Commission on Justice in Wales Call for Evidence 2018
Submission

This submission comes from the Transform Drug Policy Foundation, Barod, Kaleidoscope, Huggard Centre, Release the Wallich, the North Wales Police and Crime Commissioner, and Professor Katy Holloway at the University of South Wales.

These groups and individuals are key members of the Enhanced Harm Reduction Group for Wales which focuses on utilising an evidenced based approach to support and protect people who take illegal drugs. We come from the drug treatment, drug policy, health, homelessness and criminal justice sectors. We can submit further details about our organisations if required, or expand on the content of this submission.

We are responding to this review because many of the people we support, or seek to benefit, are involved in the criminal justice system - not least because many of the drugs they take are illegal.

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Introduction

The long-standing ideological commitment to the use of criminalisation rather than primarily health and social care to manage drug use has led to massive negative unintended consequences for the people of Wales. All too often this has been the result of prioritising appearing to be 'tough on drugs and crime', rather than looking at evidence of what actually works to deliver our shared goals of improved health and community safety, particularly for the most vulnerable in our society.

However, in reality, the environmental factors which increase the risk of a person using drugs problematically are well documented and understood. The problems that underlie most problematic drug use include: inconsistent parental engagement, difficult family background, alcohol and/or other drug abuse by parents, social and emotional deprivation, social exclusion and the failings of the education and welfare systems, failings of mental health services, failings of the care system, problems in the labour market for key populations, failure of social provision and the lack of investment in social capital for young people.[1]

None of these root causes are addressed by the prevailing absolute-prohibition of certain drugs and criminalisation of people who use them. On the contrary, the current approach creates or exacerbates many of the health harms people who use drugs are subject to, as well as fuelling the illegal drug markets, criminal entrepreneurs, and financial pressures that drive many dependent drug users into offending in the first place.

Any consideration of the interaction between the criminal justice system and drug policy in Wales must also be seen against a backdrop of the most serious failure. Drug related deaths in Wales (and across the UK) have been at record levels for four years. Around one in three of all drug related deaths in the European Union happen in the UK, and Wales' death-rate is worse than the UK average.[2] But the experience of other countries shows it does not have to be this way. Drug policy is changing, internationally (from Canada legalising and regulating cannabis, to multiple countries decriminalising people who use drugs), but also in the UK. For example, the UK Home Office explicitly supports providing a legally regulated supply of heroin through clinics to some of those dependent on it. And while still opposing them, The Home Office also now acknowledges that Supervised Drug Consumption Rooms (or Enhanced Harm Reduction Centres) save lives and reduce other harms.

Very recently, the Policing Minister Nick Hurd announced that the Home Office no longer opposes the provision of drug safety testing at festivals,[3] and it now appears certain that the UK will be widening access to medical cannabis very soon. The Home Office is also exploring 'diversion schemes' to avoid prosecuting those caught with drugs for their own use too. At the local level, particularly led by Police and Crime Commissioners and Council Commissioning Teams, a wide range of these interventions are being implemented, including in Glasgow where a Heroin Prescribing Clinic is about to open, with scope to add on a Supervised Drug Consumption Room as soon as permission is granted.

So it is timely for the Government of Wales to be exploring the interaction between the criminal justice system, drug policy and the balance of power between Cardiff and Westminster. In fact, it is hard to see how the Welsh Government can deliver the aims of the Well-Being of Future Generations Act (Wales) 2015 without a new approach to illegal drugs. And we hope this submission helps encourage the Welsh Government to seize the opportunity to ensure that Wales is on the right side of history when it comes to changing drug policy and criminal justice, and so truly puts the people of Wales first.

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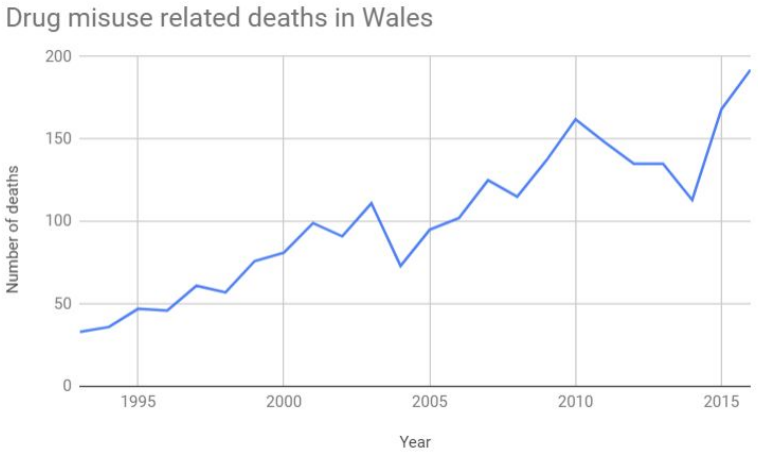
[1] ACMD Pathways to Problems (2006)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/119053/Pathwaystoproblems.pdf

[2] Deaths by drug poisoning where any opiates were mentioned on the death certificate, local authorities in England and Wales, 1993 to 2016
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/007446deathsbydrugpoisoningwhereanyopiateswerementionedonthedeathcertificatelocalauthoritiesinenglandandwales1993to2016

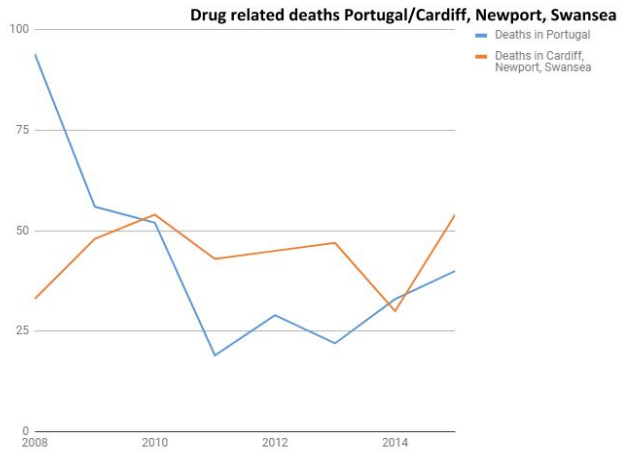
[3] See https://hansard.parliament.uk/commons/2018-07-06/debates/E0DEEB30-1E43-44C7-AFF6-108381E254F4/MusicFestivalsDrugSafetyTesting

Drug related deaths in Wales, street injecting and discarded needles

Perhaps the single most graphic demonstration of the failure of drug policy is the number of lives being lost needlessly to overdose. As noted above, drug related deaths across the UK have been at record levels for 4 years in a row, with more people now dying from overdoses than on our roads. Drug death rates in Wales are higher than England, and also at record and completely unacceptable levels, as the ONS data below shows.[4] The European Age Standardised Rate (EASR) for drug misuse deaths in 2016 in Wales was 8.0 per 100,000 population (compared to 5.8 per 100,000 in 2015). Rates vary from Abertawe Bro Morgannwg (ABMU) Health Board highest at 11.4 per 100,000 population to Powys Teaching Health Board the lowest rate at 3.2 per 100,000. Increases in rates were also recorded for Cardiff and Vale Health Board area with an increase of two deaths per 100,000 population and Hywel Dda with an increase of 3.5 deaths per 100,000 population in 2016 compared with 2015.[5] The ONS also identifies Swansea, and Neath/Port Talbot as two of the top ten heroin overdose hotspots in England and Wales.[6]



But other countries that have suffered these kind of crisis have not simply stood by and allowed it to continue. For example Portugal, faced with a similar escalation in deaths and street drug use, introduced a suite of measures from 2001 built on decriminalising people who use drugs, to reduce the stigma they felt and encourage them to come forward for help, plus redirecting the money saved from the criminal justice system into treatment and other services, while freeing police for other priorities. Even comparing Portugal's absolute drug-related death numbers 40 in 2015, from a population of over 10 million people, with that of Cardiff, Newport and Swansea - 54 in 2015 from a combined population of just 750k - is sobering.



Similarly, after Switzerland also experienced a rising death rate, and increased street injecting, they realigned to a health-lead approach including better funded treatment, heroin prescribing clinics, city-centre drug safety testing and

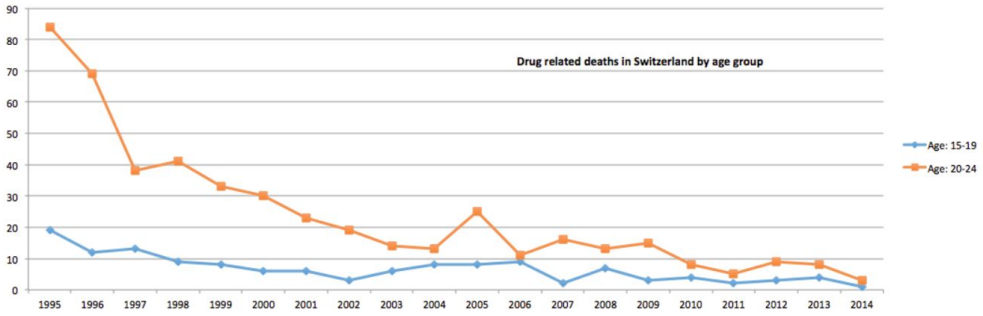
[4] ONS, *'Number of deaths related to drug misuse, local authorities in England and Wales, deaths registered 1993-2016'* https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/007338numberofdeathsrelatedtodrugmisuselocalauthoritiesinenglandandwalesdeathsregistered1993to2016/drugmisusedeathsbylocalauthority19932016registrations.xls

[5] ONS data quoted in APoSM, '*Report: Enhanced Harm Reduction Centres*', 2017 p4 https://gov.wales/docs/dhss/publications/report-on-enhanced-harm-reduction-centres.pdf

[6] ONS, *'More than half of heroin/morphine misuse death hotspots in England and Wales are seaside locations'*, 2018 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/halfofheroinmorphinemisusedeathhotspotsinenglandandwalesareseasidelocations/2018-04-04

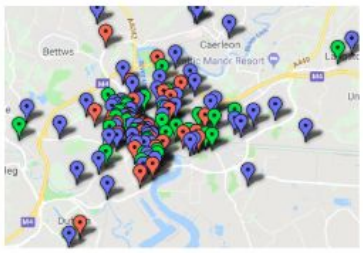
supervised drug consumption rooms. Overall opiate related overdose deaths fell by two thirds,[7] according to the Swiss Surveillance of Addictions, an epidemiological surveillance system mandated by the Federal Office of Public Health (FOPH). Specifically, opiate related deaths have fallen from 376 in 1995 when heroin prescribing clinics and drug consumption rooms first started opening, as part of their health-led approach, to 134 deaths in 2014, out of a population of 8.4 million. Wales with a population of 3 million, had 158 opiate related deaths in 2016 - so over three times the death rate of Switzerland. The drop even more pronounced for young people.

It is sometimes suggested that Wales' rising drug death rates are inevitable because we have an aging drug user population. However, so do Portugal and Switzerland, and their far more successful policy responses to drugs show that health vulnerabilities do not have to be a death sentence for people who use drugs. (See below fre heroin prescribing and supervised drug consumption rooms - including reducing drug related crime and street nuisance.)

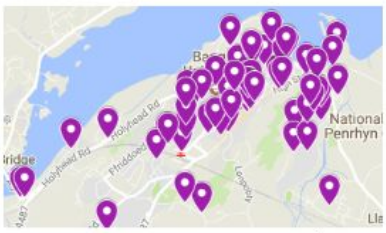


Another indicator of the levels of high-risk street injecting, often noticed by local communities, are discarded needles - something the people of most towns and cities in Wales will know about. The maps below show just needles reported to the local council - most will be cleared up by affected businesses or the public instead. Countries that have taken a new health-lead approach to drugs have also seen falls in these problems.

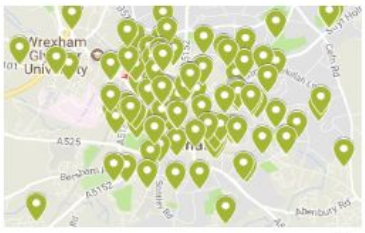
Swansea: Discarded needles 2015-17



Newport: Discarded needles 2015-17



Bangor: Discarded needles 2015/16



Wrexham: Discarded Needles 2015/16

[7]Monitorage Suisse des Addictions, http://www.suchtmonitoring.ch/fr/3/7.html?opioides-mortalite

A. Treatment in Wales

In addition to reducing pressures on health and social services, the reduction in pressure on the criminal justice system resulting from effective treatment is widely acknowledged. For example, according to the NHS, in 2010 - 11, drug treatment prevented 4.9m offences occurring and for every £100 spent on treatment, a crime is prevented.[8] But beneficial though this is from a resource use perspective, and in terms of benefits for the wider community, treatment provision is of course crucial to the wellbeing of some of the most vulnerable people in Wales, and as noted above directly relates to the Well-Being of Future Generations Act (Wales) 2015.

The Criminal Justice System often fails the very people we support

Many people in drug treatment services have mental health issues, poor educational attainment, or come from broken families. Most female clients have suffered abuse when younger, and are in situations where they are subject to abuse in their adult relationships. In essence, drugs are often the symptom and not necessarily the reason for someone's behaviour.

The policing of drugs often impacts disproportionately on these groups, as well as ethnic minorities (see below for more detail), the poor and the homeless because they are more visible. And the system impacts far more on users of illegal drugs than those who financially benefit from the sale of these drugs.

There are a number of options around treatment that would provide better outcomes in terms of cost to the Criminal Justice System, and outcomes for the end user.

Issues impacting service users

One issue is the way some people are refused the most suitable treatment because of poor behaviour issues. As a result, some of those most in need of support - and for whom the benefits are likely to be the most significant, can *only* get treatment while in the Criminal Justice System, because they are banned from NHS Services.

- An example is Meinir from Neath. https://www.walesonline.co.uk/news/wales-news/real-life-story-55-year-14838113
- In Newport, Kaleidoscope has had a number of service users who are red flagged and therefore banned from other community services. In Wales some of the most challenging drug users with complex needs cannot access treatment services - often because of behaviour related to their mental health problems, and more must be done to support this cohort.
- Currently Safehaven services do not provide opioid substitute therapy in Wales for the most challenging individuals with co-occurring mental health issues – so there is a treatment gap for these individuals.

Another critical issue is that of waiting lists. In Wales the waiting times to get into drug services are too long. Gwent, for example, which has a good record for providing access into treatment, still has is a three month waiting list (at present 60 people). The nature of funding means that treatment is effectively rationed to a certain number of clients - delaying access to treatment when sought by those most in need; prolonging the likelihood of drug related health harms and continued offending. It is a false economy that ultimately creates a greater burden for both health services and the criminal justice system.

The 'recovery agenda' has had positive effects for many people, motivating them to make changes that can be life changing. Cyfle Cymru, a Welsh Government Funded Initiative, which provides peer support for people to move into

[8] National Treatment Agency for Substance Misuse - Treat addiction, cut crime (2012) https://pdfs.semanticscholar.org/presentation/3743/2fe7371293cc269e6ceed641ca0d0f5a0f42.pdf

employment is a positive example. However, there can be real problems with the narrow focus on abstinence of the 'recovery agenda' when it is prioritised over proven harm reduction models. This is particularly the case for those who are struggling, and whose life will remain difficult for the foreseeable future, and who are simply not in a place mentally and emotionally where they are willing or able to become abstinent.

There is a case for this group to be on long term treatment, and an acceptance that stability, and staying alive, is a success in its own right - rather than focussing too narrowly on achieving abstinence in the short term. The people such an approach would help are also those who are probably closest to criminal behaviour, and at a higher risk of overdose and death if they drop out of treatment which does not meet their needs.

Providing services for these people is challenging, but experience shows successful interventions engage them with what they *actually* want - not what others think they should want. For some this will be rapid access to a regular prescription, for others support with mental health, housing and employment, and for some, a safe place to take their own drugs and rapid access to a range of services (see below).

Funding issues also run deeper. The cessation of Capital Investment in the treatment estate from the Welsh Government is beginning to create problems e.g. a number of buildings providing drug services are under threat particularly in the Gwent area. There are also problems in South Wales with facilities in Bridgend and Barry. There is a also lack of supported accommodation for many service users, in particular people needing wet houses, and there are insufficient resources to provide people with residential detox or rehabilitation across Wales, when they need it.

Success of interventions

Substance misuse services work closely together in Wales and they are now working with mental health partners (as part of the Developing a Caring Wales consortium of drug, alcohol and mental health charities). This means people are less likely to fall through the gaps of treatment in a highly competitive environment. In working together there is also innovation shown by the Cyfle Cymru Out of Work Service, Change Step supporting Veterans (another group at risk of being drawn into the Criminal Justice System), and the Lottery Funded service supporting the over 50s with Drink Wise, Age Well.

The Invisible Walls Programme by G4S and Barnardos is showing some very positive results working in keeping families together. The Dyfodol programme across South Wales has been significant in developing an innovative integrated and seamless pathway between community and prisons, as have the drug services across Wales commissioned by the Police Crime Commissioners to support people with substance issues. The tensions have been there however, in terms of what the role of the non-devolved Criminal Justice system is, and should much of the treatment provided be accessible through community treatment services. There is a high degree of flexibility and agility required to work with this cohort of service users which these services are not always able to meet.

It should be noted however that much of the innovation in regards to treatment has come from the Criminal Justice system as their approach has managed to engage with the wider issues that impact on people who take drugs. A good example of this is the provision of naloxone (a safe and easy to administer rapid antidote to opioid overdose) to prison leavers in Wales and at HMP Eastwood Park for women returning to Wales. Key criminal justice treatment providers including G4S meet on a quarterly basis in Llandrindod Wells. It is an operational meeting including team leaders in an environment of mutual learning to consider key trends in treatment and legislation across Wales.

- **Recommendation 1: The Welsh Government should encourage all relevant organisations from the criminal justice, health and social care, and treatment sectors to build on existing collegiate working practices**
- **Recommendation 2: There should be an end to banning anyone for life from treatment**

Problems for those working within the Criminal Justice System in Wales

There is a often conflict between the policy direction of the UK Government and Welsh Government which could be better resolved by the implementation of the Silk Commission recommendations, potentially including further devolution of powers over criminal justice, where the lack of powers is preventing much needed innovation.

- A key example is the case of drug consumption rooms (see below), where the matter is being actively discussed in Wales (with strong support from North Wales PCC and many treatment groups for example), but where the UK Government is exercising its powers to obstruct even pilot projects (e.g. in Glasgow).
- Police and Crime Commissioners (PCC) were created by the UK Government, through legislation in Westminster - not Wales. Although the current PCCs are working collaboratively with Welsh Government, they have the potential to divide Welsh Government policy from Police strategy.
- The present Criminal Justice System is leading to people being imprisoned who would not be if powers were devolved and better integrated with health policy. For example, the imprisonment of people with clear mental health issues is against the way Wales should - and likely would - support vulnerable people given the choice. Imprisonment is expensive, and all too often counterproductive. It should also be noted that in Wales there has been very little desire for a Welsh women's prison because of the view of many agencies based here that the UK approach is wrong, and women in the majority of cases are better assisted in the community. (See also section on Prisons)

Access to Services

If there is to be better access to treatment services - with concomitant benefits to the Criminal Justice System - across Wales, the issue of rurality has to be addressed. The problems stemming from rurality are not properly compensated for, which means people will not get access to the same level of service they would have in a city. Transport, primarily the lack of it, also presents very clear problems, and the cutting of bus services for example in Monmouthshire, will exacerbate this issue.

There needs to be investment in equipment and a safe space for people in remote areas a person to converse online [9] with treatment professionals. This could be in community buildings, where a client can have a therapeutic intervention online but it would require some significant joined up approaches utilising facilities such as one stop shops. Provision of community-based interventions as an alternative to prison are an attractive and evidence based option, but are more challenging in rural areas.

Legal advice for service users with drug and alcohol issues is patchy, and it may well be helpful to have a Welsh version of the charity Release, or funding of the equivalent services, particularly if powers are further devolved. It is to be welcomed that Clinks will be having a Welsh Officer to ensure better support to Welsh agencies, but it is vital people with drug issues have proper advocacy and support, which is separate from the service they are client of.

We notice that the Welsh Substance Misuse Strategy has been more enlightened than its English counterpart. It is a strength that it is for both illegal drugs and alcohol because it ensures a more harm reduction focussed approach. The introduction of minimum alcohol pricing is also welcome, and an example of taking an approach based on regulating problematic drugs, rather than simply prohibiting and driving more people into the Criminal Justice system.

The Transforming Rehabilitation (TR) system has not been as effective as it could be because it fails to engage with the local voluntary sector, which means there is a disconnect with services people need. There needs to be a proper

[9] See https://www.release.org.uk/

system approach to ensure people leaving prison have a supported programme ensuring they have the best opportunities possible. A more joined up approach is often using existing services better.

The Welsh Language is important and greater control of services can only promote this. The present imprisonment of women in English Prisons is an example of a system that does not work for Wales, and certainly impacts Welsh speakers.

- **Recommendation 3: Funding, and funding structures, should ensure that treatment is available to those who need it, when they need it, and where they need it.**

- **Recommendation 4: Treatment structures and funding should recognise the specific challenges faced by those living in rural areas.**

B. Prisons and Drugs

We fill prisons with people with drug dependencies: in 2002, research conducted by The Social Exclusion Unit (SEU) found that up to 70% of prisoners in England and Wales were using drugs prior to incarceration,[10] and 13 years on, the proportion remains largely unchanged; in 2015 -16, 66% of adult prisoners across the prison estate, reported using drugs problematically upon arrival[11] including 41% of women.[12] Across the UK more than 10% of prisoners are inside for specific drug offences, and estimates suggest many more are people whose offending is directly related to their use, or fundraising to support it.

A significant proportion have mental health and emotional or psychological problems. This contributes to demand for drugs that can offer some temporary relief from the tedium, trauma and misery of life in prison. In 2016-17 only 14% of prisoners across the estate remain unlocked for the recommended amount of time.[13]

Indeed, life inside can be so grim, and drugs so available, that many prisoners who arrive without a drug problem have developed one by the time they leave.

- 47% of adult male and 31% of female prisoners stated that it is easy or very easy to get hold of illegal drugs in prison[14]
- In 2010, 6% said they had developed a drug problem since their arrival, rising to 17% in certain prisons[15]
- 16% of adult men who consider themselves to have a disability stated that they started using drugs problematically since arriving in prison[16]

Many prisoners who use drugs - to self medicate their dependence, pain or trauma - will then have their stay extended, often significantly, either through acquiring additional sentences for drug offences committed while in prison, or forfeiting time off for good behaviour due to drug use.

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[10] SEU (2002) Reducing re-offending by ex-prisoners https://www.bristol.ac.uk/poverty/downloads/keyofficialdocuments/Reducing%20Reoffending.pdf
[11] HM Chief Inspector of Prisons for England and Wales Annual Report 2015 - 16
https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/07/HMIP-AR_2015-16_web.pdf
[12] ibid
[13] ibid
[14] ibid
[15] HM Chief Inspector of Prisons for England and Wales Annual Report 2011– 12
http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2011-12.pdf
[16] HM Chief Inspector of Prisons for England and Wales Annual Report 2016-17
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/629719/hmip-annual-report-2016-17.pdf

In 2017, the Chief Inspector of Prisons for England and Wales annual report stated that the prison environment is becoming increasingly violent and dangerous:[17]

- Since 2013, the number of suicides has more than doubled[18]
- 2016-17 witnessed three drug-related deaths of people held within immigration detention centres[19]
- The use of novel psychoactive substances (NPS) has increased dramatically within the prison population, with spice induced seizures reaching an estimated 737 in 2014[20]
- In 2016, the number of deaths attributable to the use of NPS, reached 39[21]

The often heard suggestion that prison is a good environment for addressing drug problems is, in the majority of cases, absurd. If treatment specialists were presented with a series of treatment/recovery options for any given patient, it is hard to imagine *any* opting for prison. Not only is prison more expensive than other treatment options, even residential rehab (it is actually more expensive than staying at many 5 star hotels, on average, costing in excess of £35,000 a year[22]), but prison's brutal reality is far more likely to be damaging and traumatic than healing and rehabilitative. When drug problems are left unaddressed in the prison environment, they inevitably deteriorate and set up an individual for failure, relapse and reconviction upon release. And risk of overdose and death. The period immediately following release is critical.

Into this population of people with drug dependencies and complex needs, we mix a significant number of criminal profiteers, many of whom are involved with or actually in prison for drug supply, and most of whom are well connected to the illegal drugs underworld. No one can be surprised at the outcome of this volatile cocktail. The demand for drugs in prison is so great and the profits so lucrative that a situation exists where a supply route will *always* be found. As successive inquiries and commissions have noted, shut down one supply route into prisons and the economic incentives immediately make securing alternative routes worthwhile, and inevitable. At some point the opportunities created even start to entice some prison staff into the market, especially when underpaid and demoralised. At this point, any vague hope of preventing drugs getting into the prisons is effectively lost, and that is a point long since passed across the prison estate.

This is exactly the same phenomenon we see on the national and international stage, with the hopeless futility of decades of drug eradication, interdiction, and populist rhetoric about 'securing our borders' that bears a non-coincidental resemblance to the political rhetoric we often hear about securing the prison estate. Despite the billions spent on supply side drug enforcement each year, the criminal trade thrives, drugs are more available, stronger and cheaper than ever before, and the violent criminals controlling the market get richer and more powerful.

Not only is the analysis of supply and demand economics in an unregulated criminal drug trade the same at prison, national and international level, so evidently are the responses: announce a 'crackdown', unveil some new technology, produce a new strategy, create a new agency (or rename an old one), then announce these process measures to show 'something is being done' whilst conveniently avoiding assessing effectiveness against troublesome 'outcome' measures. Regardless of scale, all such efforts that attempt to defy economic reality are equally futile. It is counterintuitive, but nonetheless demonstrably true that punitive supply side drug enforcement is fuelling the prisons crisis, not reducing it, and that is true of the wider drugs problem in Wales.

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[17] ibid
[18] ibid
[19] ibid
[20] Users Voice.(2016) Spice: The Bird Killer http://www.uservoice.org/wp-content/uploads/2016/05/User-Voice-Spice-The-Bird-Killer-Report-Low-Res.pdf
[21] ibid
[22] Ministry of Justice - Costs per place per prisoner 2016 - 17 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/653972/costs-per-place-per-prisoner-2016-2017-summary.pdf

A graphic recent example is the outcome of the ban on New Psychoactive Substances (NPS) brought in through the Psychoactive Substances Act (2017), then through classifying many of these substances under the Misuse of Drugs Act (1971). While successful in closing the visible 'head-shops' selling them, the market went underground, and particularly now impacts the homeless population - as noted in many Welsh towns and cities, and of course prisons. As happened when alcohol was prohibited in the US, and moonshine took over the market from beer, there has also been a marked shift upward in potency of the NPS available, with only the strongest, more dangerous and most profitable products now dominating the market.

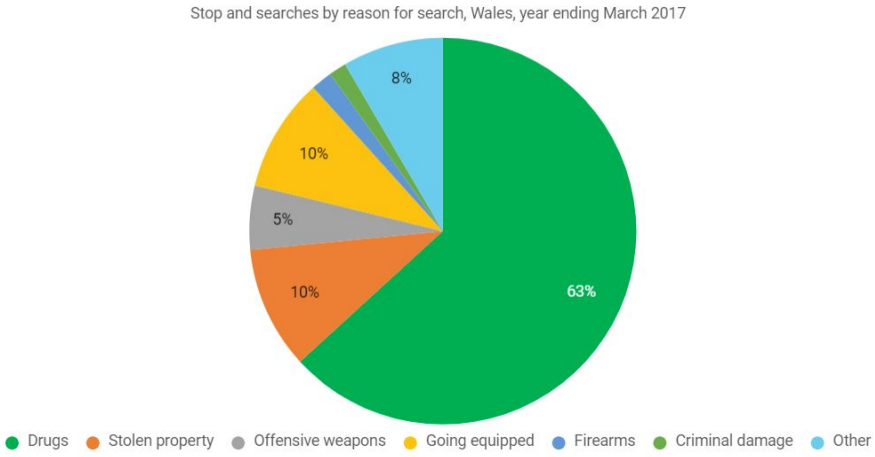
Block of compressed 'spice' confiscated from a prisoner in Wales, 2017

- **Recommendation 5: We must completely move away from using prison as a sanction for people who commit minor non-violent drug (or drug-related) offences of any kind.**

C. Policing of Drugs in Wales

Stop and search

In 2016/17 63 per cent of all stop and searches in Wales were for drugs.[23] Different police forces in the country recorded varying rates – Dyfed-Powys had the highest percentage of searches for drugs accounting for 77 percent of searches carried out by that police force, whilst South Wales recorded the lowest percentage at 56 per cent.[24] It is worth noting that Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) has estimated that 70 percent of searches are for simple possession for personal use, and that 70 per cent of that number are for cannabis possession.[25]

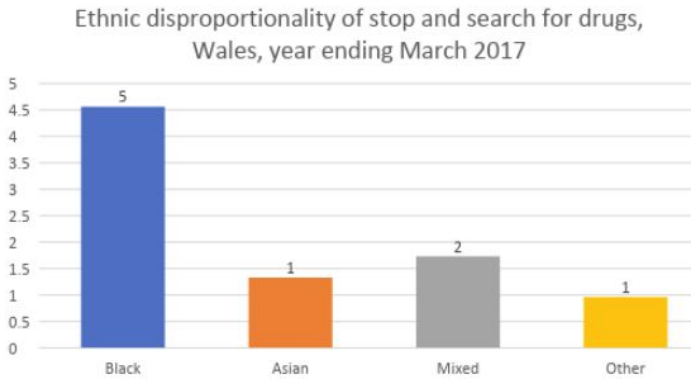


[23] Home Office (2017) *Police powers and procedures, England and Wales, year ending 31 March 2017*, https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017
[24] Ibid
[25] Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (2017) *PEEL: Police legitimacy 2017 A national overview*, https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-legitimacy-2017-1.pdf

Disproportionate impacts on minorities

Possession of drugs for personal use, in particular for cannabis, is simply not a priority for communities and so questions need to be asked as to why police are wasting resources pursuing such offences. Further to this, the focus of such searches is overwhelmingly targeted at young people aged under 24, who if caught in possession can end up with a criminal record which causes untold damage in terms of their educational and employment opportunities. The data from Wales indicates that approximately 11 per cent of stop and searches result in an arrest for drugs.[26]

Added to this is the damage that drugs policing does to communities of colour. Black people are 5 times more likely to be searched for drugs compared to the white population in Wales[27], despite the fact they use drugs at a lesser rate.[28] The damage that this type of policing can do in communities is significant, where young people from black communities or those living in deprivation are subject to repeated stop and searches, resulting in a lack of trust in the police and undermining the legitimacy forces have in these communities.



Moreover, Home Office research has shown that law enforcement has little impact on levels of drug use. A 2014 study compared 11 countries across the world – some jurisdictions took a punitive approach to drug possession whilst others had implemented policies and laws that had ended criminal sanctions for possession offences – that study found no obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country.[29]

D. Innovative Measures

Limits on power devolved to Wales makes more profound changes, such as *de jure* decriminalisation of possession of drugs for personal use, or introduction of legally regulated markets for cannabis (as Canada and other countries are doing) are currently beyond the scope of the devolved Government. There are, however, a number of evidence-based interventions Wales could take now, or could press the UK Government to allow it to take.

1. Diversion Schemes

Many countries that have implemented a model which no longer criminalises those caught in possession of drugs - and have also experienced positive health, social and economic outcomes.[30] As noted above, Portugal which

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[26] Home Office (2017) *Police powers and procedures, England and Wales, year ending 31 March 2017*, https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2017

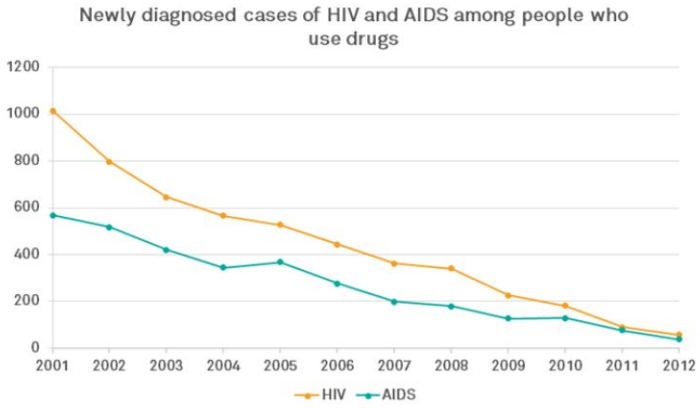
[27] Ibid

[28] Eastwood N., Shiner M. and Bear D. (2013) *The Numbers in Black and White: ethnic disparities in the policing and prosecution of drug offences in England and Wales*, Release and LSE Consulting, https://www.release.org.uk/sites/default/files/pdf/publications/Release%20-%20Race%20Disparity%20Report%20final%20version.pdf

[29] Home Office '*Drugs International Comparators', (2014)* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/368489/DrugsInternationalComparators.pdf

[30] Eastwood, Fox & Rosmarin (2016) '*A Quite Revolution: Drug Decriminalisation Across the Globe*', Release, https://www.release.org.uk/sites/default/files/pdf/publications/A%20Quiet%20Revolution%20-%20Decriminalisation%20Across%20the%20Globe.pdf

decriminalised drug possession offences in 2001, whilst also increasing harm reduction interventions and treatment availability, now has one of the lowest rates of drug related deaths in Europe. In 2017 Portugal reported that the number of deaths resulting from drugs was 3 per million of the population[31] with substantial falls following the change in policy. In Wales the drug-related death rate is 66 per million[32], and rising. Portugal has also seen similar falls in HIV infection rates, and problematic heroin use, without a significant rise in use.[33]



This approach of removing all criminal sanctions for possession of small quantities of any drugs for personal use, even if some form of civil or administrative sanction remains in place, is a policy approach that is endorsed by the Royal Society for Public Health and The Royal College of Physicians, The Advisory Council for the Misuse of Drugs, the World Health Organisation, and the UN Office of the High Commissioner for Human Rights, amongst many others. NB the RSPH and RCP additionally recommend moving the drugs brief from the Home Office to the Department of Health and Social Care - which given Health is devolved could have interesting implications for drug policy in Wales.

While as noted drug law reform *per se* is not open to the Welsh Government, as this is not currently a devolved matter, there is an opportunity for the Government and the Assembly to work with police to implement 'diversion' programmes for those caught in possession of drugs. The recent Lammy Review[34] also recommended the rolling out nationwide of diversion schemes in order to reduce racial disparities in the CJS, with the Police Foundation recently also calling for this option to be explored with particular regard to young adults.[35] This is already happening in England, with two forces having implemented such an approach, several more publicly declaring their intention to follow suit[36], and others talking about doing so privately. Of particular relevance here, North Wales Police are committed to implementing a diversion scheme as soon as practically possible.

[31] EMCDDA & SICAD (2017), *Portugal Country Drug Report 2017, http://www.emcdda.europa.eu/system/files/publications/4508/TD0116918ENN.pdf*
[32] Office of National Statistics (2017), *Deaths related to drug poisoning in England and Wales: 2016 registrations, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations*
[33] Transform Drug Policy Foundation (2016), *'Drug decriminalisation in Portugal: setting the record straight'* https://www.tdpf.org.uk/blog/drug-decriminalisation-portugal-setting-record-straight
[34] The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System, 2017 p7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf
[35] The Police Foundation, *' Policing and young adults: developing a tailored approach'*, (2018) http://www.police-foundation.org.uk/publication/policing-young-adults-developing-tailored-approach/
[36] Both West Midlands PCC https://www.westmidlands-pcc.gov.uk/news/news-2018/practical-proposals-to-tackle-the-scourge-of-drugs-announced-by-police-and-crime-commissioner/ and Thames Valley Police (personal communications) are committed to implementing drug diversion programmes in the very near future

Durham Police 'Checkpoint Scheme'

Durham Police force has implemented a diversion scheme, 'Checkpoint', for a range of low level offences. This initially included only minor drug possession offences, but due to the success of the scheme, it has been extended to include low level supply offences, where the offender is determined to be a problematic user.[37] Durham's scheme diverts people after arrest on the condition that they undertake a four month programme to address their offending behaviour. Engagement with the programme leads to a suspension of criminal justice proceedings; successful completion results in no further action being taken.[38] Some initial findings from the pilot period found those who were diverted to Checkpoint had lower reoffending rates compared to those who were subject to out of court disposals, such as cautions. The Checkpoint cohort reoffended at a rate of 14.6 per cent in the 12 months following participation, compared to 21.9 per cent for those receiving out of court disposals. Participants in Checkpoint also reported improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances and mental health.[39]

Avon and Somerset Police 'Drug Education Programme'

Whilst Durham's diversion scheme occurs after arrest, Avon and Somerset Police force have implemented an 'on the street' diversion programme in Bristol for those caught in possession of drugs for personal use. The 'Drug Education Programme' ('DEP') was launched as a pilot in 2016. Initial findings came from the first six months of the programme (1 April 2016 – 30 November 2016) by comparing outcomes for people caught in possession of drugs to those caught during the baseline period (1 April 2015 – 30 April 2015) prior to the implementation of the scheme.

These findings are similar to that of Durham Police, with attendees of the DEP less likely to reoffend when compared to those who had gone through the criminal justice system during the baseline period. The majority of attendees at the DEP reported cessation or reduction in their drug use. Avon and Somerset police also reported that the DEP saved police officers significant resources; the majority of officers reporting that a referral to DEP took less than 30 minutes compared to previous disposal methods taking two to four hours. Officers reported that the reduced burden of diverting drug possession offences to the DEP meant that it freed them up to focus on other tasks. Interestingly, the evaluation from Avon and Somerset Police also found that the new approach under DEP led to better relations between the police and people who use drugs. When people were treated not as criminals but as those needing support or treatment, they were more likely to cooperate with police officers.[40] The success of the DEP in Bristol means the scheme is being rolled out across Avon and Somerset from April 2018.

- **Recommendation 6: That the Welsh Government works with local police forces and Police and Crime Commissioners to implement a national diversion scheme.**

Such an approach would have no impact on prevalence, but would result in positive health, social and economic outcomes, reducing re-offending rates, and the burden on police and the wider criminal justice system.

2. Heroin Assisted Treatment (HAT)

Prescribing heroin for some dependent users, usually for use in clinics under medical supervision, is called heroin assisted treatment (HAT). The practice is well established, already legal under UK law, and has a long history, including in the UK, Switzerland, Germany, the Netherlands and Canada.

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[37] https://www.independent.co.uk/news/uk/home-news/drugs-addicts-heroin-not-face-prosecution-durham-police-chief-constable-mike-barton-a8063486.html

[38] Durham Constabulary '*Critical Pathways – Checkpoint'*, 2018 https://www.durham.police.uk/Information-and-advice/Pages/Checkpoint.aspx (accessed 25 March 2018)

[39] Durham Constabulary & Durham Police and Crime Commissioner, *'Checkpoint: An Innovative Programme to Navigate People Away from the Cycle of Reoffending: Implementation Phase Findings', 2017* (provided via email by Durham PCC on 16 March 2018)

[40] Luckwell J. *'Drug Education Programme Pilot: Evaluation Report',* Avon and Somerset Constabulary, 17 March 2017, Pg. 4- 5 (provided by Avon and Somerset police by email 15 March 2018)

It has successfully reduced fatal overdoses and needle sharing that can lead to infections, including HIV and hepatitis; high risk street injecting; fundraising driven acquisitive crime and street sex-work; and discarded needles, while increasing take-up and retention in treatment. Both the UK Government and its official advisers - the Advisory Council on the Misuse of Drugs (ACMD) - actively support HAT.[41] The ACMD from a health perspective, the UK Home Office from a crime reduction viewpoint as well.

"Central government funding should be provided to support HAT for patients for whom other forms of Opioid Substitution Treatment have not been effective." Advisory Council on the Misuse of Drugs, 2016

What is Heroin Assisted Treatment?

The HAT clinic model, initially developed by the Swiss, differs from the old "British System" (still in place for around 100 people in the UK) in that rather than being given 'take home' heroin prescriptions, patients attend a clinic once or twice a day, and use their prescriptions on site, under medical supervision.

The first Swiss pilot HAT clinics opened in 1994. In 1997, the federal government approved a large-scale expansion, aimed at 15% of the nation's estimated 30,000 heroin users, specifically long-term users who had not succeeded with other treatments. Other countries followed suit, with the UK opening three pilot NHS supervised injecting clinics (London, Brighton and Darlington) in 2009 - the Randomised Injectable Opiate Treatment Trial (RIOTT)[42] - extended to 2016 after proving successful.[43]

Improving Health, Reducing Crime

"The Modern Crime Prevention Strategy...highlighted the value of supervised injectable diamorphine/heroin in reducing crime... Police and Crime Commissioners and police forces wishing to explore issues relating to heroin assisted treatment are encouraged to engage with the relevant local authorities which commission drug and alcohol treatment in their areas." - Brandon Lewis, Home Office Minister, Answer to Parliamentary Question, 2016

HAT delivers the health benefits of prescribed supply - heroin of known strength, free from contaminants and adulterants, used with clean injecting equipment - combined with the benefits of supervised use in a safe and hygienic venue. So HAT clinics prevent overdose and HIV infection, provide regular access or referral to counselling, social, health-care and treatment services, while preventing diversion of prescribed heroin to the illegal market.

These positive outcomes have been widely reproduced. Reviews by the Cochrane Collaboration[44] and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[45] concluded that HAT can lead to substantially improved health and wellbeing, and marked improvements in social functioning e.g. stable housing and a higher employment rate. The reviews also found HAT lead to major reductions in participants' use of illegal heroin; and major disengagement from criminal activities, such as acquisitive crime to fund their drug use. For example, in Switzerland, HAT was credited with reducing burglaries by half, stabilising users' lives and improving communities.[46] The UK trials found health benefits, and that acquisitive crimes per user fell on average by two-thirds among this extremely

[41]Advisory Council on the Misuse of Drugs, *'Reducing Opioid-Related Deaths in the UK'* , Dec 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf

[42]Kings College London, *'Randomised Injectable Opiate Treatment Trial (RIOTT) trial'* http://www.kcl.ac.uk/ioppn/depts/addictions/research/drugs/riott.aspx

[43] Despite proving highly cost effective, as part of austerity measures funding from the Department of Health was cut in 2016, closing the clinics

[44] Ferri, M., Davoli, M. and Perucci, C.A. (2011) *'Heroin maintenance for chronic heroin-dependent individuals'*, Cochrane Drugs and Alcohol Group.

[45] European Monitoring Centre for Drugs and Drug Addiction (2012a) 'New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond'

[46] European Monitoring Centre for Drugs and Drug Addiction (2012a) 'New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond'

high-crime committing cohort - from around 40, to 13 crimes per month.[47] Given estimates that around 250k UK opiate (and crack) users commit 44% of all UK acquisitive crime,[48] there is huge potential to reduce crime by making HAT available to 10-15% of the heaviest long term users.

It has been estimated that the 10% heaviest users of heroin in Switzerland (who fall into the HAT target group) consumed around 50% of all the illegal heroin imported.[49] It is clear that the reduction in consumption of illegal heroin by those entering a HAT programme (and the absence of any increase in new users) could substantially reduce the scale of the illegal heroin market in Wales, depriving organised criminals of resources.

Is HAT Cost Effective?

Numerous studies have demonstrated HAT to be highly cost-effective - as the EMCDDA review put it "HAT saves money." The relatively high cost per client (typically £15k p.a. in the UK, but this is likely to fall[50]) is more than matched by savings across health, criminal justice and other services that cannot be achieved with other treatment options.[51]

In 2017, following 75 HIV infections from needle-sharing in 18 months (lifetime treatment cost £380k each) the Glasgow NHS conducted a business case for HAT/supervised injection facilities: *"Our proposals...would help to address a wide range of issues and so relieve considerable pressure on services elsewhere in the system. The evidence clearly shows the potential for these proposals to create long-term savings and so the economics of this issue are also compelling."*[52] Glasgow has acquired a building, and intends to open a HAT clinic in the coming months.

Are There Downsides?

Concerns that HAT may encourage drug use have proven unfounded. The EMCDDA and other reviews found that rather than patients increasing their heroin doses, they stabilised and often started reducing them, usually within two or three months, and uptake of other treatments also increased. HAT also helped reduce heroin availability and recruitment of new users by medicalising use, and reducing street-dealing and the number of user-dealers.[53] [54]

Clinics are also situated only where a street injecting problem already exists, and have soon won strong support from the public when their effectiveness is demonstrated, for example being backed by a resounding majority in a national referendum in Switzerland.[55]

For more information on HAT see the Transform Briefing: 'Heroin-assisted treatment in Switzerland: successfully regulating the supply and use of a high-risk injectable drug'[56]

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[47] BMJ, (2009), *'Heroin clinics reduce street drug use and crime, shows study'* http://search.proquest.com/openview/fdc3469e4226909939d04059acad7dd6/1.pdf?pq-origsite=gscholar

[48] Mills, H. et al (2013) *'Understanding organised crime: estimating the scale and the social and economic costs'* P68 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/246390/horr73.pdf

[49] Killias, M. and Aebi, M. (2000) *'The impact of heroin prescription on heroin markets in Switzerland'*, Crime Prevention Studies, vol. 11, pp. 83-99 http://www.popcenter.org/library/crimeprevention/volume_11/04-Killias.pdf

[50] This is likely to fall with economies of scale and an end to the current monopoly supply of the heroin used e.g. cost in other countries is £5k per patient

[51] EMCDDA (2012b) *'EMCDDA report presents latest evidence on heroin-assisted treatment for hard-to-treat opioid users'*

[52] Susanne Millar, Glasgow Health and Social Care Partnership http://www.nhsggc.org.uk/about-us/media-centre/news/2017/02/safer-consumption-facility-could-provide-substantial-financial-gain/

[53] Reuter, P. and Schnoz, D. (2009) *'Assessing drug problems and policies in Switzerland, 1998–2007'*, Swiss Federal Office of Public Health.

[54] European Monitoring Centre for Drugs and Drug Addiction (2012a) *'New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond'*, Lisbon: Portugal.

[55] Killias, M. and Aebi, M. (2000) *'The impact of heroin prescription on heroin markets in Switzerland'*, Crime Prevention Studies, vol. 11, pp. 83-99

[56] http://www.tdpf.org.uk/blog/heroin-assisted-treatment-switzerland-successfully-regulating-supply-and-use-high-risk-0

3. Enhanced Harm Reduction Centres (EHCR) (or Supervised Drug Consumption Rooms)

"Insite (Vancouver EHCR) saves lives. Its benefits have been proven." Supreme Court of Canada, 2011

What is an Enhanced Harm Reduction Centres (EHCR)?

Enhanced Harm Reduction Centres (also known as supervised drug consumption rooms or medically supervised injection facilities) are legally sanctioned facilities where people can inject their own pre-obtained drugs, under medical supervision. Some also allow drugs to be smoked. They can be in permanent clinics, mobile ambulance style units or temporary structures, and typically provide:

- sterile injecting equipment
- a hygienic space to use illegal drugs under medical supervision
- primary medical care, and emergency care in the event of overdose
- a gateway to drug treatment, counselling, social and health-care services

Are EHCRs Effective?

The UK Government has now acknowledged the evidence for their efficacy in reducing health and social harms in letters to the ACMD and Scottish Government. The extensive evidence supporting EHCRs was reviewed by the Government's official advisers, the Advisory Council on the Misuse of Drugs (ACMD), which backs them:[57] *"Research on the effects of medically-supervised drug consumption clinics has shown that they reduce injecting risk behaviours and overdose fatalities. They have been estimated to save more money than they cost, due to the reductions in deaths and HIV infections that they produce. Such facilities have not been found to increase injecting, drug use or local crime rates. In addition to preventing overdose deaths, they can provide other benefits, such as reductions in blood-borne viruses, improved access to primary care and more intensive forms of drug treatment. No deaths from overdose have ever occurred in such facilities."*

The Welsh Government's Advisory Panel on Substance Misuse (APoSM):[58] "*All reviews provide ubiquitous conclusions that [EHCRs] are efficacious to People Who Inject Drugs and the broader population... However, evidence was strongest for the effectiveness... in reducing drug related harms...including reduced syringe sharing, the use of sterile injection material, reductions in 'rushed injections', increased control over the injection process and increased requests for education on safer education practices."*

Where are EHCRs in operation?

The first opened in the 1970s. Over 100 now operate in 66 cities, in 10 countries - Switzerland, Germany, the Netherlands, Norway, France, Luxembourg, Spain, Denmark, Australia and Canada. The Irish government will open one in Dublin in 2018. Glasgow, with the support of the Scottish Government, hopes to open the first in the UK soon. The number in Canada is growing rapidly, with several US cities also exploring this option.

Are there downsides?

Use is restricted to existing dependent users, and 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.*"

EHCRs can require significant funds to set up and run, depending on what form they take, hours of operation etc. However, cost benefit analyses, including for NHS Glasgow[59] (where there are 500 people street injecting), have shown they are good value for money, and engage hard to reach populations. Given the cost of treating diseases like hepatitis C and HIV, avoiding even small numbers of infections from needle sharing can mean a EHCR pays for itself rapidly.

[57] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf
[58] APoSM, '*Report: Enhanced Harm Reduction Centres*', 2017 https://gov.wales/docs/dhss/publications/report-on-enhanced-harm-reduction-centres.pdf
[59] http://www.nhsggc.org.uk/about-us/media-centre/news/2017/02/safer-consumption-facility-could-provide-substantial-financial-gain/

What are the barriers to opening a EHCR in the UK?

A range of areas in the UK are carrying out feasibility studies into opening a drug consumption room, with the support of local and national treatment groups. Glasgow NHS is ready to open one, with the support of the Scottish Government, and unanimous support in Glasgow City Council, as soon as the UK Government allows it.

As with all drug treatment facilities, there can be local opposition, but when placed in a location with an existing visible problem, experience shows communities and businesses soon support them as street use, and drug litter, fall. The most recent Government response[60] to the ACMD's call for EHCRs accepts that they save lives, reduce disease transmission, and are cost-effective. Instead it focuses on challenges around policing, and the law. However these have been successfully overcome in every country that has them. And a growing number of Police and Crime Commissioners here support them.

"The international evidence shows that EHCRs 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….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 EHCR to operate properly – as we do with current harm reduction centres." Arfon Jones, North Wales Police and Crime Commissioner; David Jamieson, West Midlands Police and Crime Commissioner; Ron Hogg, Durham Police and Crime Commissioner. Letter to the Home Office, 4th May, 2018

So the only real barrier is political. But with cross-party support growing, including unanimous support in Glasgow City Council, this is rapidly fading.

- **Recommendation 7: A Ministerial Task and Finish Group should be created to fully explore and implement Heroin Assisted Treatment, and Enhanced Harm Reduction Centres, including feasibility studies, pilots, and funding options.**
- **Recommendation 8: The Welsh Government should call on the UK Government to formally grant permission for a pilot Enhanced Harm Reduction Centre to be opened in Wales.**
- **Recommendation 9: The Welsh Government should call on the UK Government to move the drugs brief from the Home Office to the Department of Health and Social Care, as part of a reorientation towards health based responses.**
- **Recommendation 10: The Welsh Government should call for further powers over criminal justice to be devolved as necessary to allow Wales to implement all measures needed to deliver an effective and humane approach to drugs, based on health and social care, not criminalisation.**

[60] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699825/Letter_from_Victoria_Atkins_MP_to_OBJ.pdf

Summary of Recommendations

There are no silver bullets. People will always take drugs, and some of that use will become problematic. But as groups like the Royal Society for Public Health argue,[61] the UK - and Welsh - approach to drugs needs a fundamental overhaul to put health and harm reduction instead of punishment and criminal justice at its heart. Criminalisation does not reduce use,[62] it drives vulnerable people from help, and leads them to use substances of unknown purity in more dangerous ways. And it places barriers in the way for organisations who work with them. For example, there are substantial challenges faced by the housing and homelessness sector when it comes to Section 8 of the Misuse of Drugs Act (which leaves organisations potentially open to prosecution if people in their properties use or supply illegal drugs)[63]; there are also implications for the Welsh Government's Housing First agenda.

The recommendations below will not solve all these problems, but together would constitute a big step in the right direction.

- **Recommendation 1: The Welsh Government should encourage all relevant organisations from the criminal justice, health and social care, and treatment sectors to build on existing collegiate working practices.**
- **Recommendation 2: There should be an end to banning anyone for life from treatment.**
- **Recommendation 3: Funding, and funding structures, should ensure that treatment is available to those who need it, when they need it, where they need it.**
- **Recommendation 4: Treatment structures and funding should recognise the specific challenges faced by those living in rural areas.**
- **Recommendation 5: We must completely move away from using prison as a sanction for people who commit minor non-violent drug (or drug-related) offences of any kind.**
- **Recommendation 6: That the Welsh Government works with local police forces and Police and Crime Commissioners to implement a national diversion scheme.**
- **Recommendation 7: A Ministerial Task and Finish Group should be created to fully explore and implement Heroin Assisted Treatment, and Enhanced Harm Reduction Centres, including feasibility studies, pilots, and funding options.**
- **Recommendation 8: The Welsh Government should call on the UK Government to formally grant permission for a pilot Enhanced Harm Reduction Centre to be opened in Wales.**
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[61] Royal Society for Public Health (2017), *'Taking a new line on drugs'* https://www.rsph.org.uk/resources/videos/itn-films/itn-film-2016-championing-the-publics-health/rsph-2016/taking-a-new-line-on-drugs.html

[62] Home Office, *'Drugs: International Comparators'* (2014) https://www.gov.uk/government/publications/drugs-international-comparators

[63] http://www.drugsandhousing.co.uk/faqs.htm