We were very grateful for the opportunity to provide oral evidence to the Committee yesterday. I attach the correspondence to which I referred with both the Home Office and the DHSC. NAT on behalf of the Harm Reduction Group supported the drafting of these letters. We have not seen a response to the second letter sent to the Home Office.

The main point on Drug Consumption Rooms (DCRs) made by the Home Office Minister, Victoria Atkins, in her response was that ‘we are not prepared to sanction or condone activity that promotes the illicit drug trade and the harm that trade causes to individuals and communities’. We believe this suggests a lack of understanding within the Home Office of the basic principles of harm reduction. Furthermore it is inconsistent with, for example, the acceptance by the Home Office of drug checking services such as those rolled out by The Loop and Addaction. A disturbing appearance of social bias emerges where harm reduction is permitted at festivals attended by young professionals and students but harm reduction is prohibited for often homeless and marginalised people who are injecting in unsafe public spaces. DCRs, far from promoting the harm caused by the drug trade, mitigate and prevent those harms, reducing significantly blood borne virus transmission and drug-related deaths, as well as offering a way in to drug treatment services which can support people away from any contact with the illicit drug trade. EMCDDA make clear that DCRs ‘facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime’ http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en.

We were pleased to see in the response from the DHSC Minister, Seema Kennedy, a more considered and positive view on the benefits DCRs can bring, ‘.. there is international evidence that drug consumption rooms can be effective at addressing problems of public nuisance and reducing health risks’. She did, however, raise a concern that ‘there is a risk that such facilities would be at the expense of other, more relevant, evidence-based drug services’. Of course any local area will need to decide on the cost-effectiveness of opening a DCR and how it complements other key services. The delegation of public health powers to local authorities was precisely to empower local authorities to come to a view on such spending priorities on the basis of their knowledge of local needs and populations. We do not know of any evidence that the risk referred to by the Minister actually exists. It certainly is not a reason to prohibit DCRs in law and deny local authorities and health systems the power to make up their own mind as to whether a DCR might be useful.

We would again urge the Government to allow immediately the opening of DCRs, for example in Glasgow, by assurances that no law enforcement or prosecution would take place in relation to the appropriate operation of such a facility. We would also urge as soon as possible primary legislation to make it absolutely clear that DCRs are a lawful harm reduction intervention.

I was also asked about the data I cited on the lack of HIV testing in Needle and Syringe Programmes (NSPs). In 2017, in the Unlinked Anonymous Monitoring (UAM) survey of people who inject drugs, 67% (1,326/1,971) of PWID who accessed a clinical service in the preceding year had not been tested for HIV. Most of those who had not been tested for HIV were being prescribed a substitution drug (72% not tested), had seen their general practitioner (60%) or had used a needle and syringe programme (59%) during the previous year. This was taken from PHE’s latest report on HIV in the UK, page 60: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759408/HIV_annual_report_2018.pdf
This raises for NSPs (but also of course for other services such as drug treatment and primary care) the question of why there is for such a key risk group such a high proportion of people who are not being tested for HIV. We must assume similar gaps in hepatitis C testing. More data gathering and research is needed from PHE to investigate this. But we have heard anecdotally that BBV testing is not as widespread as it used to be or should be. It would be good to know whether NSP provision is being thinned out to predominantly level 1 provision rather than also including the levels 2 and 3 provision expected by NICE where HIV and hepatitis testing can be encouraged and/or provided (see https://www.nice.org.uk/guidance/ph52/chapter/1-Recommendations).

Yusef Azad

Harm Reduction Group

June 2019
Drugs, Alcohol & Justice Cross-Party Parliamentary Group  
Co-Chairs: Lord Ramsbotham and Mary Glindon MP

Drugs, Alcohol and Justice Cross-Party Parliamentary Group  
4th Floor  
160 Falcon Road  
London  
SW112LN

The Rt Honourable Sajid Javid  
Secretary of State for the Home Department  
Home Office  
Peel Building  
2 Marsham Street  
London  
SW1P 4DF

6th August 2018

Dear Secretary of State,

Re: The opening of a Drug Consumption Room in Glasgow

As you will be aware, in 2015 an outbreak of HIV was detected amongst people who inject drugs (PWIDs) in Glasgow. The outbreak in Glasgow means that there are now over 100 cases of HIV amongst PWIDs there. While HIV prevalence amongst PWIDs in the UK remains low, standing at less than 1 in 100 (around 0.85%), 83% of those interviewed who had acquired HIV in the Glasgow outbreak reported public injecting, from a group of around 400-500 people known to inject opiates publicly in the area, which could equate to a prevalence rate far higher than the UK average. This outbreak is ongoing and without implementation of further harm reduction interventions it is unlikely that it will be controlled.

This also comes at a time of increased drug-related deaths in Scotland. New figures from the National Records of Scotland showed that 934 drug-related deaths were recorded in 2017. This is the largest number since the figures started being collated in 1996, and more than double the 2007 total.

Supervised Drug Consumption Rooms (DCRs) are legally sanctioned facilities where people can inject illicit drugs obtained themselves, under the medical supervision of trained staff. There is a wealth of evidence that suggests there are major advantages to DCRs in tackling disease transmission which include the provision of clean injecting equipment, medical supervision for injection and a space to hygienically inject drugs. The UN Office of Drugs and Crime said in 2016 that drug policy should be evidence based and focused on public health. DCRs follow this guidance as the evidence from Switzerland, Canada and elsewhere shows that they are cost-effective and have far superior public health outcomes in terms of recovery. DCRs are effective in significantly reducing the sharing of injecting equipment and drug-related deaths. Over 100 DCRs currently operate in 66 cities, in 10 countries - Switzerland, Germany, the Netherlands, Norway, France, Luxembourg, Spain, Denmark, Australia and Canada. There has never been a case of a death from overdosing in any DCR in the world.

While some politicians have voiced concern that DCRs can increase the use of illicit drugs and crime a review by the European Monitoring Centre for Drugs & Drug Addiction (EMCDDA) concluded:
"There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry, and do not result in higher rates of local drug-related crime."

The Advisory Council on the Misuse of Drugs (ACMD) in their report to the UK Government entitled 'Reducing Opioid-Related Deaths in the UK' recommended that "consideration is given - by the governments of each UK country and by local commissioners of drug treatment services - to the potential to reduce drug-related deaths and other harms through the provision of medically-supervised drug consumption clinics in localities with a high concentration of injecting drug use". "NHS Greater Glasgow and Clyde (NHSGGC) have recommended a DCR is implemented in Glasgow, and the initiative is supported by a range of stakeholders including Scottish Parliament and the Glasgow City Council. NHSGGC also canvassed views of PWID's involved in public injecting. All were in favour of introducing a safer injecting facility in Glasgow city centre and all asked agreed that they would use a DCR and that it would reduce the likelihood of injecting in public."

The position from the Government to date has been simply to insist on the unlawfulness of DCRs under the Misuse of Drugs Act 1971. We strongly believe a more open-minded and innovative approach is urgently needed to save lives and prevent the spread of blood-borne viruses such as HIV.

We believe the opening of a DCR in Glasgow is an urgent priority. In the short term, we request the Home Secretary takes the same approach as they recently announced with festival drug testing, by sending a message that local Police & Crime Commissioners and Health Authorities can develop their own positions without direction from Westminster. This would allow a DCR to open promptly. Whether the DCR is then permanently secured through an amendment of the Misuse of Drugs Act 1971 (proposed, for example by the Supervised Drug Consumption Facilities Bill 2017-19 currently before parliament) or by devolving law in relation to drug policy to the Scottish Parliament is of less importance than the immediate need for delivery of harm reduction in Glasgow.

We would welcome a meeting with you to discuss this important issue. Please send any response to this letter to Richard Hanford, Drugs, Alcohol and Justice Cross-Party Parliamentary Group.

Yours sincerely,

Lord Ramsbotham
Co-chair, Drugs, Alcohol and Justice Cross-Party Parliamentary Group

Mary Glindon MP
Co-chair, Drugs, Alcohol and Justice Cross-Party Parliamentary Group

Baroness Meacher
Co-chair, The All Party Parliamentary Group on Drug Policy Reform

Jeff Smith MP
Co-chair, The All Party Parliamentary Group on Drug Policy Reform

Richard Hanford, Co-ordinator,
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Chair, The All Party Parliamentary Group on HIV/AIDS

Baroness Masham
Co-chair, The All Party Parliamentary Group on Liver Health

Baroness Randerson
Co-chair, The All Party Parliamentary Group on Liver Health

David Amess MP
Co-chair, The All Party Parliamentary Group on Liver Health

Baroness Barker
Chair, The All Party Parliamentary Group on Sexual and Reproductive Health

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Richard Hanford, Co-ordinator,
Drugs, Alcohol and Justice Cross-Party Parliamentary Group
4th Floor, 160 Falcon Road, London SW11 2LN Tel: 0207 801 2
Dear Colleagues,

Thank you for your letter of 6 August addressed to the Home Secretary about drug consumption rooms (DCRs). I am replying as the Minister for Crime, Safeguarding and Vulnerability with responsibility for drugs. I am sorry for the delay in responding.

Our position on DCRs has been clear for some time: we have no plans to introduce them. As our 2017 Drug Strategy sets out, we are committed to preventing drug use in our communities and supporting people dependent on drugs through treatment and recovery. DCRs do not form part of that approach.

As you know, the Government has considered evidence in both our own International comparators report and in international studies. The Government's report, Drugs: International Comparators (2014), notes that DCRs have emerged in some countries as a response to public health risks associated with open drug scenes, most often to address acute problems specific to a local area. However, there remain legal and ethical issues for agencies involved, such as medical professionals and enforcement agencies.

Principally, we are not prepared to sanction or condone activity that promotes the illicit drug trade and the harms that trade causes to individuals and communities. Our clear message remains that drugs controlled under the Misuse of Drugs Act 1971, and their supply, present such harms that possessing them under any circumstances must be subject to a commensurately strict regime.

As I have mentioned, the Drug Strategy sets out a balanced approach which brings together police, health, community and global partners to tackle the illicit drug trade, protect the most vulnerable and help those with a drug dependency to recover and turn their lives around. This includes action to respond to the increases in drug-related deaths, and the measures to reduce wider healthcare issues, such as blood-borne viruses and overdose through appropriate Naloxone provision.
Additionally, the Government supports local areas that pursue heroin assisted treatment. We are clear that reducing the harms caused by drugs needs to be part of a balanced approach and the Modern Crime Prevention Strategy recognises the potential of heroin assisted treatment (prescribed diamorphine) in helping people to recover. There is evidence from the UK, and other countries, that supervised use of this in a medical environment as part of a treatment plan can help keep patients in treatment and out of criminal behaviour.

To inform our approach, we have also commissioned the Advisory Council on the Misuse of Drugs (ACMD) to explore the challenges faced by older people with a history of problematic drug use to provide insight into what recovery means for them. We expect the ACMD to publish its report into its findings later this year and will consider what action we might need to take in response.

Any options we consider must be within our existing framework and aligned to the spirit of the 2017 Strategy. We will continue to support local areas to develop a more joined-up approach to commissioning and delivering the range of services that are essential to supporting recovery and preventing drug-related deaths.

I regret that due to diary pressures I will be unable to meet you to further discuss this important issue at this time. However, I hope that this letter provides reassurance that the Government is committed to tackling the harms of drug misuse.

Yours sincerely,

Victoria Atkins MP
Re: The opening of a Drug Consumption Room (OCR) in Glasgow

Thank you for letter dated 29 October 2018 (HOCS reference MIN/0013075/18). This letter was in response to a letter (6 August 2018) sent by Chairs of the Drugs, Alcohol and Justice Parliamentary Group, the APPG on Drug Policy Reform, the APPG on HIV/AIDS, the APPG on Liver Health, and the APPG on Sexual and Reproductive Health regarding the need for a Drug Consumption Room in Glasgow - to curtail the HIV outbreak and drug-related harms experienced there by people who inject drugs.

We appreciate you outlining the Government's position on DCRs. We, however, want to take this opportunity to counter some of the reasons you have chosen not to allow a OCR to open in Glasgow.

In your letter you acknowledge that DCRs have been opened abroad to address 'acute problems specific to a local area' where there are 'public health risks associated with open drug scenes'. This is exactly why we are asking for a OCR to open in Glasgow. This is where we have the worst HIV outbreak amongst people who inject drugs that we have seen in the UK for a long time as well as one of the highest rates of drug-related deaths across Europe. The HIV outbreak is primarily affecting a group that is severely marginalised and injecting in public spaces. The OCR is supported by all the key stakeholders locally in Glasgow.

You state that you are not prepared to condone activity that promotes the illegal drug trade. However, as international evidence shows, DCRs support people into structured drug treatment that takes them away from the illicit drug trade that you speak of. As mentioned in our last letter, the ECMDDA has clearly stated that the evidence shows that DCRs do not increase criminal behaviour or illicit drug taking.

Richard Hanford, Co-ordinator,
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Co-Chairs: Lord Ramsbotham and Mary Glindon MP

They are wraparound services that protect people from overdose and death, but can also act as a first-point-of-care service that allows health professionals to engage people who require further support. If we want to protect people from the illegal drug trade, DCRs are an effective way of bringing people into care.

It seems that the UK Government’s approach to drug policy is mired in inconsistency. We would question how DCRs differ from other harm reductions interventions such as festival drug testing that the Government supports, or interventions such as needle and syringe programmes, that recognise that there is a duty to protect people from the most severe drug-related harm before and while they are being supported to recover from drug addiction.

We also dispute whether the ethical or legal barriers to DCRs that you mention in your letter are insurmountable. The legal barriers are solely created by Government. If you were to make provision for DCRs, then they could operate within the context of drug misuse legislation in the same way that other harm reduction services do currently. With regards ethical barriers, it would be good to hear what you perceive these barriers to be. Certainly, it should be noted that there is an ethical imperative to protect people from harm and death, which is exactly what DCRs do. People working within a OCR would be healthcare professionals who would be required to manage difficult situations in the same way that healthcare professionals who work across the NHS have to do every day - for which they should be commended. It is, again, important to remember that there has never been a death in any OCR across the world.

The Government appears to ignore the evidence that shows overwhelmingly that DCRs can reduce drug-related deaths, drug-related harm, drug-related litter, the sharing of injecting equipment and blood-borne viruses, and encourage people to engage in structured drug treatment.

We would ask that you agree to meet with us as a matter of urgency so that we may discuss ways forward on the current impasse around DCRs. I am sure that you will agree that regardless of our differences in position, there needs to be opportunity for discussion and debate.

Please send any response to this letter to Richard Hanford, Drugs, Alcohol and Justice Cross-Party Parliamentary Group. We look forward to hearing from you as soon as possible.

Mary Glindon MP
Co-Chair, Drugs, Alcohol and Justice Cross-Party Parliamentary Group
Dear Minister,

Re: Drug-related deaths and how local authorities are responding

As you will know, drug-related deaths (DRDs) are at their highest level since records began in 1993. There were 3,756 DRDs in England and Wales last year, 53% of which related to opiate use. Almost a third of all deaths from overdose in 2016 in Europe happened in the UK. This constitutes a public health and humanitarian crisis which must be addressed urgently.

In May 2018, we wrote to the 40 local authorities with higher than benchmarked rates of DRDs asking them to tell us what their plans were to reduce DRDs in their area. We received responses from 35 local authorities which are detailed in our recently published report ‘Drug-related deaths in England: local authorities and how they are responding’ (attached).

Many local authorities told us that both specific cuts to the Public Health Grant, and thus to funding for drugs services, as well as wider cuts to other important support services, are limiting what they can do in response to their high rates of DRDs. For example, Bournemouth, Poole & Dorset stated that “it is particularly challenging that these funding pressures are being placed on local authority public health services at a time when the need for coordinated and effective health and social care for opiate users is increasing”. This clearly illustrates how adequate funding of the Public Health Grant is a matter of life or death. We are writing to you to urge you to reverse recent cuts to public health funding, and instead provide sufficient resources to meet need, in line with your own commitment to prevention.

We also continue to be deeply concerned by the imminent end of the Public Health Grant. We strongly recommend that the Public Health Grant to local authorities is maintained. In the event the Grant does end it must be taken into consideration that, unlike for sexual health services, local authorities are not mandated in law to provide drug treatment services, which could lead to
complete decommissioning of services in some areas. To protect against this, we suggest the Government amends legislation to create a mandate in law meaning local authorities would have to provide drug treatment services.

The responses we received further revealed how local authorities are struggling to provide a number of key harm reduction interventions in line with need. Naloxone is a cheap and highly effective medication used in response to an opioid overdose and can prevent death. However, coverage overall across England remains poor. Local authorities are making welcome efforts to improve provision. But some local authorities are restricting access to take-home naloxone to only those in treatment. Given the fact that most deaths are happening to people not currently in structured treatment this is worrying. These local authorities said that a lack of funding meant they could not extend the service. Funding for naloxone should be increased to meet need. We also recommend that the Government assesses the merits of a national naloxone programme, which would improve provision and accountability.

Several local areas mentioned Heroin Assisted Treatment (HAT)-prescribing medical grade heroin, diamorphine, to patients who do not respond to first line Opioid Substitution Therapy (OST) medications, such as methadone and buprenorphine. Uptake of HAT is low across England, mainly due to the costs involved in setting a service up. In order for uptake of HAT in local areas to increase, we would encourage the UK Government to take up the Advisory Council on the Misuse of Drugs’ recommendation of central funding to be provided to support HAT for patients for whom other forms of OST have not been effective.

Finally, innovation is essential in addressing DRDs. We found that local authorities want to be able to consider introduction of Drug Consumption Rooms (DCRs) but the Government is refusing to allow this to happen. There is a wealth of evidence on the effectiveness of DCRs in reducing harms from problematic drug use, and no evidence they increase drug use or drug-related crime where they are introduced. The Government should heed the evidence and allow DCRs to be introduced where they are considered to be needed locally. While we know responsibility for changes of policy on DCRs lies with your colleagues at the Home Office, we ask that you urgently liaise with them to find a solution. In the short-term the Government could take the same approach on DCRs as they recently took with festival drug testing, by sending a message that local Police & Crime Commissioners and local authorities can develop their own positions on DCRs without direction from Westminster.

We look forward to hearing from you. Please send any response to this letter to Christopher Hicks, Policy Officer, NAT.

Yours sincerely,

—

Deborah Gold
Chief Executive
NAT (National AIDS Trust)
Thank you for your correspondence of 10 April about the increase in drug-related deaths and the public health grant.

I appreciate your concerns.

The Government firmly believes that local authorities are best placed to deal with the complexities of issues like drug abuse, harms and deaths within their local areas and according to each local area's needs. We recognise that local authorities have had to make some difficult decisions, but nevertheless the Government has made £16 billion available for public health across the current five-year spending review period. Future funding will be addressed by the next spending review but, for the current year, the grant remains in place and ring-fenced for exclusive use on public health. It is for individual local authorities to decide how best to use this resource to tackle local priorities.

No final decision has been made on replacing the grant with local authorities' own business rate income. As you may be aware, last year we published a call for evidence on the impact of regulations that mandate certain services. We have considered the responses carefully and will consult publicly on any proposal for change. Meanwhile, a condition attached to the grant continues to require authorities to use it with a view to improving take up of, and outcomes from, substance misuse treatment services.

Local authorities will receive over £3 billion in 2019/20, ring-fenced exclusively for use on public health. The Government's ambitions for prevention go far beyond any one pot of money or set of funding. The Prevention is Better than Cure strategy was widely welcomed and the Department will build on this with a comprehensive Green Paper later this year.
We are aware that, since 2012, there has been a sharp increase in dmg misuse deaths. These deaths are linked to an ageing group of older heroin users with multiple and complex needs and underlines the human cost of dmg addiction for these individuals and their families.

The Government, and Public Health England (PHE) specifically, continues to work hard to ensure that vulnerable people do not fall through cracks in the system.

Local areas should look to increase the provision of naloxone to people who are not in treatment, including through hostels, outreach workers, needle and syringe programmes and drug users themselves. PHE is also working with the National Police Chiefs' Council and Her Majesty's Prison and Probation Service on naloxone availability. Further information on PHE's guidance on naloxone can be found at www.gov.uk by searching for 'widening the availability of naloxone'.

UK clinical guidelines highlight the crucial role opioid substitution treatments, like methadone and buprenorphine, have in preventing drug-related deaths. In the small number of cases where these may not be effective, it is recognised that supervised heroin assisted treatment (HAT) can be a cost-effective way of treating a small minority of users for whom standard treatment has not worked. HAT is a recognised clinical intervention in clinical guidelines for clients who have not responded to optimised oral methadone.

Local authorities will be aware of local need and are responsible for commissioning drug treatment, including whether to commission supervised heroin services. Whilst there is international evidence that drug consumption rooms can be effective at addressing problems of public nuisance and reducing health risks, there is a risk that such facilities would be at the expense of other, more relevant, evidence-based dmg services.

In October, the Home Office announced that there would be a major independent review of drug misuse. This will look at a wide range of issues, including the system of support and enforcement around drug abuse, to better inform our thinking about what more can be done to tackle drug harms, including deaths.

I am pleased to say that Professor Dame Carol Black has been appointed to the role of independent reviewer for this piece of work. Dame Carol will bring a wealth of experience and a strong focus on analysis and evidence to the review.

I hope this reply is helpful.

SEEMA KENNEDY