>

NICE (National Institute for Health and Care Excellence) have established the basic principles of care for those who are dependent on drugs<sup>19</sup> based on examples

The question should therefore be asked, are there additional tools or services that could add value to the existing social and health care services, including DCRs?

18. Warner, S. (2018). Briefing Note For Birmingham Community Safety Partnership 15-03-2017. Birmingham: Change Grow Live 2017.  
 19. Pathways.nice.org.uk. (2019). Drug misuse prevention - NICE Pathways. [online] Available at: <https://pathways.nice.org.uk/pathways/drug-misuse-prevention> [Accessed 3 Jan. 2019].  
 20. ACMD (2017). Commissioning Impact On Drug Treatment - The extent to which commissioning structures, the financial environment and wider changes to health and social welfare impact on drug misuse treatment and recovery. [online] London: ACMD UK. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/642811/Final\\_Commissioning\\_report\\_5.15\\_6th\\_Sept.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642811/Final_Commissioning_report_5.15_6th_Sept.pdf) [Accessed 7 Jun. 2019].  
 21. Public Health England (2017). An Evidence Review of the Outcomes That Can Be Expected of Drug Misuse Treatment in England. London: Crown Copyright 2017.



### 3. Drug Consumption Rooms – What the evidence says

#### Summary

While there are limitations to the research, the evidence available indicates the effectiveness of DCRs in achieving their primary health and public order objectives. This is particularly true when they are meshed with other treatment, harm reduction, housing and support services.

Despite many millions of injections in DCRs around the world, no one has ever died from a heroin overdose in one. While remaining opposed to DCRs, the UK Home Office has also acknowledged the evidence that they can reduce overdose deaths, improve health outcomes, reduce street injecting and discarded needles without increasing crime and disorder.<sup>22</sup>

From a policing perspective, the question is whether a custody block or a prison cell is the best place for someone with drug problems or whether such experiences – and a criminal record – present another obstacle on the journey to recovery and increase the likelihood of reoffending. In such circumstances, a DCR, delivering health interventions as part of a system focused on education, prevention and harm reduction, would offer a more holistic and cost-effective solution.

While recognising the excellent work delivered through existing treatment and support agencies, if a DCR pilot was established in the West Midlands, it could add significant value working in tandem with existing services to:

- Reduce drug-related deaths locally and at city level if coverage is adequate
- Promote safer injecting practices and reduce risky behaviours including rushed injecting
- Reduce syringe sharing and the risk of blood-borne virus transmissions including HIV and hepatitis C
- Reduce the number of ambulance call outs
- Bring a population with complex needs into contact with detoxification and drug treatment services, potentially reducing drug use in the long term

- Improve access to primary healthcare, housing, welfare and other medical services to reduce adverse life circumstances
- Improve the amenity of city centres by reducing drug-related litter and street injecting
- Help tackle drug-related criminal activity and anti-social behaviour
- Save the taxpayer money because DCRs are cost-effective through preventing more complex health issues, and costs associated with responding to crime
- Make a significant contribution to a drug alert framework

#### 3.1 How many DCRs are there?

DCRs are clinical spaces where people dependent on drugs can take their own illegal drugs, using clean equipment, under the supervision of trained staff equipped to treat overdoses. They also provide wider medical support and access to drug treatment and other support services. They are targeted to reach certain groups including homeless people and those not currently engaged in treatment.

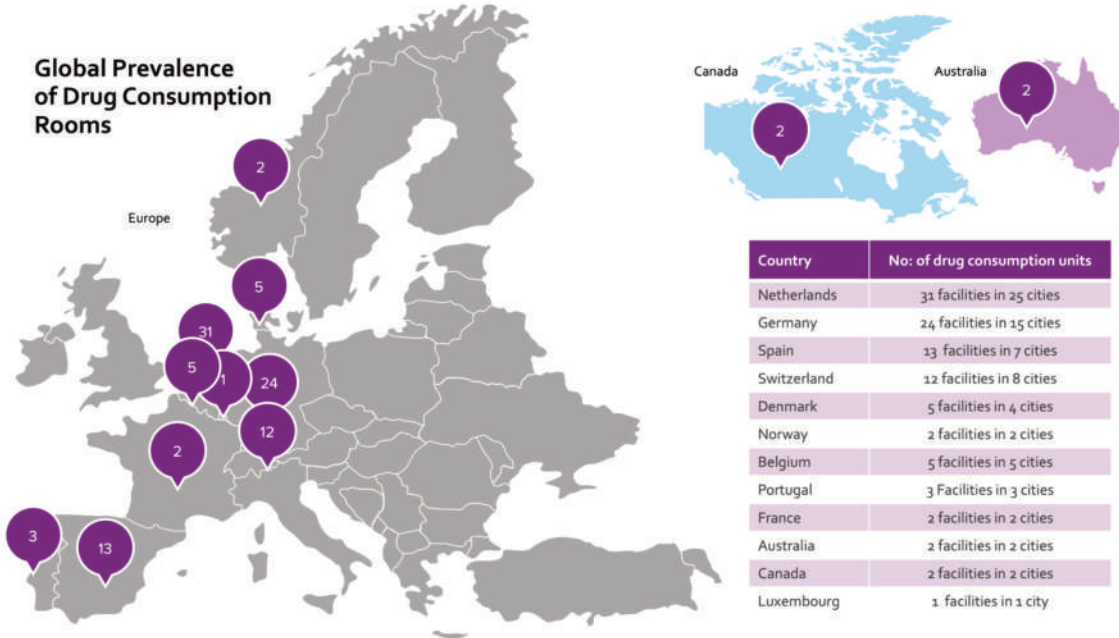
According to the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA),<sup>23</sup> the first supervised Drug Consumption Room opened in Berne, Switzerland in 1986. As of April 2018, there were 31 facilities in twenty-five cities in the Netherlands, 24 in fifteen cities in Germany, 5 in four cities in Denmark, 13 in seven cities in Spain, 2 in two cities in Norway, 2 in two cities in France, 1 in Luxembourg and 12 in eight cities in Switzerland. One has also now opened in the Ukraine. In Ireland, the Misuse of Drugs Act Supervised Injection Facilities 2017 was passed to enable the licensing and regulation of DCRs with planning permission recently granted in Dublin for one; and the locations and area of operation of 2 fixed and 1 mobile supervised drug consumption facilities were announced in Lisbon, Portugal. Based on a feasibility study on drug consumption facilities in five major cities in Belgium (Ghent, Antwerp, Brussels, Liège and Charleroi), the first Belgian DCR, in Liège, opening in September 2018. In Australia, there are 2 DCRs, in Melbourne and Sydney.

22. Glasgow.gov.uk. (2020). Home Office Accepts Public Health Case for Safer Drug Consumption Facility - Glasgow City Council. [online] Available at: <https://www.glasgow.gov.uk/article/22874/Home-Office-Accepts-Public-Health-Case-for-Safer-Drug-Consumption-Facility> [Accessed 19 Feb. 2020].

23. EMCDDA (2018). Drug consumption rooms; an overview of provision and evidence. (Perspectives on Drugs). [online] Lisbon. Available at: [http://www.emcdda.europa.eu/system/files/publications/2734/POD\\_Drug%20consumption%20rooms.pdf](http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf) [Accessed 25 Apr. 2019].

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says



Faced with an opioid overdose crisis, as of September 2019, the Federal Government of Canada has authorised around 50 DCRs since 2017, including the two pre-existing facilities in Vancouver.<sup>24</sup> In addition, there are a range of lower-threshold ‘Overdose Prevention Sites’ (OPSs) that do not have the formal federal legal exemption but are run by provincial health authorities in conjunction with other local bodies. For example, British Columbia alone has over 20 OPSs.<sup>25</sup>

It is anticipated that, by the end of 2020, there will be almost 200 officially sanctioned supervised drug consumption facilities of one design or another either operating or authorised.

There are three models of Drug Consumption Rooms operating in Europe:<sup>26</sup>

**Specialised:** offering a narrower set of services directly related to consumption including injection materials, advice, emergency care and after-care observation.

**Integrated:** low threshold facilities where supervision of drug consumption is one part of a survival-orientated set of services offered including the provision of food, needle exchange, counselling, showers and condoms etc.

**Mobile Facilities:** a mobile service that moves from one locality to another but offers similar services to that of a specialised service.<sup>27</sup>

People using these facilities may have access to a range of services including provision of food, showers, clothing, harm reduction advice, prevention materials, clean needles and counselling and treatment, depending on the design.

24. Health Canada. (2019). Supervised consumption sites: Guidance for Application Form - Canada.ca. [online] Canada.ca. Available at: <https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html> [Accessed 27 Dec. 2019].

25. Wwww2.gov.bc.ca. (2019). Overdose Prevention - Province of British Columbia. [online] Available at: <https://www2.gov.bc.ca/gov/content/overdose/what-you-need-to-know/overdose-prevention> [Accessed 27 Dec. 2019].

26. Ibid, P3. EMCDDA (2018.)

27. Ibid, P3. EMCDDA (2018.)

### Professionals in a DCR



Source: Based on Figure 7 in Belackova et al. 2017<sup>28</sup>

### 3.2 Potential benefits

Proposed benefits for DCRs can be divided into reducing harms to individuals such as wounds, overdose deaths and blood-borne viruses, while providing a place of sanctuary, support and access to other services. They have also been said to reduce harms affecting communities such as discarded syringes, street injecting and inefficient use of resources.

Depending on where DCRs are located, the type, size and communities who access the facilities, means that caution is required when making direct comparisons between sites. That said the evidence available indicates the effectiveness of DCRs in achieving their primary health and public order objectives. This is particularly true when they are meshed with other treatment, harm reduction, housing and support services.

28. Belackova, V., & Salmon, A. M. (2017), Overview of international literature - supervised injecting centers & drug consumption rooms – Issue 1, Uniting Medically supervised injecting center, Sydney.

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

Notably, while remaining opposed to DCRs, the UK Home Office has acknowledged that they can reduce overdose deaths, improve health outcomes, reduce street injecting and discarded needles, without increasing crime and disorder. For example, a letter from the Home Office Drug Legislation Team to Glasgow City Council (which had voted unanimously to open a DCR<sup>29</sup>) says:

“The Government’s own report, *Drugs: International Comparators (2014)*, acknowledges that there is some evidence for the effectiveness of drug consumption rooms in addressing the problems of public nuisance associated with open drug scenes, and in reducing health risks for drug users. The Government’s Advisory Council on the Misuse of Drugs (ACMD) has also provided additional evidence based on studies of the effectiveness of facilities in Vancouver and Sydney, noting that they reduce injecting risk behaviours and overdose fatalities. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) too finds that drug consumption facilities have the ability to reach and maintain contact with high-risk drug users who are not ready or willing to quit drug use.”<sup>30</sup>

### 3.3 Reducing drug related deaths

Perhaps most strikingly, despite many millions of injections in DCRs around the world, operating in different social and healthcare systems over three decades, no one has ever died from an overdose in a DCR.

The most recent research available (June 2019) by the British Columbia Centre for Disease Control concluded that overdose deaths would be more than twice as high in British Columbia

in Canada (which has a population around double that of the West Midlands) without the scaling up of harm reduction measures including naloxone provision, Opioid Substitution Therapy and Supervised Drug Consumption Rooms. The rapid development of a network of DCRs alone saved around 230 (range 160-350) lives in a twenty month period in the province.<sup>31</sup> While Canada is suffering a worse overdose crisis than most of the UK (the exception being Scotland which has a similar drug death rate), this is a powerful indication of the potential for DCRs, as part of a wider drug treatment and support system, to save lives.

This is a position supported by the UK Government’s Advisory Council on the Misuse of Drugs in several reports, including one specifically concerning reducing opioid-related deaths which called for DCRs to be piloted. This position was repeated most recently by the ACMD in a report released in June 2019 about reducing harms from drugs to the homeless which also notes that: “The EMCDDA fully supports the use of safer injecting sites to prevent overdose deaths.”<sup>32</sup>

### Interventions to reduce opioid-related deaths

(Data Source: EMCDDA (2017)<sup>33</sup>)



29. Hunter, M., Cllr. (2018). Safe drug consumption rooms – Motion approved. [online] Glasgow City Council. Available at:

<http://www.glasgow.gov.uk/Councillorsandcommittees/viewSelectedDocument.asp?c=P62AFQDN2U0G0GUTT1>

30. Home Office UK (2018). Ref TRO/0003293/18. London SW1P: Drugs and Alcohol Unit - Home Office UK. Available at:

<http://www.glasgow.gov.uk/councillorsandcommittees/viewSelectedDocument.asp?c=P62AFQDN2UZLZ30GNT> [Accessed 22 Dec. 2019]

31. British Columbia Centre for Disease Control (2019). Overdose deaths would be at least twice as high without emergency harm reduction and treatment response. [online] Vancouver: BCCDC. Available at: <http://www.bccdc.ca/about/news-stories/news-releases/2019/overdose-deaths-would-be-at-least-twice-as-high> [Accessed 11 Dec. 2019].

32. Advisory Council on the Misuse of Drugs (2019). Drug-related harms in homeless populations and how they can be reduced. [online] London UK, p.29. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/810284/Drug-related\\_harms\\_in\\_homeless\\_populations.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf) [Accessed 28 Dec. 2019].

33. EMCDDA (2018). Preventing Overdose deaths in Europe. [online] Lisbon: EMCDDA, p.2. Available at:

[http://www.emcdda.europa.eu/system/files/publications/2748/POD\\_Preventing%20overdose%20deaths.pdf](http://www.emcdda.europa.eu/system/files/publications/2748/POD_Preventing%20overdose%20deaths.pdf) [Accessed 28 Nov. 2019].

The systematic literature review of DCRs undertaken by Kennedy et al<sup>34</sup> scrutinised 47 studies of DCRs in Canada, Sydney, Germany, Denmark, Spain and the Netherlands. They concluded that the literature evinces the significant impact that DCRs have on managing overdose incidents and reducing overdose mortality.

“Consistent evidence demonstrates that SCFs [DCRs] mitigate overdose-related harms and unsafe drug use behaviours, as well as facilitate uptake of addiction treatment and other health services among people who use drugs (PWUD). Further, SCFs have been associated with improvements in public order without increasing drug-related crime. SCFs have also been shown to be cost-effective.” Kennedy, Karamouzian and Kerr.

A similar review by Milloy et al<sup>35</sup> sought to estimate the number of deaths potentially averted by the implementation of the medically supervised safer injection facility in Vancouver and found that, in a four year period from 2004-8, there were 766,486 injections in the facility resulting in 1004 overdose events, none of which resulted in death, with 453 requiring the provision of naloxone. The study went on to suggest that the number of overdose deaths averted over the study period was 50.9 which equates to between 2 and 12 per annum. The story is similar for the DCR in Sydney where the Evaluation Committee (2003) estimated that the clinic saved four lives annually.<sup>36</sup>

Nearer to home, in Germany, a national survey was conducted in 2009 across 11 cities and 13 facilities to assess the impact of DCRs in relation to drug related deaths due to overdose. During the six-month project,

266 drug emergencies were documented of which 139 were rated as low/medium while 124 were indicated as severe/life threatening. It is likely that a proportion of these people would not have survived the emergency situation in a different setting, such as their own home or open public spaces, particularly if they were alone. So, in this context, the employees of the DCR are highly likely to have saved lives.<sup>37</sup>

A review by Caulkins et al<sup>38</sup> notes that DCRs have a strong ‘logic model’, i.e. no one has ever died from an overdose in a DCR despite millions of injections or caught a blood-borne disease in one, and it is undoubtedly safer to inject under supervision. So, logically, DCRs probably reduce risks to people who use drugs.

The authors also note that the published literature on DCRs is large and almost unanimous in its support. However, they comment that it is also limited in nature in view of the number of sites evaluated (with much of it examining Insite in Canada and the MSIC in Sydney) and a lack of Randomised Controlled Trials (RCTs) which are hard to achieve for a DCR. Comparisons tend to be made by comparing an area with a DCR with a similar area that does not have one. However, for example, randomly refusing entry to half the people who want to use the DCR so that they have to inject in the street or elsewhere then trying to monitor how many of them die from an overdose etc. versus those allowed to use the DCR would be problematic for a range of practical and ethical reasons.

34. Kennedy, M., Karamouzian, M. and Kerr, T. (2017). Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review. *Current HIV/AIDS Reports*, [online] 14(5), pp.161-183. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28875422> [Accessed 9 Sep. 2018].

35. Milloy, M., Kerr, T., Tyndall, M., Montaner, J. and Wood, E. (2008). Estimated Drug Overdose Deaths Averted by North America's First Medically-Supervised Safer Injection Facility. *PLoS ONE*, [online] 3(10), p.e3351. Available at: [https://www.hri.global/files/2010/08/23/Milloy\\_-\\_Estimated\\_Drug\\_OD\\_Deaths.pdf](https://www.hri.global/files/2010/08/23/Milloy_-_Estimated_Drug_OD_Deaths.pdf) [Accessed 11 April. 2019].

36. MSIC (2003). Final report of the evaluation of the Sydney Medically Supervised Injecting Centre. [online] Sydney, Australia: MSIC Evaluation Committee. Available at: [https://www.drugsandalcohol.ie/5706/1/MSIC\\_final\\_evaluation\\_report.pdf](https://www.drugsandalcohol.ie/5706/1/MSIC_final_evaluation_report.pdf) [Accessed 9 Apr. 2019].

37. Köthner, U., Langer, F. and Klee, J. (2011). Drug Consumption Rooms in Germany. [online] Berlin: Deutsche AIDS-Hilfe e.V., p.18. Available at: [https://www.aidshilfe.de/sites/default/files/documents/DAH\\_akzept\\_DCR%20in%20Germany\\_2011.pdf](https://www.aidshilfe.de/sites/default/files/documents/DAH_akzept_DCR%20in%20Germany_2011.pdf) [Accessed 11 Apr. 2019].

38. Caulkins, J., Pardo, B. and Kilmer, B. (2019). Supervised consumption sites: a nuanced assessment of the causal evidence. *Addiction*, 114(12), pp.2109-2115.

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

So, the authors question to what extent the benefits noted for the few sites evaluated can be confidently extrapolated to other DCRs with different designs in different environments. They conclude that, while DCRs may be saving lives, on the basis of the research they reviewed there was currently a lack of strong evidence for a direct causal link between observed benefits and the DCRs themselves. However, as they also note, their review mentions, but did not incorporate, the latest research from British Columbia noted above which was published as this paper was being prepared and which does make a strong link between DCRs and reduction in overdose deaths.

More importantly, the authors point towards the need to find a nuanced position between, on the one hand, not opening any new DCRs because no RCTs have been undertaken to 100% demonstrate that they work and, on the other, because people are dying on the streets but not one has died from an overdose in a DCR. Therefore, immediate expansion is imperative and anything less is immoral.

As they note: “Given the scale and rapid evolution of the overdose crisis...there ought to be greater policy innovation, not just evaluation of traditional models. After all, the adage says that necessity is the mother of invention, not just replication of existing evidence-based practice.”

This approach of enabling further pilots is also supported by recently published research (Nov 2019) also from British Columbia which concluded that frequent use of DCRs not only reduced the risk of death inside the facility, but also when clients are outside it as well i.e. they lead to beneficial behavioural or other changes that continue once the client is back in the outside environment:

“Frequent SIF [DCR] use was associated with a lower risk of death, independent of relevant confounders. These findings support efforts to enhance access to SIFs as a strategy to reduce mortality among PWID.”<sup>39</sup>

Suggesting further pilots, including in UK-specific environments with rigorous evaluation, would be a reasonable approach to take.

### 3.4 Accessing information and advice

Unsafe injecting practice – including rushed injections, poor hygiene and poor techniques can lead to injuries, abscesses and infections. These can be painful and lead to severe short and long term health problems, including potential fatality. They are also expensive to treat. A range of factors can encourage risky injecting practices including homelessness, injecting in public places, fear of policing and a lack of education or sterile injecting equipment.

Many of the harms relating to injecting drug use can be minimised or avoided when better injection practices are used. Evidence suggests that DCRs can be an effective source of harm reduction information, education and advice leading to changes in clients’ behaviour when injecting inside and outside of the facilities. Belackova et al<sup>40</sup> cite a number of studies that suggest the effectiveness of DCRs when it comes to reducing unsafe injection practices. The first four relate to Insite, the facility based in the Vancouver, and are summarised as follows;

1. Stoltz et al.<sup>41</sup> research found that, when injecting took place outside of the DCR, service users were found to be three times more likely to use sterile water, 2.8 times more likely to clean their injection site before using, more than twice as likely to safely dispose of their used needles and 2.8 times more likely not to rush the injection process when compared to those who did not use the DCR.

39. Kennedy, M., Hayashi, K., Milloy, M., Wood, E. and Kerr, T. (2019). Supervised injection facility use and all-cause mortality among people who inject drugs in Vancouver, Canada: A cohort study. *PLOS Medicine*, [online] 16(11), p.e1002964. Available at: [https://www.researchgate.net/publication/337551109\\_Supervised\\_injection\\_facility\\_use\\_and\\_all-cause\\_mortality\\_among\\_people\\_who\\_inject\\_drugs\\_in\\_Vancouver\\_Canada\\_A\\_cohort\\_study](https://www.researchgate.net/publication/337551109_Supervised_injection_facility_use_and_all-cause_mortality_among_people_who_inject_drugs_in_Vancouver_Canada_A_cohort_study) [Accessed 19 Feb. 2020].

40. Ibid, p 8,11 & 12. Belacova and Salmon (2017)

41. Stoltz, J., Wood, E., Small, W., Li, K., Tyndall, M., Montaner, J. and Kerr, T. (2007). Changes in injecting practices associated with the use of a medically supervised safer injection facility. *Journal of Public Health*, 29(1), pp.35-39.

2. Petrar et al.<sup>42</sup> surveyed 1,082 service users and discovered that 75% of them claimed their injecting behaviour had changed as a result of using the DCR.
3. Wood et al.<sup>43</sup> discovered that 48% of respondents who also used Insite reported receiving safer injection education and advice. This was particularly helpful for those who rely on others to inject.
4. Fast's<sup>44</sup> analysis at Insite concluding that "The overall environment at the facility encouraged them to adopt safer practices and to make a habit of using them both within and outside the facility"

Research along the same theme was also noted at facilities in Sydney, Australia where, over a six year period, injection and vein care advice was given out approximately 20,000 times by MSIC staff at the National Centre in HIV Epidemiology and Clinical Research (NCHECR);<sup>45</sup> 56% of service users reported making changes to their injecting practice where they had improved their injection technique since coming into contact with the DCR, 54% reported a reduced likelihood of needle sharing and 54% an increased understanding of overdose risk.

In the Netherlands, service users based at the Arnhem DCR reported that safer injection education had increased their knowledge and that they were taking less risks as a result while service users in Rotterdam reported overwhelmingly positive changes in their injecting hygiene and cleanliness since receiving education from their DCR according to Hedrich<sup>46</sup>. In Germany, the work of Stoever<sup>47</sup> also identified a strong link between the use of DCRs and a reduction in risk behaviours with one fifth of respondents saying their injection practice had changed as a result of information they had received at their DCR. According to Schatz & Nougier,<sup>48</sup> 26 German DCRs reported that their clients experienced fewer abscesses and less drug-related health problems in general.

42. Petrar, S., Kerr, T., Tyndall, M., Zhang, R., Montaner, J. and Wood, E. (2007). Injection drug users' perceptions regarding use of a medically supervised safer injecting facility. *Addictive Behaviors*, 32(5), pp.1088-1093.

43. Wood, R., Wood, E., Lai, C., Tyndall, M., Montaner, J. and Kerr, T. (2008). Nurse-delivered safer injection education among a cohort of injection drug users: Evidence from the evaluation of Vancouver's supervised injection facility. *International Journal of Drug Policy*, 19(3), pp.183-188.

44. Fast, D., Small, W., Wood, E. and Kerr, T. (2008). The perspectives of injection drug users regarding safer injecting education delivered through a supervised injecting facility. *Harm Reduction Journal*, 5(1), p.32.

45. National Centre in HIV Epidemiology and Clinical Research (2007). Sydney Medically Supervised Injection Centre interim Evaluation Report No.3: Evaluation of Client Referral and Health Issues. [online] Sydney, Australia: NCHECR. Available at: <https://kirby.unsw.edu.au/sites/default/files/kirby/report/IntEvalReport3SMSIC%2B.pdf> [Accessed 29 Dec. 2019].

46. Ibid, p49. Hedrich (2004)

47. Stoever, H. (2002). Consumption Rooms — A Middle Ground between Health and Public Order Concerns. *Journal of Drug Issues*, 32(2), pp.597-606.

48. Schatz, E. and Nougier, M. (2012). IDPC Briefing Paper - Drug Consumption Rooms: Evidence and Practice. SSRN Electronic Journal. [online] Available at: [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2184810](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2184810).

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

### 3.5 Reducing risky injecting behaviour

Sharing of equipment such as syringes, needles, filters and spoons is known to spread infection of blood borne viruses. Belackova and Salmon's literature review lists a

number of studies that show DCRs have a positive impact upon risky behaviours among PWID. The table below lists their findings.<sup>49</sup>

Kerr et al <sup>50</sup>	Concluded that users of Insite, when injecting outside of the facility, were 70% less likely to share needles than those who did not use the facility.
Bravo et al <sup>51</sup>	Found that service users in Madrid and Barcelona were less likely to share needles if injecting outside of the DCR.
Kinnard et al <sup>52</sup>	Three-quarters of DCR service users in Copenhagen reported a reduction in their injection risk behaviours.
Hedrich <sup>53</sup>	Three surveys conducted on service users in Berne, Switzerland (1990, 1995 and 2001) found that the rates and perceived acceptability of sharing injecting equipment fell considerably.
MSIC Evaluation Committee <sup>54</sup>	While HCV and HIV infection rates from 1998 to 2002 rose across Sydney as a whole, new infection rates in the area surrounding the DCR remained stable.
Bayoumi & Zaric <sup>55</sup>	Estimated that Insite would prevent between 1191 and 1517 HIV infections over the following 10 year period.
Andresen & Boyd <sup>56</sup>	Estimated that Insite prevented 35 new HIV infections annually.
Pinkerton <sup>57</sup>	Concluded that, if Insite were to close, HIV infections among PWIDS in Vancouver would rise from 179 to 263 per year, an increase of 68%.

The research above should be treated with a degree of caution as a common understanding amongst some researchers, for example Hedrich<sup>58</sup>, warns of the difficulties in establishing the causal effects of DCRs upon BBV transmission rates among PWIDs.<sup>59</sup> However, it is acknowledged that DCRs have a tendency to attract PWIDs and the homeless who, as has already been noted, are at greatest risk of BBV

infection according to Wood.<sup>60</sup> In addition, many DCRs offer BBV screening services to PWIDs and make referrals to treatment services for service users found to be infected.

In the UK, the Hepatitis C Trust<sup>61</sup>, National AIDS Trust<sup>62</sup> and other HIV and hepatitis related groups are supporters of DCRs.

49. Ibid, P8, 11 & 12. Belacova and Salmon (2017)

50. Kerr, T., Tyndall, M., Li, K., Montaner, J. and Wood, E. (2005). Safer injection facility use and syringe sharing in injection drug users. *The Lancet*, 366(9482), pp.316-318.

51. Bravo, M., Royuela, L., De la Fuente, L., Brugal, M., Barrio, G. and Domingo-Salvany, A. (2009). Use of supervised injection facilities and injection risk behaviours among young drug injectors. *Addiction*, 104(4), pp.614-619.

52. Kinnard, E., Howe, C., Kerr, T., Skjødt Hass, V. and Marshall, B. (2014). Self-reported changes in drug use behaviors and syringe disposal methods following the opening of a supervised injecting facility in Copenhagen, Denmark. *Harm Reduction Journal*, 11(1), p.29.

53. Hedrich, D. (2004). European Report On Drug Consumption Rooms. [online] Luxembourg: European Monitoring Centre for Drugs and Drug Addiction. Available at: [http://www.emcdda.europa.eu/attachements.cfm/att\\_2944\\_EN\\_consumption\\_rooms\\_report.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf) [Accessed 24 Apr. 2019]

54. Ibid, p12. MSIC Evaluation Committee (2003)

55. Bayoumi, A. and Zaric, G. (2008). The cost-effectiveness of Vancouver's supervised injection facility. *Canadian Medical Association Journal*, [online] 179(11), pp.1143-1151. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582765/> [Accessed 23 Dec. 2019].

56. Andresen, M. and Boyd, N. (2010). A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. *International Journal of Drug Policy*, 21(1), pp.70-76.

57. Pinkerton, S. (2010). Is Vancouver Canada's supervised injection facility cost-saving?. *Addiction*, 105(8), pp.1429-1436.

58. Ibid, p77. Hedrich (2004)

59. Kimber, J., Palmateer, N., Hutchinson, S., et al. (2010). Harm reduction among injecting drug users: evidence of effectiveness, in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Harm reduction: evidence, impacts and challenges*, Rhodes, T. and Hedrich, D. (eds), Scientific Monograph Series No10, Publications Office of the European Union, Luxembourg.

60. Wood, E., Tyndall, M., Li, K., Lloyd-Smith, E., Small, W., Montaner, J. and Kerr, T. (2005). Do Supervised Injecting Facilities Attract Higher-Risk Injection Drug Users?. *American Journal of Preventive Medicine*, 29(2), pp.126-130.

61. Hepatitis C Trust. (2019). The Hepatitis C Trust welcomes Labour Party support for drug consumption rooms. [online] Available at: <http://www.hepctrust.org.uk/blog/mar-2019/hepatitis-c-trust-welcomes-labour-party-support-drug-consumption-rooms> [Accessed 29 Dec. 2019].

62. Nat.org.uk. (2019). Glasgow's major HIV outbreak amongst people who inject drugs shows no sign of slowing | National AIDS Trust - NAT. [online] Available at: <https://www.nat.org.uk/blog/glasgows-major-hiv-outbreak-amongst-people-who-inject-drugs-shows-no-sign-slowing> [Accessed 29 Dec. 2019].



### 3.6 Engaging the 'hard to reach'

The NHS refers to people who use drugs problematically as often experiencing a combination of social vulnerabilities including homelessness, recent incarceration and chronic poverty.<sup>63</sup> It is also well documented that the stigmatisation of people who use drugs leads to them feeling alienated, mistrustful of those in authority and unwilling to come forward for help. As a result, the most chaotic homeless people who use drugs are extremely difficult to engage with services, including treatment.

The EMCDDA concluded in its wide-ranging review of DCRs that: "The effectiveness of drug consumption facilities to reach and stay in contact with highly marginalised target populations has been widely documented. This contact has resulted in immediate improvements in hygiene and safer use for clients, as well as wider health and public order benefits."<sup>64</sup>

The Government's Advisory Council on the Misuse of Drugs agrees:

"The use of supervised injection sites is often most effective for the hardest to reach homeless drug users, providing a safe space for safe injecting practice, medical attention, prevention of overdose and engagement with health care service...[and to] maintain contact with and act as access points for housing and other social services for highly marginalised target populations has been widely documented."<sup>65</sup>

For example, in a study undertaken in Vancouver over a nine-month period with young people between the ages of 14 and 26, Hadland et al<sup>66</sup> found that DCRs were successful in attracting the young and homeless as well as high frequency injectors, the cohort most likely to contract a blood borne infection and also often difficult to

engage with services. The research found that 42.3% of 414 injecting youths reported using the DCR at least once and, of all the youths using the DCR, 51.4% visited the facility at least weekly while 44.5% used it for at least a quarter of all injections. The DCR therefore attracted a high proportion of young drug users, those who are most at risk of blood-borne infection and overdose and who would otherwise inject in public spaces.

Although there are no DCRs in the USA, Bouvier et al<sup>67</sup> investigated the factors associated with willingness to use a DCR among young participants who were habitual drug injectors in the state of Rhode Island which has experienced high rates of drug related deaths over the past 10 years and now has one of the highest per capita overdose mortality rates in the USA. The research concluded that six out of 10 young adults who used opioids, or were at risk of initiating drug use, reported willingness to use a DCR and therefore Supervised Injection Facilities merited further consideration to reduce overdose mortality in the USA.

In terms of restrictions that might deter hard to reach groups from accessing a DCR, Potier et al<sup>68</sup> stated that some of those who were considered as 'at risk' were unable to self-inject due to poor veins or physical impairment. This meant they had to rely upon a network of other users, friends or intimate partners to insert the needle.<sup>69</sup> Because some DCRs, due to legal parameters, are not allowed to assist with injections, this cohort of 'hard to reach' users was sometimes excluded from using the facility. Notwithstanding this issue, Potier et al<sup>70</sup> concluded that, despite differences in operation, "DCRs ubiquitously and effectively succeeded in attracting the marginalised PWID, i.e., those who generally have not joined any already existing care system".

63. NHS 2017. "Taking away the chaos" The health needs of people who inject drugs in public places in Glasgow city centre. Glasgow: NHS Greater Glasgow and Clyde.

64. Ibid, p2 (Analysis). EMCDDA (2018)

65. ACMD (2018). Drug-related harms in homeless populations and how they can be reduced. [online] p.29. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/810284/Drug-related\\_harms\\_in\\_homeless\\_populations.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf) [Accessed 30 Oct. 2019].

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/810284/Drug-related\\_harms\\_in\\_homeless\\_populations.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf)

66. Hadland, S. E., Debeck, K., Kerr, T., Nguyen, P., Dobrer, S., Montaner, J. S. & Wood, E. 2014. Use of a Medically Supervised Injection Facility Among Drug-Injecting Street Youth. *Journal of Adolescent Health*, 54, S88-S89.

67. Bouvier, B. A., Elston, B., Hadland, S. E., Green, T. C. & Marshall, B. D. 2017. Willingness to use a supervised injection facility among young adults who use prescription opioids non-medically: a cross-sectional study. *Harm Reduct J*, 14, 13.

68. Potier, C., Lapr v te, V., Dubois-Arber, F., Cottencin, O. & Rolland, B. 2014. Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*, 145, 48-68.

69. Tom, M. (2017). A Review of the Effectiveness of Medically Supervised Injecting Centres. Pontypridd: Advisory Panel on Substance Misuse, p.26.

70. Ibid, p18. Potier et al (2014)

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

### 3.7 Improving access to treatment

At the end of the pilot that saw the DCR established in Sydney, a final report by KPMG assessed the outcomes of the project based on the proposed benefits:<sup>71</sup>

1. Decreasing overdose deaths
2. Providing a gateway to drug treatment
3. Reducing discarded needles and drug use in public places
4. Reducing the spread of diseases such as HIV and hepatitis C

The report revealed all the Government's objectives were met throughout the pilot including bullet point number 2 above. The findings recognised that, while the treatment options for people experiencing alcohol and other drug problems were wide ranging, for those with long term dependence on opioids, effective drug treatment options, and routes into them, became more limited. As a result, the referral of clients became key to the facility, helping to create links to other services that could offer help.

The DCR also provided the professionals with the opportunity to identify the 'right time to refer' based on the idea that, on average, opioid dependent people take a minimum of 3.3 years before entering treatment. The change of behaviour moves through four key stages – pre-contemplation, contemplation, action and maintenance. The facility staff were well positioned to "over time, develop strong therapeutic relationships with clients and more easily encourage and support the client to move through the stages of change from pre-contemplation, to contemplation, to action, at which point clients can be referred to drug treatment" (KPMG).<sup>72</sup>

The EMCDDA's review of the evidence also concluded that the use of DCRs is "associated with increased uptake both of detoxification and drug dependence treatment, including opioid substitution. For example, the Canadian cohort study documented that attendance at the Vancouver facility was associated with increased rates of referral to addiction care centres and increased rates of uptake of detoxification treatment and methadone maintenance."<sup>73</sup>

Research has also demonstrated that DCRs were positively associated with consistent condom use among drug users with regular but not casual partners.<sup>74</sup>

### 3.8 Offering sanctuary to the vulnerable

McNeil et al<sup>75</sup> talk about the "risk environment" where risk and harm are the product of the interplay between types of environment (i.e., social, physical, economic and political) operating at different levels of environmental influence. Their research looked closely at the cohort of users who required help injecting from another person, a boyfriend/girlfriend or family friend, who they felt were disproportionately vulnerable to drug related harm. Not only were they more likely to contract disease from their helpers by using the same needle, they were more prone to infection, violence, overdose and were often shaped by gender powered relationships of an intimate nature.

71. KPMG. Further evaluation of the Medically Supervised Injecting Centre during its extended trial period 2007-2011. (2010). [online] Sydney, Australia, pp.5, 17,18,19 & 20. Available at: <https://www.health.nsw.gov.au/aod/resources/Documents/msic-kpmg.pdf> [Accessed 12 Apr. 2019].

72. Ibid, p54. KPMG (2010).

73. Ibid, p2 (Analysis). EMCDDA (2018)

74. Marshall, B., Wood, E., Zhang, R., Tyndall, M., Montaner, J. and Kerr, T. (2008). Condom use among injection drug users accessing a supervised injecting facility. *Sexually Transmitted Infections*, 85(2), pp.121-126.

75. Ibid, p473. McNeil et al (2013)

Women were perceived as being more vulnerable because they are shaped by everyday violence – “rendered invisible due to its pervasiveness” whereupon older males competed with one another to control young women by “initiating them to inject drug use”. Male injectors then assumed control over the resources generated by the women (typically via street-based sex work) often forbidding women to self-inject under threat of physical violence. McNeil and Small’s<sup>76</sup> research demonstrated how the off-street environment associated with a DCR helped clients to escape the violence and exploitation that shaped the local drug scene. While interpersonal conflicts sometimes occurred, prevailing social norms within the drug scene did not, in particular acts of violence and exploitation associated with assisted injection. Fairbairn et al<sup>77</sup> added further to the discussion referring to the ability of a DCR to “mediate the impact of violence among women during the injection process”.

The research concludes that DCRs are a unique controlled environment where “women who inject drugs are provided refuge from violence and gender norms that shape drug preparation and consumption practices”.

Hunt’s<sup>78</sup> qualitative study interviewed users regarding the risks to health as a result of injecting. The conversations revealed a desire to use a DCR because it was associated with a place of “comfort”, offering a sense of “safety” which alleviated concerns about injecting on the street where “coppers” and “little kids” would see them. They were also keen to access medical

treatment and advice, viewing the facilities as somewhere to go “as a relief from outdoors”.

On a similar theme of safety, Bouvier et al.<sup>79</sup> found that PWIDs demonstrated a willingness to use DCRs where they would feel safer after injecting the drug, particularly if they had accidentally overdosed in the past. The KPMG<sup>80</sup> interviews with clients endorsed this view that DCRs provided a safe place to wait where they must remain for at least 15 minutes before departing. They liked being able to sit down for a short while with a coffee – even if they felt fine – and where, as part of the post injection process, staff “keep an eye” on everyone; “staff never seem to be watching you but, as soon as something’s wrong, they’re there like a shot, sometimes before anyone else has noticed anything at all”. They also liked the idea that there were “multiple opportunities to obtain advice and information”.

### 3.9 Reductions in street injecting and discarded needles

One of the main concerns of the public around drug use is the prevalence of street injecting and discarded needles. Both pose problems to people who use drugs, local businesses and the wider community. One of the arguments made in favour of DCRs is their potential to take injecting off the streets and into a clinical environment with clean needles that are disposed of safely.

76. Ibid, p479. McNeil et al (2013)

77. Fairbairn, N., Small, W., Shannon, K., Wood, E. & Kerr, T. 2008. Seeking refuge from violence in street-based drug scenes: women’s experiences in North America’s first supervised injection facility. *Soc Sci Med*, 67

78. Hunt, N. (2006). Indicators of the need for drug consumption rooms in the UK. [online] Joseph Rowntree Foundation. Available at: <https://pdfs.semanticscholar.org/3f3d/2777753243a56efb574dcf5a2abb4cab35b9.pdf> [Accessed 30 Dec. 2019].

79. Bouvier, B., Elston, B., Hadland, S., Green, T. and Marshall, B. (2017). Willingness to use a supervised injection facility among young adults who use prescription opioids non-medically: a cross-sectional study. *Harm Reduction Journal*, 14(1),p.1.

80. Ibid, p203. KPMG (2010)

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

Potier et al<sup>81</sup> notes the work completed in Sydney and Vancouver in relation to public nuisance that focused mainly on reducing syringe litter and public injecting. Year-long research by McKnight et al<sup>82</sup> engaged with users to examine the factors associated with public drug injection and found that DCRs contributed to a significant reduction of drug injection in public spaces. This concurred with the work completed by Salmon et al<sup>83</sup> who looked at the community perceptions of a public amenity where supervised injecting centres operated. The research, conducted in Sydney via survey, showed that “there was a significant decrease in the proportion of residents and business operators who reported having witnessed public injecting and publicly discarded injecting equipment”. Moreover, residents were less likely to have seen public injecting in the previous month if they were female, retired or lived over 500m from the DCR.

Nearer to home, the work of Hedrich<sup>84</sup> explored whether the expected benefits of DCRs had been realised in Europe, namely:

- Reduced drug use in public
- Reduced level of nuisance in neighbourhoods with visible drug scenes

Hedrich<sup>85</sup> cites Poschadel et al<sup>86</sup> who found that drug users preferred a safe hygienic and stress free environment to consume their drugs because it allows them to avoid use in public, especially in places where they themselves find it unacceptable to inject, such as playgrounds or parks. The 168 clients interviewed in 18 consumption rooms across Germany considered the

opportunity to avoid public drug use to be one of the most positive aspects of the service. Furthermore, 64% considered consumption rooms to be their “most important” place of drug use, compared with only 6% reporting that they used drugs most frequently in public spaces.

In Biel, Switzerland, where the DCR had been open for one year, 49% said that this was where they had most often used drugs. The same percentage said that they had used mainly at home, with only one client continuing to inject in public. In Geneva, 61% of clients interviewed in 2002 reported that they had most frequently injected at home with 29% regularly using the DCR and 10% continuing to inject in public. However, the service in Geneva had been running for less than five months at the time of the survey. Finally, Hedrich<sup>87</sup> refers to Van der Poel et al<sup>88</sup> and the statistics in Rotterdam where 80% of DCR card holders were reported as having used less often in public after becoming registered service users.

Needle litter is unsightly, off-putting to businesses and can pose issues to the general public who, if accidentally pricked, run a small risk of becoming infected with HIV, hepatitis B or C and thus may be deterred from using parks and other amenities. Changes in the number of syringes and needles found in public spaces in the vicinity of a DCR may be an indicator of its success in reducing street injecting. In Barcelona, after opening the DCR, the number of syringes collected on the streets fell from a monthly average of just under 13,500 syringes in 2004 to just under 4000 in 2012.<sup>89</sup>

81. Ibid, p53. Potier et al (2014)

82. McKnight, I., Maas, B., Wood, E., Tyndall, M., Small, W., Lai, C., Montaner, J. and Kerr, T. (2007). Factors Associated with Public Injecting Among Users of Vancouver's Supervised Injection Facility. *The American Journal of Drug and Alcohol Abuse*, 33(2), pp.319-325.

83. Salmon, A., Thein, H., Kimber, J., Kaldor, J. and Maher, L. (2007). Five years on: What are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre?. *International Journal of Drug Policy*, 18(1), pp.46-53.

84. Ibid, p61 & 63. Hedrich (2004)

85. Ibid, p44. Hedrich (2004)

86. Poschadel, S., Höger, R., Schnitzler, J. and Schreckenberger, J. (2003) Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland: Endbericht im Auftrag des Bundesministeriums für Gesundheit. Das Bundesministerium für Gesundheit und Soziale Sicherung (Schriftenreihe Bd 149). Baden-Baden: Nomos-Verlags- Gesellschaft.

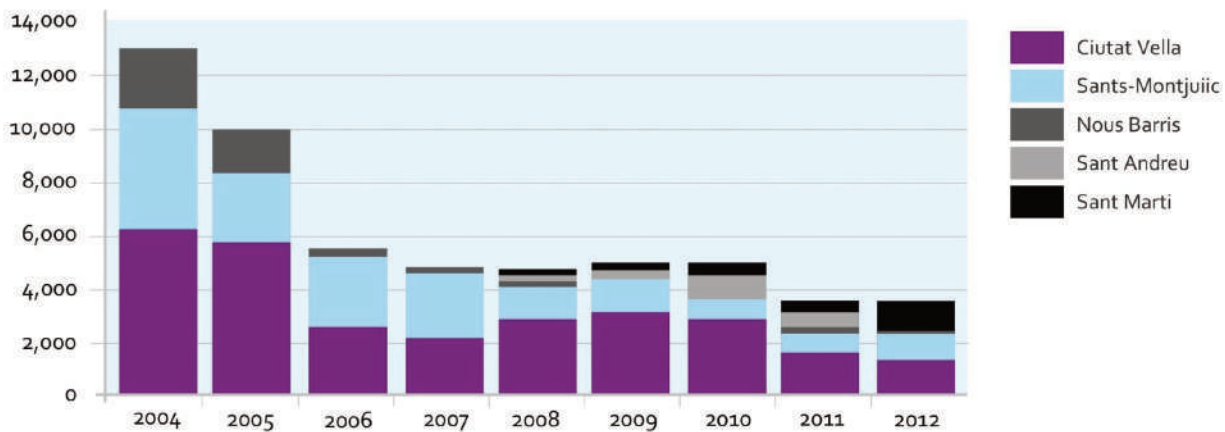
87. Ibid, p47 Hedrich (2004)

88. van der Poel, A., Barendregt, C. and van de Mheen, D. (2003) Drug consumption rooms in Rotterdam: an explorative description. *European Addiction Research*, 9, 94–100.

89. EMCDDA (2016). 2. Video; Drug Consumption Rooms. [image] Available at: <http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms> [Accessed 19 Apr. 2019].

## Distribution of the monthly average of syringes re-harvested in the street by district in Barcelona 2014-12

Data: EMCDDA (2016)



The MSIC Evaluation Committee<sup>90</sup> also reported a drop in discarded needles during the initial trial period of their DCR but were unsure whether this was as a result of the DCR or was related to a heroin draught experienced in Sydney at the time. Hedrich<sup>91</sup> also notes the work of Biesma and Bieleman<sup>92</sup> regarding the DCR in Venlo, Netherlands where residents reported a reduction in the number of improperly discarded syringes following the opening of the facility.

### 3.10 Reducing ambulance call outs

In the West Midlands, the Ambulance Service Trust is under great pressure. It received more than 1.2 million emergency phone calls in the 12 months to July 2018, an increase of 150,000 in a year.<sup>93</sup> Each emergency call costs approximately £7.00 to answer, £180 if an ambulance is dispatched and between £233 and £260 if the patient is brought into an emergency department.<sup>94</sup> In these circumstances, measures that reduce ambulance call-outs are to be welcomed.

Salmon et al<sup>95</sup> concluded that opening the MSIC facility in the red-light district of Sydney had eased the burden of ambulance call outs in the area. The research was conducted 36 months prior and 60 months after the DCR had opened and recorded 20,409 ambulance attendances between May 1998 and May 2006.

The authors found that, during the operating hours of the DCR, the burden on ambulance services attending opioid related overdoses declined in the immediate vicinity of the DCR by 80% and in the neighbouring area by 45%. They concluded that, where IDUs (intravenous drug users) could access supervised injection facilities, the pressure on ambulance services could be reduced, making financial savings to the public purse and freeing ambulances to attend other medical emergencies. Reduced ambulance call outs for opiate overdoses may also indicate that fewer overdose fatalities are occurring. Moreover, Clark and Torrance et al, revealed that there had been an 80% reduction in opioid ambulance call-outs.<sup>96</sup>

90. Ibid, p117 MSIC Evaluation Committee (2003)

91. Ibid, p63. Hedrich (2004)

92. Biesma, S. and Bieleman, B. (1998a) Keetje Tippel gebruikt. Evaluatie van gebruikruimte de Buren bij Keetje Tippel te Rotterdam. Groningen-Rotterdam, Intraval.

93. Aru, D. and Rodger, J. (2019). Revealed: This is how under pressure Birmingham ambulances are. [online] birminghammail. Available at: <https://www.birminghammail.co.uk/news/midlands-news/revealed-how-under-pressure-birmingham-16016266> [Accessed 3 May 2019].

94. Clay Shepard, K. (2018). Sore throats and false nails – the ambulance call-outs that cost millions. [online] The Independent. Available at: <https://www.independent.co.uk/life-style/health-and-families/ambulance-call-outs-cost-millions-sore-throats-false-nails-a8299306.html> [Accessed 7 Jun. 2019].

95. Salmon, A., Van Beek, I., Amin, J., Kaldor, J. and Maher, L. (2010). The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia. *Addiction*, 105(4), pp.676-683.

96. Clark, J. and Torrance, J. (2018). *Drug Consumption Room*. Bristol: Safer Bristol Partnership

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

### 3.11 Impact on drug related crime

Research into the impact on crime in the area around DCRs suggests that there is either little change or that there are positive benefits through a reduction in crime.

For example, Pardo et al<sup>97</sup> note four studies that sought to evaluate the effects of a DCR on crime. The first of these, by Freeman et al,<sup>98</sup> examined trends in robbery reported to the police in Sydney, Australia where the DCR was located. Although the research was conducted at the beginning of, and throughout a heroin drought, it did show that crime trends were broadly similar to other areas of the city leading the authors to conclude that crime trends were neither positively nor negatively related to the opening of the DCR in Sydney.

Fitzgerald et al<sup>99</sup> developed the findings of Freeman et al<sup>100</sup> by investigating whether, in the Kings Cross Local Command where the DCR was sited, there had been:

- a) Increases in the volume of robbery, property crime and drug offences
- b) Increases in the proportion of drug offences occurring in the immediate vicinity of the DCR which could be attributed to the facility

Their review, conducted over a longer period of time, broke crime types down into more detailed categories for analysis such as robbery with firearms, robbery without a weapon etc. and their conclusions were

broadly in line with those of Freeman et al<sup>101</sup>. While they did find some slight variations between the locality and the rest of the city, the analysis showed that there was no evidence to suggest that the DCR negatively impacted on:

- Property crime in the locality
- Incidents of drug dealing or possession in the locality
- Incidents of drug dealing or possession in the vicinity of the MSIC

In more general terms, with a few minor exceptions, the incidents of robbery and property crime had fallen in the locality since the opening of the DCR although this was consistent with decreases in crime for the rest of Sydney.

The work of Donnelly and Mahoney<sup>102</sup> looked at trends in robbery, theft and specific drug related offences in the locality of the DCR by counting the number of criminal incidents and comparing these to the trends in the rest of Sydney. While acknowledging there had been a decline in crime locally around the DCR, their research reached similar conclusions to those of Fitzgerald et al<sup>103</sup> insofar as the trends in property crime incidents and illicit drug crime incidents were similar, both in the geographical locality where the DCR was situated and the rest of Sydney.

97. Pardo, B., P. Caulkins, J., and Kilmer, B. (2018). Assessing the Evidence on Supervised Drug Consumption Sites. [online] Santa Monica, California, USA: RAND Health Care and RAND Social and Economic Well-Being. Available at:

[https://www.rand.org/content/dam/rand/pubs/working\\_papers/WR1200/WR1261/RAND\\_WR1261.pdf](https://www.rand.org/content/dam/rand/pubs/working_papers/WR1200/WR1261/RAND_WR1261.pdf) [Accessed 22 Apr. 2019].

98. Freeman, K., C. G. Jones, D. J. Weatherburn, S. Rutter, C. J. Spooner, and N. Donnelly, "The impact of the Sydney Medically Supervised Injecting Centre (MSIC) on crime," *Drug Alcohol Rev*, Vol. 24, No. 2, 2005, pp. 173-184

99. Fitzgerald, J., M. Burgess, and L. Snowball (2010). Trends in property and illicit drug crime around the Medically Supervised Injecting Centre in Kings Cross: An update, Sydney: NSW Bureau of Crime Statistics and Research, As of 30 March 2018: <http://apo.org.au/system/files/22857/apo-nid22857-27411.pdf>

100. Ibid, Freeman et al (2005)

101. Ibid, Freeman et al (2005)

102. Donnelly, N., and N. Mahoney, "Trends in property and illicit drug crime around the medically supervised injecting centre in Kings Cross: 2012 update," 2013, p. 10.

103. Ibid. Fitzgerald et al (2010)

Myer and Belisle<sup>104</sup> appear to be much more conclusive regarding the question of crime and the impact of a DCR. Their research, conducted in Vancouver over two years, assessed weekly counts of reported violent and property crimes in four policing districts, one of which housed the DCR which had opened in 2003, thus allowing a before and after assessment. They used a system based on the Autoregressive Integrated Moving Average (ARIMA) technique which is designed to take account of the fluctuations in crime due to seasonality and the non-stationary nature of time series data. Remarkably, in police district 1, the home of the DCR, all crimes declined by approximately 42 incidents a week. Incidents of both robbery and violent crime declined by six incidents a week and property crimes, theft from vehicle etc., declined by 35 incidents a week. The changes were “abrupt and permanent” whereas there were no statistically significant changes in the other three policing districts.

McCulloch<sup>105</sup> suggests that there is no conclusive evidence that DCRs lead to either increases or decreases in crime but suggests that, because clients are often referred on to other services, this could, in the long term, lead to reductions in criminal behaviour.

### 3.12 Cost-effectiveness

There is a strong evidence base indicating that DCRs are cost effective and so can have economic benefits for the wider community through more efficient resource use. **The chart on page 13** of this report demonstrates the levels of drug related deaths across the West-Midlands. Many of these deaths will pose a significant financial as well as human cost. The presence of high rates of hepatitis B and C and HIV infection as a result of needle sharing will also add to

the overall costs of health and social care support. The West Midlands has seen a significant rise in the number of homeless people, many of whom have dependencies which are a factor in their A&E attendance being approximately 60 times higher than observed in the general population.<sup>106</sup> While it is difficult to determine exactly how many PWID attend hospital and access care, if we consider hospital admissions alone, in the period 2017-18 there were 7,625 hospital admission episodes<sup>107</sup> with a primary or secondary diagnoses of drug related mental and behavioural disorders. Based on these figures, if 762.5 (10%) users visit a West Midlands hospital in one year as an emergency inpatient as a result of their drug use, the average cost to the taxpayer would be £491,436. This is without factoring in any resulting infections such as HIV where the lifetime treatment cost of treating just one person is estimated at £360,000.<sup>108</sup> Clearly the potential to reduce health care costs, thus freeing resources, are substantial (see cost of healthcare in the UK in appendices A).<sup>109</sup>

For example, the 2017 business case for Glasgow’s Integrated Joint Board, which considered creating a DCR alongside a Heroin Assisted Treatment Clinic, concluded there would be substantial savings to the public purse by:<sup>110</sup>

- Reducing the risk of blood-borne virus transmissions
- Reducing the risk of overdose or drug-related death and reducing drug-related infections by promoting safer injection practice
- Bringing a population with complex needs into contact with effective links to housing, welfare rights and other medical needs
- Improving the amenity of city centres by reducing drug-related litter and public injecting while also tackling drug-related criminal activity and anti-social behaviour

104. Myer, A.J., and L. Belisle, "Highs and Lows: An Interrupted Time-Series Evaluation of the Impact of North America's Only Supervised Injection Facility on Crime," *Journal of Drug Issues*, Vol. 48, No. 1, 2018, pp. 36-49.

105. McCulloch, L. (2018). *An Investigation Into the Feasibility Of Establishing Drug Consumption Rooms*. London: Volteface.

106. Bowen, M., Marwick, S., Marshall, T., Saunders, K., Burwood, S., Yahyouche, A., Stewart, D. and Paudyal, V. (2019). Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice. *British Journal of General Practice*, 69(685), pp.e515-e525.

107. NHS Digital (2018). *Statistics On Drug Use (November 2018 update)*. [online] Richmond, Surrey UK: OGL. Available at: <http://digital.nhs.uk/pubs/statdrugs18nov> [Accessed 7 Jan. 2020].

108. Nakagawa, F., Miners, A., Smith, C., Simmons, R., Lodwick, R., Cambiano, V., Lundgren, J., Delpech, V. and Phillips, A. (2015). Projected Lifetime Healthcare Costs Associated with HIV Infection. *PLOS ONE*, 10(4), p.e0125018.

109. Lesley, A, C. and Burns, A. (2019). *Unit Costs of Health and Social Care 2018*. [online] Kent: Personal Social Services Research Unit. Available at: <https://kar.kent.ac.uk/70995/1/Unit%20Costs%202018%20-%20FINAL%20with%20bookmarks%20and%20covers%20%282%29.pdf> [Accessed 22 Jun. 2019].

110. Miller, S. (2017). *Safer Consumption Facility and Treatment Service Pilot*. [online] Glasgow: Glasgow Integration Joint Board. Available at: [https://glasgowcity.hsc.scot/sites/default/files/publications/IJB\\_15\\_02\\_2017\\_ItemNo13\\_-\\_SCF\\_and\\_HAT.pdf](https://glasgowcity.hsc.scot/sites/default/files/publications/IJB_15_02_2017_ItemNo13_-_SCF_and_HAT.pdf) [Accessed 22 Sep. 2019].

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

The study noted that the 78 new HIV cases diagnosed in Glasgow between 2015 and 2016 among people who injected drugs (primarily from sharing injecting equipment) could create lifetime costs to the health service of £29.64 million with that number having risen substantially since to in excess of 170.<sup>111</sup> Pinkerton calculated that Insite in Canada saves health care services \$17.6m yearly by preventing new blood borne virus infections.<sup>112</sup>

An economic evaluation commissioned by the New South Wales Government and completed in 2008 demonstrated that the DCR in Sydney, Australia was cost effective, stating: <sup>113</sup>

- That the DCR was estimated to save \$658,000 per annum compared to the provision of similar health outcomes via other drug related services (although this is likely to be an underestimate)
- The outcomes provided by the DCR could only have been achieved if the Government provided additional funding with estimates ranging from \$1.1m to \$3.3m
- Based on the assumption that the 'mid-point value' of a human life is \$3.5m, the DCR would have to prevent only 0.8 deaths a year to break-even, significantly fewer than the estimated 25 lives saved in the comparison year
- That, even based on conservative estimates of the number of deaths the DCR would prevent in a year, there are massive positive outcomes in economic terms for the current funding of the facility

Clark and Torrance's review refers to 15 Dutch, German and Swiss DCRs and found that DCR overdose incidents were 10 times less likely to result in a hospital admission than incidents that took place outside of the facility. Those that did go to hospital from the DCR were 10 times less likely to stay in hospital overnight.<sup>114</sup>

Finally, of six studies relating to the viability of the DCR in Vancouver, five found it to be cost effective with one study suggesting that it provided in excess of \$6m (CAD) per year. Others were more conservative with savings estimated between \$200,000 and \$400,000 (CAD) per year. The sixth and final study found savings of \$1.8m (CAD) due to the potential to reduce the high incidence of hepatitis C infection in the client group.<sup>115</sup>

It is important to note that, while some DCRs operate long hours, many in Europe are only open for a few hours a day which is sufficient to provide a useful, if not ideal, service. It often depends upon local need and local funding.

### 3.13 The impact of DCRs on the support from local residents

Evaluation studies have found that, overall, DCRs have had a positive impact in the communities where they have been located, with initial scepticism usually turning to broad support after the impact of DCRs has been observed.

111. Nhs.gov.uk. (2019). NhsGCGC : Proposed SDCF and HAT. [online] Available at: <https://www.nhs.gov.uk/about-us/media-centre/news/2017/06/proposed-sdcf-and-hat/#> [Accessed 31 Dec. 2019].

112. Pinkerton, S. (2010). Is Vancouver Canada's supervised injection facility cost-saving?. *Addiction*, [online] 105(8), pp.1429-1436. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20653622>.

113. Ibid, p193. KPMG (2010)

114. Kimber, J., Dolan, K. and Wodak, A. (2005). Survey of drug consumption rooms: service delivery and perceived public health and amenity impact. *Drug and Alcohol Review*, [online] 24(1), pp.21-24. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16191717>

115. Ibid, p18. Kennedy, Karmouzian, and Kerr (2017)

Barry, C., Sherman, S., Stone, E., Kennedy-Hendricks, A., Niederdeppe, J., Linden, S. and McGinty, E. (2019). Arguments supporting and opposing legalization of safe consumption sites in the U.S. *International Journal of Drug Policy*, [online] 63, pp.18-22.



A study by Barry et al<sup>116</sup> concentrated on the arguments opposing DCRs in the USA by conducting a detailed analysis of news, media coverage, public reports and advocacy materials. The most highly ranked argument was that public funds were better spent on treatment and that sites allowed illegal activity and encouraged people to take drugs. However, looking at the work of Thein et al<sup>117</sup> who set out to evaluate public opinion towards DCRs in Vancouver and the MSIC situated in Sydney, the attitudes of the local community clearly changed when they had a better understanding of the benefits of DCRs.

In the case of the DCR in Sydney, Thein et al<sup>118</sup> conducted a series of interviews before and after the facilities had opened. Respondents who reported some knowledge of DCRs were more likely to respond positively. However, the perceptions that such facilities attracted drug users, made policing difficult or condoned drug use decreased significantly during the term of the research. The authors suggest that the change in views is consistent with that of European studies conducted by Biesma,<sup>119</sup> where the attitudes of local residents towards DCRs tended to “become more positive after a period of service operation compared to the attitudes at the commencement of service”. Thein et al<sup>120</sup> concluded that public opinion towards the establishment of a DCR was generally supportive in the long term but assessing whether the support would be sustained over a longer period of time would naturally depend upon the benefits and effectiveness of such facilities.

In the case of ‘Fixpunkt’, a DCR based in Hannover established in 1997, a steep rise in use was recorded, being visited by 150 - 200 persons daily, with the weekly number of injections peaking at 300 a day by the

third month of operation. Early successes were followed by a sharp fall. One reason cited was the policing controls the users encountered when moving from the place of purchase to the DCR. This prompted the police to change their controls which resulted in the number of weekly injections rising to the previous level of 300 weekly. During the first year, no ‘open’ drug scene established itself outside the unit but, when police banned people with drug addiction problems from the city centre (a 10 minute walk from the facility), the area in front of the DCR became a new meeting area for users resulting in considerable nuisance problems in the neighbourhood of the DCR. This led to police action, mainly related to small scale drug dealing.<sup>121</sup> So, the problem arose not because of the DCR but because of changes to the way drugs were policed across the city.

Conversely, in Biel Switzerland, as part of their research, Spreyermann et al<sup>122</sup> interviewed shop owners, business associations, health and social administrators as well as the local police who maintained a high profile near the facility. The policing role was mainly around dispersing drug dealers but all participants reported that the facility contributed to keeping the inner-city area clean and safe and played a role in preventing the emergence of an ‘open’ drug scene.

The work of Barry et al<sup>123</sup> concluded that it would be difficult to promote any form of self-injecting facility without public education to confront persistent myths that the sites encourage drug use and do not facilitate treatment access. In Berlin, near the site of the DCR, acceptance was high at 70-80% of randomly selected residents with those with a higher level of education and political interest showing greater approval.<sup>124</sup>

116. Barry, C., Sherman, S., Stone, E., Kennedy-Hendricks, A., Niederdeppe, J., Linden, S. and McGinty, E. (2019). Arguments supporting and opposing legalization of safe consumption sites in the U.S. *International Journal of Drug Policy*, [online] 63, pp.18-22.

117. Thein, H., Kimber, J., Maher, L., MacDonald, M. and Kaldor, J. (2005). Public opinion towards supervised injecting centres and the Sydney Medically Supervised Injecting Centre. *International Journal of Drug Policy*, [online] 16(4), pp.275-280. Available at: [https://www.researchgate.net/publication/236582801\\_Public\\_opinion\\_towards\\_Supervised\\_Injecting\\_Centres\\_and\\_the\\_community\\_impact\\_of\\_Sydney\\_Medically\\_Supervised\\_Injecting\\_Centre](https://www.researchgate.net/publication/236582801_Public_opinion_towards_Supervised_Injecting_Centres_and_the_community_impact_of_Sydney_Medically_Supervised_Injecting_Centre) [Accessed 21 Apr. 2019].

118. Ibid, p209. Thein et al (2005).

119. Biesma, S., Sok, J., Spreen, M., & Bieleman, B. (1998). Keetje Tippel gebruikt. Evaluatie van gebruikruimte de Buren bij Keetje Tippel te Rotterdam [Evaluation of ‘De Buren’ and ‘Keetje Tippel’, care center and user rooms for prostitutes in Rotterdam]. Groningen-Rotterdam: Intraval

120. Ibid, p280. Thein et al (2005)

121. Ibid, p64. Hedrich., D. (2004).

122. Spreyermann, C. and Willen, C (2002) Evaluationsbericht Pilotproject Cactus. Evaluation der Kontakt- und Anlaufstelle des Contact Netz Drop-in Biel. Berne: Sfinx.

123. Ibid, p18. Barry et al (2019)

124. Konsumraum, A. (2011). Drug Consumption Rooms In Germany. [online] Berlin: Deutsche AIDS-Hilfe e.V, p.33. Available at: [https://www.aidshilfe.de/sites/default/files/documents/DAH\\_akzept\\_DCR%20in%20Germany\\_2011.pdf](https://www.aidshilfe.de/sites/default/files/documents/DAH_akzept_DCR%20in%20Germany_2011.pdf) [Accessed 18 Jun. 2019].

# Out of harm's way

## 3. Drug Consumption Rooms – What the evidence says

The evidence highlighted in two of the research programmes outlined above demonstrates that the way in which the police respond can be critical to the way in which a DCR is perceived. In particular, policing can influence the levels of anti-social behaviour and nuisance in and around the area where the DCR is sited but, overall, if policed in a balanced and sensitive way, DCRs can contribute to keeping an area clean, tidy, safe and prevent the emergence of a more 'open' drug scene.

More recently, the DCR in Paris has encountered

ongoing concern from local residents who, while recognising the evidence for potential benefits of DCRs, say the existing facility is simply too small to achieve visible falls in street use and needle litter given the scale of the street drug using scene around the Gare du Nord.<sup>125</sup>

In contrast, the Dr Peter's Hospice DCR in Vancouver has widespread support as these quotes from a video the facility made for the Toronto Health Board (who were considering opening a DCR, and now have) demonstrate.<sup>126</sup>

*"We recognise the value of a supervised injection service being integrated into nursing care at the Dr. Peter Centre. In addition to bringing individuals into care, it means Dr. Peter Centre clients have an alternative to injecting publicly in the neighbourhood."*

Nitin Madhvani  
Chair of the Board of Directors  
Mole Hill Community Housing Society

*"The West End Business Improvement Association represents over 500 businesses and 197 commercial property owners. The supervised injection service supports a core tenant of our vision for the commerce area, that being - clean and safe."*

*In our experience, we have no issues with the services provided. It is better for our trading area to have individuals supervised rather than being sent out of the Centre with sterile needles, with the possibility they will publicly inject."*

Steve Regan  
Executive Director  
West End Business Improvement Association

*"The VPD solicited input and observations from the staff and volunteers at Davie St. Community Police Centre and, based on past experience and observations, as well as the evidence obtained from the police records system, the VPD has no public safety concerns regarding the DPC and Vancouver Coastal Health Authority application for an exemption under sec. 56 of the CDSA."*

Jim Chu  
Chief Constable  
Vancouver Police Department

*"Without doubt, the services provided by the Dr. Peter Centre are vital and necessary in our community. WERA fully supports the continuation of the safe injection site services."*

Christine Ackermann  
President  
West End Residents Association

While winning over support after a DCR has opened may be welcome, establishing one would not be without its challenges. It would be important not to raise unrealistic expectations and to consult and engage with the public and local businesses from the inception of any project.

125. Jacobs, J. (2019). Bloomberg - Are you a robot?. [online] Bloomberg.com. Available at: <https://www.bloomberg.com/news/articles/2019-07-31/france-is-testing-safe-drug-consumption-rooms-for-opioid-addicts> [Accessed 8 Jan. 2020].

126. Drpeter.org. (2020). Community Support for Supervised Consumption Service. [online] Available at: <https://www.drpeter.org/dr-peter-centre/knowledge-transfer/community-support-for-sis/> [Accessed 3 Jan. 2020].

## 4. Arguments against DCRs

A range of other arguments have been made against DCRs, some of these outlined in a letter from the UK Government when rejecting calls from its own expert body, the Advisory Council on the Misuse of Drugs, to pilot a DCR.<sup>127</sup> The arguments against are underpinned by the following assumptions:

- DCRs would be difficult to police. A number of PCCs, including the West Midlands PCC, have visited DCRs overseas, heard evidence from local police and concluded the challenges are manageable in the UK too.
- DCRs encourage the use of drugs and support the illegal market. These concerns are unfounded. DCRs do not increase the number of people using drugs or the frequency with which they inject. Instead of increasing drug use, by helping people engage with treatment, DCRs have the potential to reduce the scale of the drug market.
- DCRs ‘send the wrong message’. There is no evidence to support the premise that allowing DCRs would send a message that injecting heroin was not dangerous or that people would take more drugs as a result. In fact, as noted above, there is clear evidence that DCRs do not increase use.
- DCRs act as a ‘honey-pot’ attracting people from other areas, increasing crime and street drug dealing. DCRs are only located where there is an existing problem, which is reduced by taking street-use inside, and the vast majority of people with severe drug problems will not travel far.
- Because some people using a DCR will die of an overdose outside of the facility at a later date instead, DCRs don’t work. DCRs provide an opportunity to make a life-saving medical intervention to reverse otherwise fatal overdoses. To further increase the

number of lives they save, DCRs should be part of a wider strategy to reduce drug related deaths, including well-funded evidence-based treatment, naloxone provision and wrap-around social and other healthcare. The latest evidence (noted above) shows those attending a DCR not only will not die in the facility itself but also reduce their risk of fatality outside it as well.<sup>128</sup>

### Are DCRs too difficult to police?

A number of PCCs, including David Jamieson, the West Midlands PCC, have visited DCRs overseas, heard evidence from local police and concluded that the policing challenges are manageable in the UK. Three of these PCCs wrote to the Home Office to that effect (Appendix B).<sup>129</sup> They wrote:

“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 [Needle and Syringe Programmes]. 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.”<sup>130</sup>

### Do DCRs encourage the use of drugs and support the illegal market?

These concerns are unfounded. DCRs do not increase the number of people using drugs or the frequency with which they inject. Instead, by helping people to engage with treatment, so reducing the illegal drug use, DCRs have the potential to reduce the scale of the drug market.

127. Atkins (MP), V. (2019). Reducing Opioid Related Deaths in the UK Report - Further Response Regarding Drug Consumption Rooms. [online] London: Home Office, UK Government. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/699825/Letter\\_from\\_Victoria\\_Atkins\\_MP\\_to\\_OBJ.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699825/Letter_from_Victoria_Atkins_MP_to_OBJ.pdf) [Accessed 5 Dec. 2019].

128. Kennedy, M., Hayashi, K., Milloy, M., Wood, E. and Kerr, T. (2019). Supervised injection facility use and all-cause mortality among people who inject drugs in Vancouver, Canada: A cohort study. *PLOS Medicine*, 16(11), p.e1002964.

129. Jones, A., Jamieson, D. and Hogg, R. (2018). Statement on Reducing Opioid-Related Deaths in the UK Report - Further Response Regarding Drug Consumption Rooms. Birmingham: Office of West-Midlands Police and Crime Commissioner.

130. Ibid, p4. Jones et al (2018)

# Out of harm's way

## 4. Arguments against DCRs

The EMCDDA<sup>131</sup> concluded that there was no evidence to suggest that DCRs encourage further drug use. Instead, they facilitate rather than delay entry to treatment. Potier et al<sup>132</sup> refer to two studies at the DCR in Vancouver designed to establish whether the facility would increase drug usage. The first study, conducted by Kerr et al,<sup>133</sup> found that 25 months after the facility had opened, there was no increase in the number of users locally, no decrease in the number of users who started methadone therapy and no increase in relapse rates.

The second study, also by Kerr et al,<sup>134</sup> was designed to establish whether DCRs promoted initiation into drug use using a sample of 1065 drug users in Vancouver. They found most users of the facility were long time drug users and that there was no evidence to suggest that the safer injection facility prompted or elevated rates of initiation into injection drug use in the community. Although there were 14 users who became first time injectors after the DCR had opened, none reported performing their first injection within the facility.

Initial research by Benninghoff et al<sup>135</sup> found that, out of the 17 clients interviewed at the DCR in Geneva, two said they had reduced their drug intake and three had increased. A subsequent follow up, where 60 users were interviewed in Groningen, the Netherlands four months after the service had opened, the authors found reductions in levels of heroin and cocaine use whereas poly-drug use remained the same.<sup>136</sup>

### Do DCRs act as a 'honey-pot' attracting people from other areas?

DCRs are only located where there is an existing problem of street use and dealing which is reduced by taking street use inside. The vast majority of people with severe drug problems and chaotic lives will not travel

far, therefore DCRs almost exclusively serve the existing local community of people who use drugs. The Government has raised the example of Swedes accessing DCRs in Denmark but, as the letter from the PCCs for the West Midlands, Durham, and North Wales to the Home Office (see Appendix B), states:

"[T]he 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".<sup>137</sup>

### Allowing DCRs 'would send the wrong message'.

There is no evidence to support the premise that allowing DCRs would send a message that injecting heroin was not dangerous or that people would take more drugs as a result. As noted earlier in this chapter, there is clear evidence that DCRs do not increase use. Public health messages are better sent using the health services with DCRs providing a direct opportunity to educate and inform an otherwise difficult to reach at risk group.

131. Ibid, p6. EMCDDA (2018)

132. Potier, C., Laprêvôte, V., Dubois-Arber, F., Cottencin, O. and Rolland, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*, 145, pp.48-68.

133. Kerr, T., Stoltz, J.-A., Tyndall, M., Li, K., Zhang, R., Montaner, J., Wood, E., 2006a. Impact of medically supervised safer injection facility on community drug use patterns: a before and after study. *BMJ* 332, 220-222.

134. Kerr, T., Tyndall, M., Zhang, R., Lai, C., Montaner, J. and Wood, E. (2007). Circumstances of First Injection Among Illicit Drug Users Accessing a Medically Supervised Safer Injection Facility. *American Journal of Public Health*, 97(7), pp.1228-1230.

135. Benninghoff, F., Solai, S., Huissoud, T. and Dubois-Arber, F. (2003) Evaluation de Quai 9 'Espace d'accueil et d'injection' à Genève: période 12/2001-12/2000. Lausanne: Institut universitaire de médecine sociale et préventive.

136. Ibid, p47. Hedrich (2004)

137. Ibid, p2. Jones et al (2018)



**Because some people using a DCR will die of an overdose outside of the facility at a later date instead, DCRs don't work.**

DCRs provide an opportunity to make a life-saving medical intervention to reverse otherwise fatal overdoses. In terms of reducing deaths at the population level, rather than just locally, to be effective, DCR provision should be correctly scaled as well as integrated into a wider strategy to reduce drug related deaths. This should include well-funded evidence-based treatment, naloxone provision and wrap-around social and other healthcare. As noted above, recent research in Canada shows DCRs can reduce fatality rates for clients when they are outside as well as inside the facility.

No one would argue that ambulance paramedics should deliver CPR to heart-attack victims, even though a good percentage of those receiving the treatment will not leave the hospital alive, or if they do will die later. There is perhaps a double standard here that highlights the stigmatisation of people who take drugs versus other people needing healthcare.



# Out of harm's way

## 5. Costs of operating a DCR

There are a range of variables that will significantly affect the cost of setting up and running a DCR including which model is chosen, opening times, the number of booths available for injections and whether it is possible to share existing buildings, management and admin to reduce costs.

While staffing is the main ongoing cost, most proposals for a DCR in the UK suggest using a high level of fully trained nurses. While this has advantages in terms of public confidence and in being precautionary in allowing a period of maximum medical support to assess actual need, in reality many DCRs in operation use a mixture of trained nurses and non-medical staff (including client peer groups) who are trained to manage overdoses and other emergency healthcare issues likely to be encountered. Some DCRs have wound care clinics with a nurse on certain days or have a nurse on call and, as a result, staffing costs are substantially reduced compared with DCRs running on a fully trained nurse model. So, in the costings below, staffing should be viewed as a maximum cost which could decrease over time.

The Toronto “Supervised Injection Services Toolkit”<sup>138</sup> includes a template for a budget that comprises renovations/furniture, registered nurses, client support workers, admin/reception, manager/supervisor, rent, supplies, insurance and legal fees. It also suggests setting aside money for community engagement and education.

### A large standalone specialised model

The standalone model described below uses the Sydney staffing model (for a precautionary approach as described above). Sydney’s DCR has a minimum of three professional nurses and three health education officers available at any one time and a full time referral coordinator, responsible for coordinating referrals to a range of medical and social welfare services.<sup>139</sup>

To replicate this approach would necessitate a staffing structure that operates independently from the broader drug service provision so would not therefore benefit from shared resources.

For a stand-alone consumption room, the costs are estimated to be between £800k to £1m pa, 90% of this on staffing, for a dedicated site with 12 injecting booths and five smoking booth facility, recovery room, reception and staff spaces, open 12 hours a day, 365 days per year.<sup>140</sup>

- Service manager, 0.5 clinical lead, nurse team leader, admin support
- 19 full-time equivalent nurses, two at Band 6-7 rate (£30k), rest Band 4 (£21k pa)
- Six to eight nurses on duty at any time, increased costs due to some out-of-hours working
- Rent, cleaning contract, other overheads including insurance

### Small model integrated into existing services

\*(see Appendix B)

The treatment organisation, Kaleidoscope, priced running a two-injecting booth DCR in under-utilised space at their existing premises in Wales at between £50-60,000 pa but operating limited hours, e.g. an 8 hour day, and buying second hand furniture etc. to reduce costs.

Costs such as rent, management, insurance etc. would already be largely covered by the existing services provided.

### Facility set up costs

Second-hand furniture: 2 x stainless steel clinical tables for injecting (£200), chairs (£100), clinical couch (£100), other furnishing (£400), IT and other office equipment (£300), vaccination fridge (£300), anaphylaxis/resuscitation kit (£200).

### Operating costs

- Full time RGN Band 6 £30k
- Pension, NIC, training and supervision of nurse £5k
- Bank/Agency nurse cover (six weeks) £7k
- Small clinical and NPS supplies £500
- Additional insurance/registrations etc. tbc
- Management charge 10%
- Naloxone tbc depending on use levels

138. Toronto Drug Strategy Implementation Team (2013). Supervised Injection Services Toolkit. [online] Toronto. Available at: <https://www.toronto.ca/legdocs/mmis/2013/hl/bgrd/backgroundfile-59914.pdf> [Accessed 5 Dec. 2019].

139. <http://www.drugconsumptionroom-international.org/index.php/locations/australia2/australia-overview>

140. Ibid, p22. Clark and Torrance (2018)



### **Mobile unit**

A mobile unit could cost in the region of £250 – £350k per annum (based on the Copenhagen model.<sup>141</sup>) This would provide:

- Three to four booth mobile unit open 5.5 hours per day, 365 days per year
- Four nurses (two on duty at any time), two at £30k Band 6 salary, two at £21k Band 4 - £102k
- Training and salary on costs - £15k
- Admin and supervisions staff (one on duty) - £25k
- Van cost (hire ex-ambulance, fit out plus running costs) - £45k pa
- Overheads - share with existing organisation - £15k

141. Ibid, p22. Clark and Torrance (2018)

# Out of harm's way

## 6. Added value for the West Midlands

### 6.1 The West Midlands and National Homelessness Strategies

Commissioned by Public Health and the West Midlands Combined Authority, the Final Study Report<sup>142</sup> is an analysis of the healthcare issues amongst the homeless in Birmingham which demonstrates the link between homelessness, mental health conditions, substance and alcohol dependence and infectious diseases such as hepatitis B and C. In particular, the report found evidence of multi-morbidity for the homeless with the rate of A&E attendance at approximately 60 times higher than that observed in the general population.

However, although rough sleeping has more than tripled since 2010 in the West Midlands, with a six-fold increase in Birmingham, the region is no different to any other part of the country where homelessness and rough sleeping have seen sharp increases. Of an estimated 250,000 people known to be currently homeless in England alone, with over 4,000 sleeping rough overnight, the West Midlands accounts for 20,897 registered homeless and 289 rough sleepers, although this is considered to be the “tip of the iceberg”.<sup>143</sup>

The Government’s Rough Sleeping Strategy<sup>144</sup> notes the high proportion of drug-related deaths amongst rough sleepers and makes the following observations:

- 40% of the homeless population misuse drugs
- Some have been convicted for drug offences
- 35% of people who die while sleeping rough or living in homeless accommodation die due to alcohol or drugs, compared to 2% of the population

The evidence cited in this report suggests that DCRs can play a role in the reduction of mortality rates. It is therefore easy to comprehend how such a facility could add value in the West Midlands simply by saving the lives of the homeless population.

### 6.2 Why Housing First and DCRs share a common analysis

The ‘Housing First Initiative’<sup>145</sup> is part of a relatively new international evidence-based approach that is backed by the Government and being piloted across the UK. A dedicated funding stream was launched in January 2019 that will see £9.6 million spent in the region with the aim of providing housing for the homeless.

In essence, the idea is that once accommodation is secured, other issues affecting the household can be more easily dealt with. This involves identifying and helping with the problems that led to living on the streets in the first place which, in some cases, can include mental illness and drug use. Fundamentally, Housing First involves accepting that many people will continue to use drugs until they have built the social and psychological assets to stop – something they would not be able to do on the streets.

This rationale is similar for DCRs which also recognise that many people with drug problems are not currently able to stop and the best way to manage this reality is to help keep them alive and bring them into an environment where they can begin to engage with other services when they are ready.

The Final Study Report<sup>146</sup> implies that, without such support, the homeless are more likely to slide into decline and thus potentially developing any number of complex health issues. Maintaining a healthy lifestyle can become extremely challenging and mortality rates are higher. Injury, assault and skin problems are rife – conditions that worsen as homelessness persists. Opioid overdose as well as accidents, heart failure and infectious disease can also contribute to excess mortality. In addition, the transient nature and chaotic lifestyle of rough sleepers means accessing services in a more formal and scheduled way becomes a difficult proposition.

142. Public Health England & West Midlands Combined Authority (2017). Healthcare Issues Amongst the Homeless In Birmingham. Birmingham, West Midlands: University of Birmingham.

143. Shelter (2017). Far From Alone: Homelessness in Britain in 2017. London: Shelter 2018.

144. Brokenshire, J. (2018). Rough Sleeping Strategy. London: Crown Copyright 2018.

145. Dare, T. (2019). First Look Inside A New Home for the Homeless In Birmingham. Birmingham: BirminghamLive, p. <https://www.birminghammail.co.uk/news/midlands-news/first-look-inside-new-home-15733287>

146. Ibid, p14. Public Health England & West Midlands Combined Authority (2017).



A network of DCRs across the West Midlands could be focal points where other services are housed and where further support, such as healthcare, housing and benefits etc., can be obtained. This would offer new opportunities to engage drug-using rough sleepers in treatment since many do not have a GP or access to services through conventional means. CGL, the key provider for addiction services in Birmingham, has said that it would engage with any proposals to develop a DCR, recognising that they offer an “evidenced based approach” and provide a service to those who are ‘hard to reach’. CGL agrees it would “certainly be open to working with any of our commissioners who may wish to consider the initiative” [DCRs].<sup>147</sup>

Given the evidence cited in this report, it is clear that a DCR could support the drivers for change outlined in the West Midlands Combined Authority’s ‘Homeless Strategy’ and fit with the new Housing First ethos whilst also supporting the Government’s Rough Sleepers Strategy.

### 6.3 Impact on crime in the West Midlands

The ONS crime figures relating to the West Midlands Police tend to capture those associated with drug related crime across multiple offences, including possession and distribution, of which there were 10,594 in 2018/19 (year ending September 2019).<sup>148</sup> There is a wide range of drug-related offending (from lower levels of crime to fund a drug habit to violence related to drug supply)<sup>149</sup> that may not be flagged as involving drugs. Data regarding drug-related offending is difficult to

capture and therefore providing an overall picture of the impact drugs have on crime and policing is challenging. However, current data suggests that an estimated 48% of acquisitive crimes (such as burglary, theft, shoplifting and robbery but excluding fraud) are committed at least once a week by people who use heroin, crack cocaine or cocaine powder.<sup>150</sup> Moreover, the volume of drug-induced acquisitive crime committed by a heroin injector is estimated at 200-260 offences a year<sup>151</sup> while the annual cost of each problematic drug user is estimated at £62,320 when considering only four indicators: drug-related crime, health service use, drug related deaths and social care.<sup>152</sup> The West-Midlands 2018 drug policy report noted that there were approximately 14,734 PWIDs. At that time, the estimated cost the public purse was calculated to be £1.4bn a year.<sup>153</sup>

The evidence suggests that a DCR, working in tandem with other key services, could result in significant savings, not only in policing and the CJS, but across the healthcare sector too where basic health issues that start with injecting could be prevented from developing into a set of more complex problems requiring higher levels of care not to mention the potential for fewer ambulance call outs, needle litter and a decline in drug related deaths where police officers are often required to respond in a variety of ways.

147. Ibid, p20. West Midlands Police and Crime Commissioner (2018).

148. Ons.gov.uk. (2019). Crime in England and Wales - Office for National Statistics. [online] Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/policeforceareadatatables> [Accessed 06 Jan. 2020].

149. Bryan, M., Del Bono, E. and Pudney, S. (2013). Drug-related Crime. [online] Essex: Institute for Social and Economic Research - University of Essex. Available at: <https://www.iser.essex.ac.uk/research/publications/working-papers/iser/2013-08.pdf> [Accessed 22 Oct. 2018].

150. Mills, H., Skodbo, S. and Blyth, P. (2013). Understanding Organised Crime: Estimating The Scale And The Social And Economic Costs - Research Report 73. [online] London: Crown Copyright 2013. Available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/246390/horr73.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/246390/horr73.pdf) [Accessed 10 Oct. 2018].

151. Bryan, M., Del Bono, E. and Pudney, S. (2013). Drug-related Crime. [online] Essex: Institute for Social and Economic Research - University of Essex. Available at: <https://www.iser.essex.ac.uk/research/publications/working-papers/iser/2013-08.pdf> [Accessed 22 Oct. 2018].

152. Ibid, p6. West Midlands Police and Crime Commissioner (2018)

153. Ibid, p6. West Midlands Police and Crime Commissioner (2018)

# Out of harm's way

## 6. Added value for the West Midlands

Police officers have limited options when it comes to supporting PWID on their journey to recovery. Nevertheless there is clearly a part for policing to play that goes beyond enforcement. For WMP this revolves around diverting people away from the criminal justice system into proper treatment and drug intervention programmes, training officers to carry and use naloxone for those who have overdosed and ensuring the money from organised crime is used to improve the response to those with an addiction. To that end, a DCR would be invaluable to local command units. The referral and diversion routes would be straightforward and consistent when officers were confronted by PWID related crime with monies taken from the proceeds of crime used to help support the facility. Furthermore, the evidence suggests that there are reductions in anti-social behaviour and disorder in the localities where DCRs are sited which means that officers who would otherwise be tied up dealing with such issues would be free to deal with other matters.

The Office of the West Midlands Police and Crime Commissioner recognises that, on balance, the response to drug addiction is best treated as a health concern where harm reduction becomes the ultimate aim. The criminal justice system and custody blocks should not be populated by PWID who are 'picked up off the streets'. Keeping people out of cells will require a proactive approach. This means finding a way that would see harm reduction carrying as much weight as enforcement – where those who are picked up on the street can easily be referred/taken to a place where they can access support but also where those who are involved in organised crime benefit from the illicit drug trade and cause harm to others are dealt with accordingly. The encapsulation of such an approach could include a DCR where the wrap-around support for PWID could play a key role in harm reduction.

The West Midlands Police have also referred to "intervention and prevention, protecting people from harm and helping those in need" in the 2018-2020 Ambition Plan<sup>154</sup> and are therefore focused on being more proactive when it comes to policing. Similarly, the NHS are also looking to be more forward thinking concerning drug services, in particular when working with the local authorities.<sup>155</sup> In this sense, the development of a DCR, where the emphasis is very much centred on taking a proactive approach with clients, would fit well with the core drivers associated with more recent NHS and policing policies.

Whilst Fortson et al<sup>156</sup> recognise that DCRs have no direct effects on crime (i.e. there is no conclusive evidence that DCRs lead to increases or decreases in crime), they do acknowledge that there are reductions in criminal behaviour, in part due to people addicted to drugs being referred into support services which inevitably leads to improved cost effectiveness in policing, especially if other aspects are considered (e.g. drug overdose prevention, anti-social behaviour and crime). There is at least one piece of research cited in this report that appears to be much more conclusive where particular crimes, such as property and violent crime, were significantly reduced with the changes being "abrupt and permanent". It would thus be easy to argue a case for a DCR in the West Midlands given that, on balance, it would appear that such facilities have the potential to impact upon crime although the 'causal' linkages do not always appear so obvious.

154. West-midlands.police.uk. (2018). [online] Available at: [https://www.west-midlands.police.uk/\\_flysystem/public-sync/inline-files/Ambition\\_Plan\\_FINAL\\_0.pdf](https://www.west-midlands.police.uk/_flysystem/public-sync/inline-files/Ambition_Plan_FINAL_0.pdf) [Accessed 1 Jul. 2019].

155. GOV.UK. (2018). Health matters: preventing drug misuse deaths. [online] Available at: <https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths> [Accessed 21 Oct. 2018].

156. Ibid, p10. Fortson and McCulloch (2018)

An early warning drugs alert system acts as a trigger, informing both professionals and users of an emergent risk whether from a new synthetic drug that provokes a particular physiological response or where minimal quantities are required to bring on a rapid overdose. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)<sup>157</sup> note “as a frontline, low-threshold service, drug consumption rooms are often among the first to gain insights into new drug use patterns and thus they also have a role to play in the early identification of new and emerging trends among the high-risk populations using their services”. Such systems inevitably rely upon the collecting of intelligence from front line staff which can be used to inform others. A series of DCRs across the West Midlands would offer vital intelligence to the emerging West Midlands early warning network.

## 6.5 Domestic abuse and offering sanctuary

The Birmingham Domestic Abuse Strategy<sup>158</sup> recognises that victims of domestic abuse may resort to alcohol or drugs in order to cope with the abuse experienced or, worse still, may have been forced into dependency by their abusers. The report states that women who experience domestic abuse are eight times more likely to be drug dependent than others. Likewise, the Coventry Domestic Abuse Strategy notes that substance abuse (misuse of alcohol or drugs) may co-exist with mental health problems and is independently associated with domestic abuse.<sup>159</sup> These assertions are drawn from an understanding that problematic substance use overlaps with domestic and sexual violence<sup>160</sup> in behaviour which is often cyclical, starting

and ending with users in close personal relationships. The ONS statistics regarding intimate personal violence and partner abuse found that, among other factors, illicit drug use was associated with a higher risk of domestic abuse and a higher risk of sexual assault.<sup>161</sup> In section three of this report, reference is made to a cohort of users who require help injecting, mostly women who become shaped by gender powered intimate relationships and where coercive behaviour and violence plays a daily part in their lives.

In the West Midlands, reported domestic abuse incidents are increasing with 52,363 reports recorded in March 2017 and 54,583 incidents reported in the year ending March 2018.<sup>162</sup> Whilst it is difficult to know just how much of this abuse/violence involves drugs, there is strong evidence of a link. As evidenced in this report, a DCR can offer refuge to those who are caught up in intimate and violent relationships where drugs are sometimes used as a mechanism for control. There is no reason why a DCR could not play some part in reducing incidents of domestic abuse across the West Midlands, offering victims an escape from an abusive relationship.

157. European Monitoring Centre for Drugs and Drug Addiction (2016). Drug Consumption Rooms: An Overview Of Provision And Evidence. Perspective On Drugs. [online] Lisbon 2016. Available at: [http://filesserver.idpc.net/library/Drugconsumptionrooms\\_update%202016.pdf](http://filesserver.idpc.net/library/Drugconsumptionrooms_update%202016.pdf) [Accessed 22 Sep. 2018].

158. Birmingham City Council (2018). Domestic Abuse Prevention Strategy 2018-2023 - Changing Attitudes Changing Lives. Birmingham UK.

159. Coventry City Council (2018). Coventry Domestic Abuse Strategy. Coventry UK.

160. AVA (Against Violence and Abuse) (2013). AVA Toolkit. London.

161. Office National Statistics (2011). Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin. London: UK Government.

162. Rodger, J. (2018). There's a report of domestic abuse in West Midlands every nine mins. [online] birminghammail. Available at: <https://www.birminghammail.co.uk/news/midlands-news/theres-report-domestic-abuse-west-15467708> [Accessed 1 Jul. 2019].

# Out of harm's way

## 6. Added value for the West Midlands

### 6.6 Strategic connectivity

A DCR would provide additional value by contributing to the national and local strategic drivers that apply to the West Midlands in a variety of ways. For example, of the eight recommendations in the Reducing Crime, Preventing Harm report issued by the West Midlands Police and Crime Commissioner, David Jamieson, the seventh seeks to consider the benefits of a DCR and how it could add value to the current services. From the evidence cited in this report, DCRs could play a significant role in the mix of interventions that exist across the West Midlands and would also add value to the remaining seven recommendations in the Commissioner's report as well as contributing to some elements of national and local policy including the Government's 2017 Drug Strategy,<sup>163</sup> the 2018 Rough Sleeping Strategy (RSS),<sup>164</sup> the Domestic Abuse

Strategy 2018-2023,<sup>165</sup> the West Midlands Police Ambition Plan 2018-2020,<sup>166</sup> the Housing First initiative<sup>167</sup> and the West Midlands Combined Authority's 2017 joint report on healthcare issues amongst the homeless.<sup>168</sup> Crossover with the 2018 Serious Violence Strategy<sup>169</sup> can also be established in that it makes a link between criminality and drugs.

Furthermore, the Local Medical Committee, made up of GP representatives in Birmingham, elected to support a DCR in Birmingham in December 2017. Much of the evidence supports the idea that, since DCRs are primarily concerned with reducing the risk of disease by promoting sterile needle use, they play a role in the prevention of drug related deaths within a health and social care environment where routes into addiction treatment are well established.<sup>170</sup>

### How a DCR could work with existing services and current policy



163. Rudd, A. (2017). 2017 Drug Strategy. London: Crown Copyright 2017.

164. Ibid, Brokenshire, J. (2018).

165. Ibid, Birmingham City Council (2018).

166. Ibid, West-midlands.police.uk. (2018).

167. Ibid, Dare, T. (2019)

168. Ibid, Public Health England & West Midlands Combined Authority (2017).

169. Rudd, A. (2018). 2018 Serious Violence Strategy. London: Crown Copyright 2018

170. European Monitoring Centre for Drugs and Drug Addiction (2016). Drug Consumption Rooms: An Overview Of Provision And Evidence. Perspective On Drugs. [online] Lisbon 2016. Available at: [http://fileserver.idpc.net/library/Drugconsumptionrooms\\_update%202016.pdf](http://fileserver.idpc.net/library/Drugconsumptionrooms_update%202016.pdf) [Accessed 22 Sep. 2018].

## 6.7 Summary of section

This section of the report has demonstrated how DCRs could add value to the existing service provision across the West Midlands. Based on the evidence cited, additional day to day value would be had by:

- Providing emergency care
- Reaching out to the homeless and connecting with the hard to reach
- Better supporting PWIDs with their health needs
- Helping to address some of the risk factors associated with misuse
- Helping to prevent the spread of hepatitis B and C
- Reducing needle litter
- Impacting upon crime
- Being part of an early warning system
- Offering sanctuary for PWID
- Reducing encounters with the police and street disorder

The research also suggests that DCRs can add further value by augmenting other services. In France, for example, the facilities in Paris and Strasbourg are seen as an addition to existing Opioid Management Treatment, a Needle Exchange Programme (NEP) and the education programme for safer injection services. A report by the European Harm Reduction Network recognised the benefits of an “integrated model” for DCRs where they were interlinked with other services.<sup>171</sup>

Therefore, it remains to be said that a network of DCRs across the West Midlands could, in a wider more strategic sense, add value to existing services by:

- Working in tandem and co-ordinating with existing services
- Promoting a policy that puts harm reduction on an equal footing with enforcement
- Improving engagement with drug treatment, counselling services, housing and benefits advice
- Offering care and support and addressing adverse life circumstances
- Playing a role in the reduction of acquisitive crime
- Making savings to the public purse by way of preventing more complex health issues and the costs associated with responding to crime
- Supporting the health and policing prevention agenda
- Increasing the number of people accessing primary health care and drug treatment, especially among the hard to reach, such as homeless people
- Leading to fewer needle dumps by way of promoting sterile injection equipment
- Making a significant contribution to a drug alert framework
- Reducing the amount of ambulance call outs

171. Schäffer, D, Heino, S and Weichert, L (2014) Drug consumption rooms in Europe: Models, best practice and challenges, European Harm Reduction Network, Amsterdam

# Out of harm's way

## 7. The Challenges

### 7.1 The law

There are currently no DCRs in the UK despite support for opening them in several areas and, in the case of Glasgow, funding from the NHS being available. Their development has been stymied in part due to the nervousness of politicians at both local and national level and perhaps concerns among some members of the general public.

\*The main issue, however, relates to a legal framework which does little to provide comfort for clients, staff, regulatory agencies and law enforcement, in particular whether there could be a legal challenge based on contravention of the Misuse of Drugs Act 1971 (MDA) or the Serious Crime Act 2007 (SCA). These issues have been covered in detail by Rudi Fortson QC<sup>172</sup> and the lawyers at Release.<sup>173</sup>

Release observes that a DCR engages with a number of possible offences. Those accessing the facility will be in possession of a controlled substance and therefore at risk of arrest and prosecution under section 5 of the MDA.<sup>174</sup> This is equally true of staff under section 8 where there is a risk of criminal liability for managers in relation to related activities.<sup>175</sup> There are also offences which may be considered to have been committed under the SCA (although these do not apply in Scotland).

However, Release concludes that these risks are already being managed by other drug services who provide needle exchange programmes where those collecting new needles will be in possession of the drugs they are about to inject. There are also policies in place to protect staff under section 8 of the 1971 Act, such as taking action if there is dealing in the facility.

As far as policing is concerned, a DCR could theoretically operate with a memorandum of understanding between the local police, Crime Commissioners, the local authority, relevant health and treatment groups and the local CPS<sup>176</sup>. This stance is already taken for needle exchange programmes when it is not seen as expedient to prosecute for possession of a controlled substance where a user has been accessing sterile equipment provided by a treatment service.<sup>177</sup> Moreover, the CPS charging standards state categorically that it is not in the public interest to bring charges against people accessing or working in needle exchanges due to public health objectives outweighing public interest in prosecution.<sup>178</sup>

At present, many bodies are unwilling to proceed without Government approval and, to date, the Home Office has said it does not intend to amend the law to clarify the legal situation around DCRs. However, legal concerns could be addressed through:

- In the short term, the Home Office issuing an explicit statement stating that the operation of DCRs is a matter for local authorities and police forces working together with the CPS, health bodies and treatment groups.
- In the long term, the UK Parliament amending the relevant legislation to make operating DCRs explicitly legal.

Whilst a legal challenge might currently be seen as a barrier, given the establishment of DCRs across Europe and beyond, many requiring amendments to local drugs laws, clearly this is not insurmountable.<sup>179</sup>

172. Fortson (QC), R. (2017). Setting Up A Drug Consumption Room. [online] London: Rudi Fortson. Available at: <https://www.rudifortson4law.co.uk/legaltexts/Rudi-Fortson-DCR-legal-issues-17thOct2017-v1.pdf> [Accessed 6 Jan. 2020].

173. Eastwood, N. and Carre, Z. (n.d.). Release's Written Submission to the Scottish Affairs Committee: 'Use and Misuse of Drugs in Scotland' Inquiry. [online] London: Release. Available at: <https://www.release.org.uk/sites/default/files/pdf/publications/Release%20submission%20to%20Scottish%20Affairs%20Committee%20on%20%27Drug%20use%20%20misuse%20in%20Scotland%27%20-%20Copy.pdf> [Accessed 6 Sep. 2019].

174. Ashton, M. (2016). Time for safer injecting spaces in Britain?. [online] Findings.org.uk. Available at: [https://findings.org.uk/PHP/dl.php?file=hot\\_rooms.hot&s=eb](https://findings.org.uk/PHP/dl.php?file=hot_rooms.hot&s=eb) [Accessed 16 Jul. 2019].

175. Ibid, Ashton, M (2016)

176. Browne, S. (2019). Safety First? A critical analysis of emerging alternatives to law enforcement of illegal drug use in the United Kingdom. Undergraduate. Canterbury Christ Church University.

\* Release is a charity, they are the national centre of expertise on drugs and drug law.

178. Ibid, Ashton, M (2016)

179. Ibid. Ashton, M (2016)

## 7.2 Attempts to develop a facility (UK)

Although there were informal consumption rooms in London in the 1970s, there are currently no official DCRs in the UK. In 2002, a Home Affairs Select Committee recommended that “an evaluated pilot programme of safe injection houses for [illicit] heroin users [be] established without delay”<sup>180</sup> and, depending upon its success, the Committee would then recommend that the programme be extended across the country. They also sought to amend section 9A of the Misuse of Drugs Act 1971 to ensure that agencies could conduct harm reduction work and provide safe areas without fear of prosecution.<sup>181</sup> However, the Labour government at the time rejected the recommendation for DCRs, in part because they feared being open to legal challenge and wanted to maintain their commitment as being seen to be ‘tough on crime’.

In 2004, the British Medical Journal published a paper arguing for the pilot of DCRs in the UK seeking to override the rejection of the concept as they felt it would benefit a different cohort to those engaged in HAT, namely long term heroin addicts and people who are socially excluded such as the homeless.<sup>182</sup>

2006 saw the establishment of an Independent Working Group (IWG) set up to revisit the case for DCRs. It was chaired by Dame Ruth Runciman, known for her work in the drugs sector, and was populated by a professor, senior police officers and a barrister<sup>183</sup>. A report was produced in partnership with the Joseph Rowntree Foundation that recommended the establishment of a

DCR pilot in the UK. The Home Office rejected the idea and although the opposition leader at the time, David Cameron, voiced support, he did nothing to develop the agenda.

In 2012, an independent drugs commission was set up in Brighton which, at the time, had the highest rates of drug related mortality in the UK. The Brighton Safety City Partnership paper recommended a feasibility study that would look at incorporating a DCR as part of the service offer to support PWID<sup>184</sup> focusing on those who were hard to reach and not engaged in treatment. The feasibility study recommended a DCR but, due to budget priorities, unsupportive advice from the Home Office and opposition from the then Association of Police Chiefs and the Sussex police, the plans were abandoned, concluding that DCRs were not a priority for Brighton and Hove at that time.<sup>185</sup>

Due to the rapid rise in HIV, hepatitis B and C in 2015, the Greater Glasgow and Clyde and Glasgow City Alcohol and Drugs Partnership initiated a project to review the health needs of people who inject drugs. An information report, ‘Taking Away the Chaos’, was commissioned which included seven recommendations, the fifth of which was to evaluate a pilot for a safer injecting facility in the city.<sup>186</sup> Projected to open in early 2018, plans for the facility were put on hold after the Lord Advocate ruled a DCR could not be established without a change in the law.<sup>187</sup>

180. Joseph Rowntree Foundation (2006). The Report of the Independent Working Group on Drug Consumption Rooms. [online] York: Joseph Rowntree Foundation, p.7. Available at: <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/9781859354711.pdf> [Accessed 22 Sep. 2019].

181. Ibid. Ashton (2016)

182. Wright, N. (2004). Supervised Injection Centres. [online] The BMJ. Available at: <https://doi.org/10.1136/bmj.328.7431.100> [Accessed 20 May 2019].

183. Lloyd, C., Stöver, H., Zurhold, H. and Hunt, N. (2016). Similar problems, divergent responses: drug consumption room policies in the UK and Germany. *Journal of Substance Use*, [online] 22(1), pp.66-70. Available at: <https://www.tandfonline.com/doi/abs/10.3109/14659891.2016.1143049> [Accessed 22 Sep. 2019].

184. Ibid. Ashton (2016)

185. Chute, T. (2014). Drug consumption rooms off the agenda. [online] Brightonandhoveindependent.co.uk. Available at: <https://www.brightonandhoveindependent.co.uk/news/drug-consumption-rooms-off-the-agenda-1-7720228> [Accessed 19 Jun. 2019].

186. Ibid, p5. NHS (2017)

187. Paterson, S. and Naysmith, S. (2018). Glasgow undeterred as Home Office blocks ‘fix room’ plan. [online] Herald Scotland. Available at: <https://www.heraldscotland.com/news/16265011.uk-government-accepts-drugs-fix-rooms-will-work-but-wont-allow-glasgow-to-open-one/> [Accessed 20 Apr. 2019].

# Out of harm's way

## 7. The Challenges

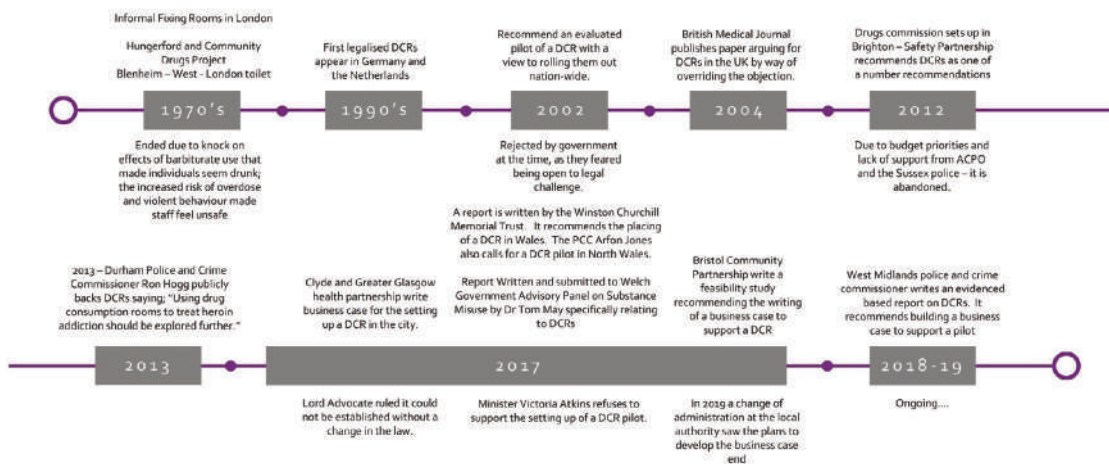
The Winston Churchill Memorial Trust Fellowship's document, 'A Welsh Response' (2017), looks specifically at the benefits of DCRs with recommendation nine seeking to establish multiple DCRs in Wales that ideally are attached to established drug and alcohol treatments services.<sup>188</sup> 2017 also saw the submission of a report written for the Advisory Panel for Substance Misuse at the Welsh Government that specifically related to DCRs and which recommended a feasibility study.<sup>189</sup> Support was received from the previous North Wales Police and Crime Commissioner, Arfon Jones, who called for a DCR pilot in Wrexham, recognising that it could contribute to reductions in drug related deaths and help to prevent fear of crime and anti-social behaviour.<sup>190</sup>

In 2017, a feasibility study was conducted that asked the question as to whether a DCR could bring

significant benefits in reducing drug related deaths and other community harm in Bristol. The report ended by recommending the Safer Bristol Partnership to support the development of a draft business case to scope the provision of a DCR.<sup>191</sup> In April 2019, it was announced that the council had decided not to proceed with the study, having undergone a change in administration at the local authority.<sup>192</sup>

Over the past few years there have been various reports written that support the development of a DCR in the UK. Many of these have been referenced in the footnotes of this report and evidence has been drawn from them. Thus far, four Police and Crime Commissioners have actively called for DCRs: David Jamieson (West Midlands)<sup>193</sup>, Arfon Jones (North Wales)<sup>194</sup>, Ron Hogg (County Durham)<sup>195</sup> and Martyn Underhill (Dorset).<sup>196</sup>

### At a glance history - attempts to set up a DCR in the UK



188. Barker-Williams, R. (2017). Drug Consumption Rooms: A Welsh Response. [online] Winston Churchill Memorial Trust, p.9. Available at: <https://www.wcmt.org.uk/sites/default/files/report-documents/Barker-Williams%20R%20Report%202017%20Final.pdf> <https://www.wcmt.org.uk/sites/default/files/report-documents/Barker-Williams%20R%20Report%202017%20Final.pdf> [Accessed 21 Jun. 2019].

189. May, T. (2017). A Review of the Effectiveness of Medically Supervised Injecting Centres. Pontypridd: Centre for Criminology - University of South Wales.

190. Jones, A. (2017). Looking to the Future. [online] Office of the Police and Crime Commissioner for North Wales. Available at: <https://modgoveng.conwy.gov.uk/documents/s94516/11.Looking%20to%20the%20future.Draft.pdf> [Accessed 21 Jun. 2018].

191. Ibid, p26. Clark and Torrance (2018)

192. Edwards, M. (2019). Revealed: Council shelves study into safe consumption rooms after restructure | The Bristol Cable. [online] The Bristol Cable. Available at: <https://thebristolcable.org/2019/04/revealed-council-shelves-study-into-safe-consumption-rooms-after-restructure/> [Accessed 21 Jun. 2019].

193. Ibid, West Midlands Police and Crime Commissioner (2018)

194. Ibid, Arfon, J. (2017)

195. Marshall, C. (2018). Police commissioners urge Home Office to drop opposition to addicts' 'fix rooms'. [online] Scotsman.com. Available at: <https://www.scotsman.com/news-2-15012/police-commissioners-urge-home-office-to-drop-opposition-to-addicts-fix-rooms-1-4762383> [Accessed 23 Jun. 2019].

196. Lewis, J. (2019). Dorset Backing for Introduction of Supervised Drug Consumption Rooms. Daily Echo.



## 8. Conclusion and recommendations

The evidence explored throughout this report suggests that a Drug Consumption Room in the West Midlands would significantly help to reduce the cost, reduce the crime and reduce the harm from drugs. A DCR can support other harm reduction measures, control the spread of HIV and Hepatitis and help to engage vulnerable individuals into treatment and other support services.

The research suggests that DCRs can augment other services. In France, for example, the facilities in Paris and Strasbourg are seen as an addition to existing Opioid Management Treatments, Needle Exchange Programmes (NEP) and the education programme for safer injection services. A report by the European Harm Reduction Network recognised the benefits of an “integrated model” for DCRs where they were interlinked with other services.<sup>197</sup>

The key provider for addiction services in Birmingham and Coventry, has indicated that they would engage with any proposals to develop a DCR, recognising that they offer an “evidenced based approach” and provide a service to those who are ‘hard to reach’.<sup>198</sup>

There are currently no DCRs in the UK, their growth and potential having been stilted in part due to nervous politicians at both local and national levels, a legal framework which does little to provide comfort for users, staff, regulatory agencies and law enforcement and the wider general public who understandably show cause for concern.

The paradox is plain to see. In one context, DCRs appear to endorse the purchasing and taking of class A drugs for individuals who, as a consequence of their addiction, often do damage not only to themselves and their families, but to society at large. In another context, such practices are seen by many as being worthy of prosecution. Wherever there is a desire to develop a DCR, this contradiction has to be negotiated.

Thus far, attempts to find a way around the law have failed, leaving the UK far behind other countries in Europe who have turned to harm reduction strategies grounded in health and not criminality. Once the

discourse is framed within the context of harm reduction, the proposition of a DCR becomes much more plausible simply because such facilities keep PWID safe out of harm’s way as they manage the highs and lows that an individual will experience. The trained staff at a DCR who build relationships with individuals are more likely to assess when someone is ready to begin to take control of their lives or to reduce their substance intake and can support those who lapse before they completely lose themselves.

An injection centre could also help to manage and control the spread of HIV and hepatitis as well as the current levels of drug-related deaths across the West Midlands. The evidence suggests that DCRs do not lead to an increase or decrease in drug usage. On the contrary, such a facility could also act as a central hub and referral mechanism, linking with local support services, and thereby offering a web of social support based on the health needs of individuals using the facility. Such facilities have been shown to be cost effective in health, social and economic terms and, in some cases, impact upon elements of acquisitive crime.

The Police and Crime Commissioner’s report (2018)<sup>199</sup> points to a new perspective in drugs policy, one which is dictated by evidence and compassion, devoid of political cynicism and hysteria where the emphasis is centred on harm reduction. The evidence cited in this report shows that DCRs are essentially orientated towards supporting individuals and reducing the harms that they might otherwise be exposed to. Custody or prison is not the best place for someone with an addiction, this often becomes yet another obstacle on a journey to recovery where, upon release, a seasoned user may well re-visit crime to fund an addiction. Solutions must address the root cause of criminality to prevent future offending. In such circumstances, the establishment of a DCR might offer a more holistic solution as their primary function is centred on harm reduction. The development of a network of DCRs would therefore meet the aspirations of the West Midlands PCC in that they would limit the social and economic impacts of daily users thus providing the potential for additional savings to the public purse, less crime and less victims as a result.

197. Schaffer, D., Stover, H. and Weichert, L. (2014). Drug consumption rooms in Europe: models, best practice and challenges. Amsterdam: European Harm Reduction Network.

198. Ibid, p20. West Midlands Police and Crime Commissioner (2018)

199. Ibid, p3 West Midlands Police and Crime Commissioner (2018)

# Out of harm's way

## 8. Conclusion and recommendations

DCRs could therefore make a significant contribution to the PCC's drug strategy by;

- a) Reducing acquisitive crime by helping people into treatment
- b) Reducing the harm that those suffering from addiction cause to themselves and to society
- c) Helping to reduce the estimated annual bill associated with substance misuse to the West Midlands of £1.4bn

The law would seem to be the biggest obstacle to overcome. But, in spite of the associated challenges and sensitivities connected with DCRs, it is clear that such a facility would be a valuable asset in supporting those suffering from addiction in the West Midlands. The evidence cited in this report leads to two key recommendations and the West Midlands Police and Crime Commissioner will be working with key stakeholders and service providers across the West Midlands to:

- Develop a business case through a multi-agency steering group for a drug consumption room in the West Midlands, based on the overwhelming evidence detailed within this report.
- Work with Government and the multi-agency steering group to support a DCR pilot site in the West Midlands.



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### Appendix A – Cost of UK healthcare

#### The cost of healthcare in the UK 2018

Curtis and Burns (2018)

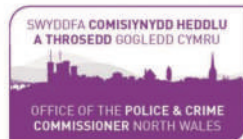
GP appointment	£37.00
Drug services – admitted into care per day	£454 - £535
Drug services – out-patient visit	£96 - £149
Community drug services	£208 - £297
Ambulance – see treat and convey	£250 - £260 per incident
Non-elective inpatient stays – short	£626 - £714
Inpatient emergency	£383 (decedent £5,231)
Inpatient non-emergency	£102 (decedent £1395)
Outpatient	£44 (decedent £600)



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## 9. Appendices

### Appendix B – Letter to Victoria Atkins MP



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Victoria Atkins MP  
Minister for Crime, Safeguarding and Vulnerability  
Home Office  
2 Marsham Street  
London  
SW1P 4DF

Our Ref: AJ/HE/1713

04 May 2018

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"<sup>i</sup>. 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**

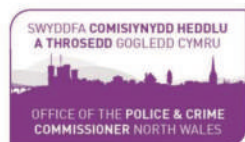
In your letter to the ACMD you state that The Home Office's International Comparators report "concluded that DCRs have often been legally problematic, pose ethical issues for medical professionals and difficulties for law enforcement"<sup>i</sup>. However the same report found that DCRs "increase access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

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"<sup>ii</sup>.

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

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:



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*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.* <sup>vii</sup>

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. <sup>viii</sup>

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

In your letter to the ACMD you state:

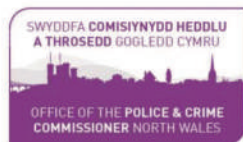
**"Over half of all organised crime groups operate in the UK are involved drug-related crime"** <sup>ix</sup>

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]" <sup>x</sup>, 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

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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”<sup>xi</sup>**

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

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<sup>xv</sup> - a cost which could be significantly reduced by introducing DCRs<sup>xvi</sup>.

**“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”**

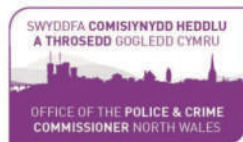
This figure is from the Home Office's evaluation of the Drug Strategy 2010, which also notes that “activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability”. This enforcement also has many “potential unintended consequences”, the report describes, including drug market violence, “health harms from varying purity of drugs”, and the “negative impact of involvement with the criminal justice system”.<sup>xvii</sup> 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;*



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- *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 borne 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

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### Appendix C – Cost of a small Enhanced Harm Reduction Centre (outline proposal Wrexham)

#### Proposal

This proposal is to establish an Enhanced Harm Reduction Centre (EHRC) on the Kaleidoscope/ARCH premises at 21 Grosvenor Rd, Wrexham, LL11 1BT. The building is leased by ARCH/Kaleidoscope on a five year lease, running until 31st October 2020, and it currently has the necessary planning consent class (D1) which allows medical or health services to be delivered on site.

The building is currently used by the Kaleidoscope/ARCH Drug Interventions Project (DIP) Affinity Partnership, a service for drug and alcohol users involved with the Criminal Justice system, commissioned by the North Wales Police and Crime Commissioner. The building is used for non-clinical substance misuse treatment and support activity which primarily involves one to one case management/psychosocial intervention with drug and alcohol users, in addition to group work and various on-site recreational activities. Service user activity takes place on the ground floor. Staff members have office space on the first floor where some desk space is also made available to staff members employed by the probation service.

The proposal has been developed as a lowest-cost option to establish an EHRC. Premises costs are already funded by the PCC, hence the costs are largely limited to premises adjustment, equipment and staffing.

#### Service scope

Two injecting booths and space for people to undergo recovery so four people at any one time max?



*Chill-out/recovery space*

#### Operating considerations

Opening the unit will depend on having a clinically qualified member of staff on site at all times. This is a highly specialised area of work. A full-time RGN will be recruited and, in the initial stages, the unit will only be operational whilst the post-holder is in work and on site. This will mean that the EHRC will not be open during periods of the post-holder's absence. However, the intention would be to identify other clinical staff in the area who would be willing to work 'bank' shifts to cover the unit.

#### Premises redesign

In order to accommodate the EHRC, consideration will be given to the current use of the building, acknowledging that current activity and the proposed EHRC activity need to be completely separate. This will be best achieved by creating an access to the EHRC at the rear of the building with a dedicated entrance to a self-contained area of the building.

The EHRC will be sited in the current rear training/meeting room.





### Reconfiguration costs

Create porch area above car park steps	
Remove patio door and install external door	
Install door entry buzzer system	
Change toilet layout and isolate disabled toilet for EHRC use	
Split and extend remaining toilets to create a disabled toilet	
Redecorate walls	
Remove existing carpet and lay vinyl	
Partition walls to create two independent booths	
Install clinical area/sink	
<b>Total (complete guess at this point)</b>	<b>£15,000</b>

### Facility set up costs

2 x stainless steel clinical tables for injecting in each booth	£200
Chairs for the above	£100
Clinical couch	£100
Vaccination fridge	£300
Anaphylaxis / resuscitation kit	£200
Other furnishings	£400

### Operating costs

Area	Cost
Full time RGN (Band 6 equivalent)	£30,000
(Pension, NIC, training and supervision of nurse)	£5,000
Bank/Agency nurse cover (six weeks)	£7000

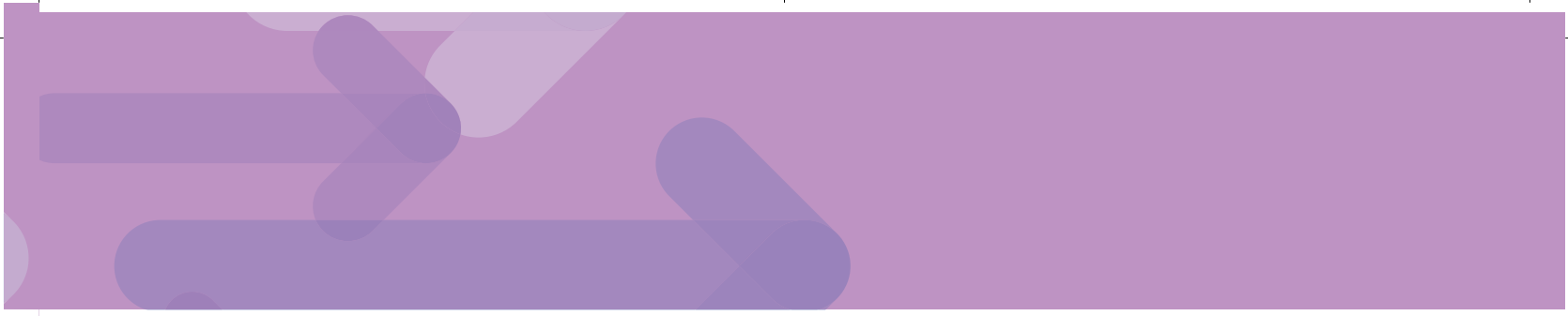




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## Notes







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