

volteface

BACK YARD

AN INVESTIGATION INTO THE FEASIBILITY OF ESTABLISHING DRUG CONSUMPTION ROOMS

Liz McCulloch

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry, no matter how small, should be recorded to ensure the integrity of the financial statements. This includes not only sales and purchases but also expenses, income, and transfers between accounts.

Next, the document outlines the process of reconciling bank statements with the company's records. This involves comparing the bank's record of transactions with the company's ledger to identify any discrepancies. Common reasons for differences include timing issues, such as deposits in transit or outstanding checks, as well as errors in recording or bank charges.

The document then addresses the preparation of the income statement. It explains how the data from the ledger is used to calculate the company's net income for a specific period. This involves summing up all revenues and gains, and then subtracting all expenses and losses. The resulting net income is a key indicator of the company's profitability.

Finally, the document discusses the importance of reviewing and auditing the financial records. Regular audits help to detect and correct errors, prevent fraud, and ensure that the financial statements are accurate and reliable. It also highlights the role of external auditors in providing an independent opinion on the company's financial health.

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Foreword

The time is right to look at new ways of reducing mortality among people who use illicit drugs. Across the UK, we are seeing record levels of drug-related deaths. These deaths often occur among people who use heroin, as well as alcohol and tobacco. The appearance of synthetic opioids like fentanyl and carfentanil in the UK drug markets threatens to cause even more harm. Many of the most vulnerable people are not well served by existing models of treatment. So we need new ways of engaging these people in services that can save their lives. The need for drug consumption rooms is urgent.

As this report shows, providing facilities where people can use illicitly purchased heroin under the supervision of trained staff has saved many lives in the countries where they already exist. There has never been a death from overdose in a drug consumption room. Although many overdose events have occurred, the presence of trained staff and swift delivery of oxygen and naloxone prevents death. Such facilities do not increase drug use or crime in their neighbourhoods. Rather, they reduce risks related to public injecting and discarded needles. They form a valuable part of the mix of interventions that are required to reduce deaths. This also includes opioid substitution therapy of optimal dosage and duration, wider provision of naloxone, heroin-assisted treatment and investment in welfare, social and mental health services.

The legal barriers to the establishment of drug consumption rooms have been reduced by acknowledgement at UN and UK government level that they can form a legitimate part of local responses to drug-related harms. But the Scottish Lord Advocate's recent advice shows that a clearer legal framework will need to be provided. In the meanwhile, as this report explains, it is still possible for local areas to develop a discretionary model that enables the establishment of drug consumption rooms in places which have a high concentration of injecting drug use. The longer we wait to set them up, the more people will die preventable deaths.

Professor Alex Stevens
University of Kent

Executive Summary

The ACMD and other bodies have recommended that the UK introduces drug consumption rooms (DCRs) to reduce drug-related deaths and other drug-related harms. Drug consumption rooms are professionally supervised healthcare facilities where people can consume drugs in safer conditions.

Robust evidence demonstrates that DCRs are effective in reducing self-reported risk behaviors associated with injection, such as syringe sharing, reaching and staying in contact with highly marginalised target populations, reducing drug-related deaths, increasing uptake of detoxification and drug dependence treatment, decreasing public injecting and reducing the number of syringes discarded in a vicinity. The evidence does not suggest that a DCR increases drug use, frequency of injecting, drug dealing, drug trafficking or drug-related crime in the surrounding environment. A DCR offers numerous benefits to the community and to people who use drugs.

The UK is currently experiencing record numbers of drug-related deaths, particularly among people who use opioids and who are not in drug treatment. These deaths could escalate even further following the emergence of fentanyl, a highly potent opioid which has been linked to at least 60 deaths since December 2016. Call-outs for the removal of drug-related litter are also rising with Leeds, Cardiff, Doncaster, Belfast, Liverpool and Sheffield seeing an increase in the last five years.

Existing policies are failing to meet the needs of the UK's communities and society's most vulnerable people. The evidence indicates that DCRs could address this gap in provision, but that there are a number of issues affecting feasibility. This report examines these issues.

The answers lie with the innovations occurring in Glasgow and Dublin. The Glasgow Health and Social Care Partnership is currently identifying a site for a DCR, and the Irish Health Service

Executive is undergoing a tendering process for a service in Dublin city centre.

The first hurdle would be making the case that the facility would have sufficient impact. People will not travel to use a DCR and thus qualitative and quantitative data collection should be used to identify a location for the service where there is a concentrated drug-using population. A business case should also be guided by other needs than just the presence of an open drug scene, which the UK may not see to the same extent as international comparators.

Funding is a core concern and financial provision should not come solely from treatment budgets, which are already under significant strain. Alternative funding streams may include: central budgets, contingency funding, diversion from services targeted towards the population who are likely to use the DCR such as homeless addiction services, or diversion from services which would see savings as a consequence of the DCR being established. It is appropriate that funding is allocated to a DCR as existing services are failing to engage marginalised groups and failing to address drug-related litter and public injecting, which is a significant burden in some communities.

Residents may have concerns that a DCR will create more drug-related disorder, though evidence points to the contrary. The community should be continually engaged in the proposal and clear communication channels provided with the local authority. As evidenced elsewhere, levels of community support are likely to increase after the facility is established. To avoid media coverage derailing attempts to establish a DCR, stakeholders are advised to seek out media opportunities to promote the proposal, though the expression of formal interest by the locality should be accompanied by a bedrock of local stakeholder support.

To encourage support from politicians, the proposal should be championed by their peers and framed as a humanitarian, evidence-based intervention, rather than as a wider call for drug reform. It is also advantageous for structures to be in place that ensure politicians are involved and consulted throughout the planning and development process and prior to key political decisions. DCR acceptability also depends on how consistent it is with the recovery agenda. Although the primary remit is to reduce harm, DCRs are a recovery-orientated service as they improve engagement with treatments for addiction, offer care and support, and address adverse life circumstances.

The legality of DCRs was cited as one of the most significant feasibility hurdles, as there are persisting legal barriers that would challenge its operation. A DCR could operate through a discretionary model, pursuant to guidance given by the police and prosecution service. Alternatively, a discretionary model could operate without legal guidance from the prosecution service and instead rely solely on multi-agency support, with local stakeholders signing a document regarding the establishment and running of the DCR. A legislative route is a longer process but offers a more stable and permanent legal solution. DCR pilots operating on a discretionary legal basis could be used to build the case for legislative change. The international community does also play a role in determining the legality of DCRs. The UN no longer cites concerns, and now just asks that DCRs should reduce the negative consequences of drug abuse and lead to treatment and rehabilitation, without condoning or encouraging drug abuse and drug trafficking. The international community can also be a highly useful source of expertise.

New policing practices would be required, but they are unlikely to be a significant departure from existing procedure for policing drug services. Forces would benefit from receiving clear guidance and legislation and observing models of practice in countries with DCRs.

There may be apprehension over the risks involved for DCR operators, but providers can turn to existing protocol as most of the risks are similar to those they already manage.

It is likely that drug consumption will continue outside of service hours, however, to minimise the extent to which this occurs, opening hours should be balanced against community need and local capabilities.

Stakeholders can learn from innovation in Glasgow and Dublin, but can also turn to existing practice, realising that the way forward may not be a significant departure from well trodden paths. By following in the footsteps of Glasgow and Dublin, but also turning to what is already known, localities will be best placed to replicate their progress and success.

DCRs are now a viable policy option and serious consideration should be given to their introduction.

Key Terminology

NHSGGC:

National Health Service Greater Glasgow & Clyde

DCR:

Drug Consumption Room

PWUD:

People Who Use Drugs

HAT:

Heroin Assisted Treatment

OST:

Opioid Substitution Treatment

ACMD:

Advisory Council for the Misuse of Drugs

Chapter 1

Introduction

For the first time in the UK and Ireland, the establishment of a drug consumption room is in progress. A drug consumption room¹ (DCR) is a professionally supervised healthcare facility where people can consume drugs in safer conditions. Additional services include sterile injecting equipment, counselling services before, during and after drug consumption, emergency care in the event of an overdose, primary medical care, and a referral to appropriate social healthcare and addiction treatment services (EMCDDA, 2017a). The Glasgow Health and Social Care Partnership is currently identifying a site for a DCR, and the Irish Health Service Executive is undergoing a tendering process for a service in Dublin city centre. These innovations offer an insight into how the UK can move forward with DCRs. We are currently lagging behind many other countries, which have at least 96 facilities in operation². The case has already been well made, multiple times, that DCRs would be a worthwhile addition to our health and social care offer (Select Committee on Home Affairs, 2002; JRF, 2006; Independent Drugs Commission for Brighton and Hove, 2013; ACMD, 2016; CGL, 2017; see Appendix 6.4). We must now turn to our counterpart stakeholders in local areas 'close to home' to find out how we can act on what we already know.

We know opioid-related deaths among older, marginalised users are rising alarmingly. These deaths could rise even further with the emergence of fentanyl and other related analogues in the UK drug supply. We also know that there is robust evidence that DCRs are efficacious in engaging and maintaining contact with highly marginalised target populations, reducing drug-related deaths, risky injecting practices, drug-related litter and public injecting, and do not lead to increases in drug use, frequency of injecting, drug dealing, drug trafficking or drug-related crime in the surrounding environment. The Home Office has acknowledged that there is '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' (Home Office, 2014, p.5) and the Advisory Council for the Misuse of Drugs has recommended that DCR provision should be considered by the governments of each UK country and by local commissioners of drug treatment services (2016).

If the UK accepts that DCRs can bring benefits and are very much needed, the question remains: how can they feasibly be introduced? Previous answers have been hypothetical in nature or have had to rely solely on international experience (JRF, 2006; Independent Drugs Commission for Brighton and Hove, 2013), but there is now the opportunity to turn to Glasgow and Dublin. This report considers how concerns relating to the impact, funding, acceptability and operation of DCRs can be alleviated by offering case study-based, practical advice from stakeholders in local areas 'close to home'.

To find out what current concerns and barriers could prevent the establishment of DCRs, Voltface interviewed 15 people in England and Wales who have advocated for DCRs, attempted to establish them or raised concerns surrounding their provision³. Interviewee contributions were collated and taken to 10 stakeholders in Glasgow and Dublin who have been named as playing a role in progressing the establishment of a DCR (see Appendix 6.1 for further detail on methodology).

Their contributions have been used to make the case that current concerns and barriers can be overcome and that drug consumption rooms are feasible in a UK context.

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Chapter 2

Evidence

The benefits of DCRs have not always been apparent as the evaluations of the original facilities located in Europe were not widely published in international literature (EMCDDA, 2017a). However, when DCRs were established in Sydney in 2001 and Vancouver in 2003, multiple university standard evaluation studies were undertaken which strengthened the existing evidence base. In 2006, an Independent Working Group on DCRs, convened by the Joseph Rowntree Foundation, concluded from the evidence base that DCRs 'offer a unique and promising way to work with the most problematic users, in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society' (2006, p.108). Since then, numerous evaluations have been published and the evidence base has been further strengthened. In 2014, the Home Office recognised the evidence for the effectiveness of DCRs in reducing drug-related harm among local communities and people who use drugs (PWUD) (Home Office, 2014).

Recent reviews of the evidence base conclude that DCRs can be efficacious in (Potier, Laprévotte, Dubois-Arber, Cottencin and Rolland, 2014; EMCDDA, 2017a):

- Reducing drug-related deaths at a city level, where coverage is adequate
- Reducing self-reported injection risk behaviors, such as syringe sharing
- Promoting safer injecting conditions
- Reaching and staying in contact with highly marginalised target populations
- Increasing uptake of detoxification and drug dependence treatment, including opioid substitution
- Enhancing access to primary healthcare
- Decreasing public injecting
- Reducing the number of syringes discarded in the vicinity

The evidence does not suggest that a DCR:

- Increases drug use or frequency of injecting in the surrounding environment
- Increases drug dealing, drug trafficking or drug-related crime in the surrounding environment

Chapter 3

Need

Calls for DCRs have arisen from concerns about persisting and increasing needs among people who use drugs (PWUD) (Select Committee on Home Affairs, 2002; JRF, 2006; Independent Drugs Commission for Brighton and Hove, 2013; ACMD, 2016). These calls have become more urgent as a result of increases in drug-related deaths right across the UK (Office for National Statistics, 2017; National Records of Scotland, 2017; Northern Ireland Statistics and Research Agency, 2015). In England and Wales, they are now at their highest level since comparable records began in 1993 (see Figure 1) (Office for National Statistics, 2017) and account for 31% of European drug-related deaths (EMCDDA, 2017c).

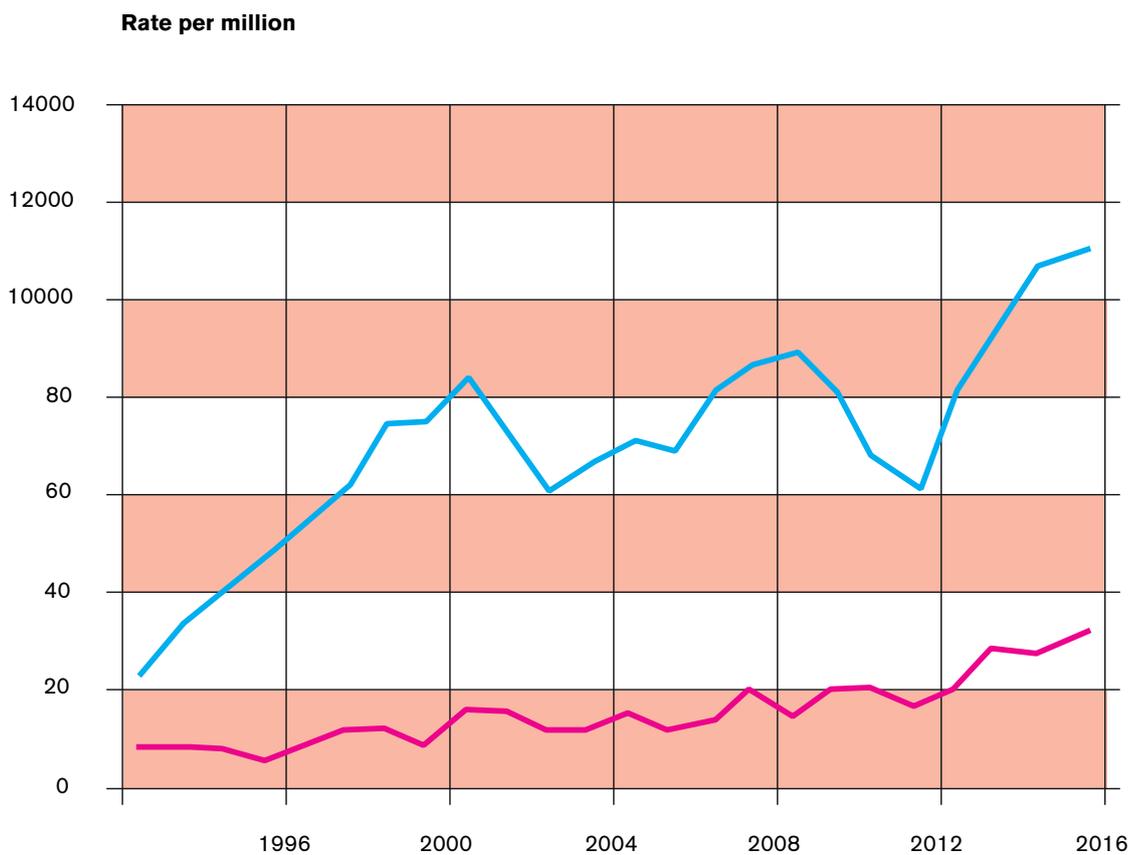


Figure 1. Age-standardised mortality rates for deaths related to drug misuse, by sex, deaths registered in 1993 to 2016.

● Males ● Females

The ACMD's examination of rising opioid-related deaths concluded that the most significant contributing factor has been the premature ageing of people who have been using heroin since the 1980s and 1990s, alongside increasingly complex health needs resulting from long-term conditions and polysubstance use. This trend takes place within a context of existing social care needs and continuing multiple risk behaviours. Another identified cause was the rise in availability of street heroin after a 'heroin drought' in 2010-2012, during which the purity of heroin fell and street prices increased. Changes to drug treatment and commissioning practices have also been named as contributing factors. These include: sub-optimal dosing of opioid substitution treatment putting PWUD at greater risk of overdose, and frequent recommissioning of services diminishing their ability to retain people in treatment (ACMD, 2016). Retention in treatment is a protective factor against drug-related death, where treatment comprises of optimal opioid substitution treatment (OST) and psychosocial interventions (White et al, 2015). It should be noted though that the majority of drug-related deaths occur among people who have had no contact with treatment services (Public Health England, 2016). The ACMD has also cited rising socioeconomic deprivation and a lack of access to mainstream mental and physical health services as possible contributors (2016). A combination of rising health needs and inadequate service provision has left a cohort of people at greater risk of drug-related death. The ACMD has recommended that DCRs should be considered as an intervention for drug-related deaths and other drug-related harms (2016, p.40).

There are concerns that drug-related deaths could further escalate with the emerging prevalence of fentanyl and related analogues (fentanyls) in the UK drug market. Fentanyls are synthetic opioids that come from the same family as heroin, but are far more potent on a weight for weight basis (O'Connor, 2017). Fentanyl is approximately 50 times more potent than heroin, with some related analogues being significantly stronger (NCA, 2017a).

In August 2017, the National Crime Agency warned that post-mortem toxicology results had indicated that 60 drug-related deaths in the UK were known to be linked to fentanyls since December 2016 (NCA, 2017a). Although it is currently unclear why fentanyls have emerged in the UK drug market, they pose the risk of escalating an existing crisis in opioid-related deaths and DCRs have been recommended as an intervention which could control potential outbreaks (CGL, 2017).

A Freedom of Information Request has also shown that call-outs to local authorities for the removal of drug-related litter is rising in some UK cities.

Drug-related litter adversely affects public amenity and could transmit infectious diseases, such as HIV and Hepatitis C, through needlestick injuries (See Figure 2) (Leeds City Council, 2017; City of Cardiff Council, 2017; Doncaster Council, 2017; Belfast City Council, 2017; Liverpool City Council, 2017; Sheffield City Council, 2017)⁴

National and local monitoring indicates that existing policies are failing to curb drug-related harms, which could be addressed through DCRs.

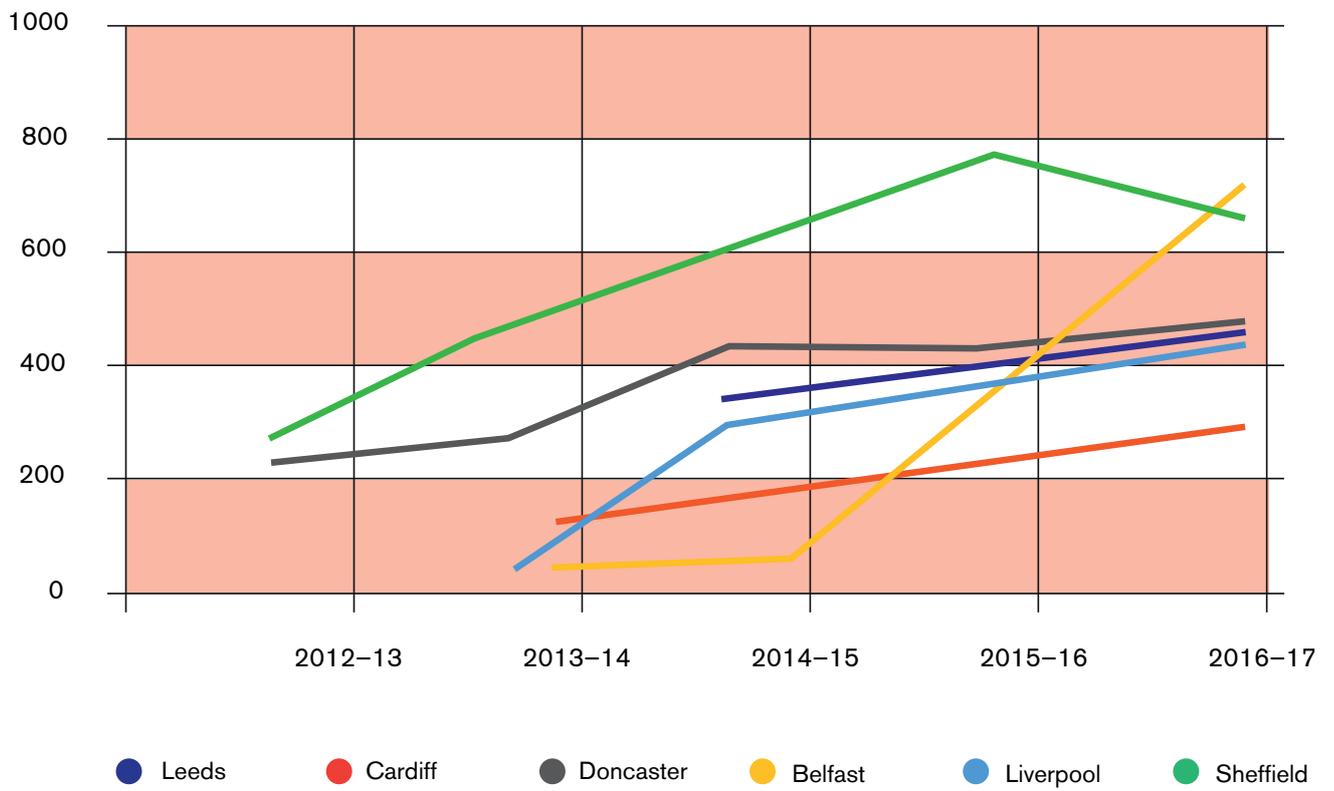


Figure 2. Call outs for the removal of drug-related litter

Chapter 4

Policy Developments in Glasgow and Dublin

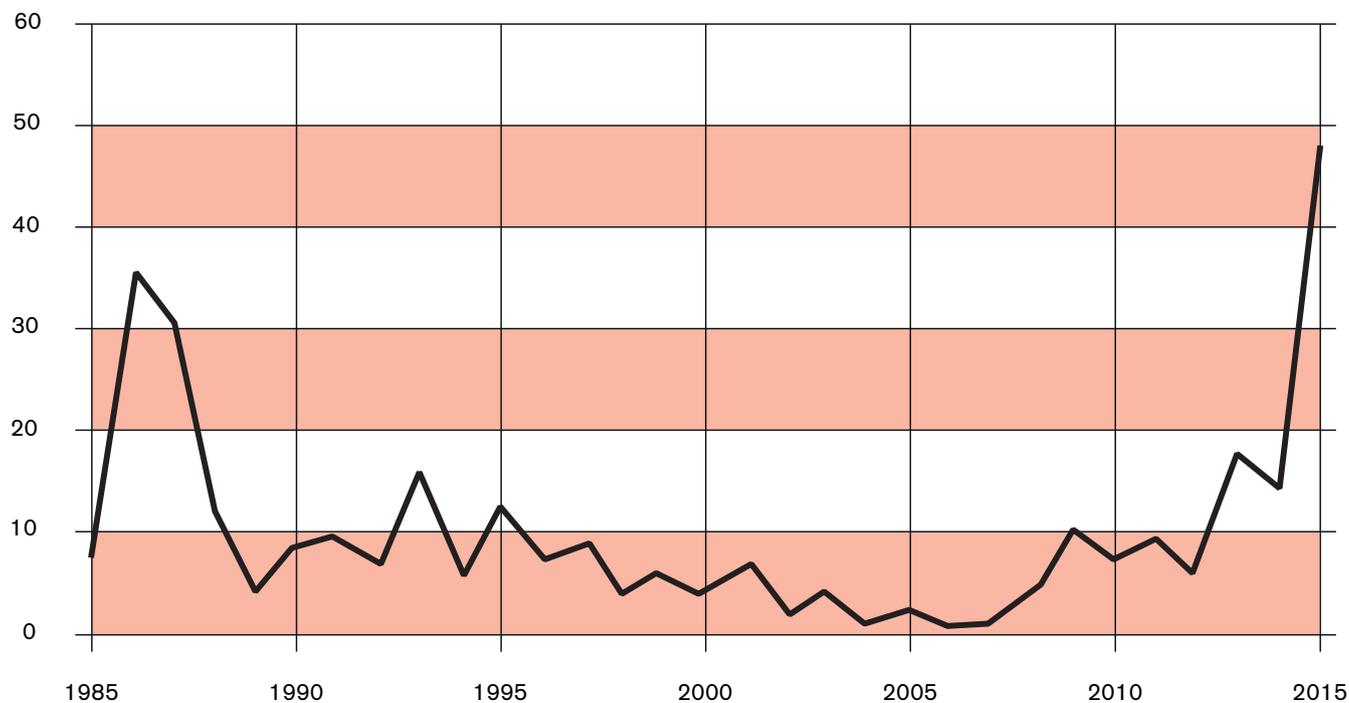


Figure 3. New HIV diagnoses among people who inject drugs in NHS GGC

Innovative policy responses have been taken forward in Glasgow and Dublin to respond to persisting and increasing drug-related harms. Both cities have made significant progress in establishing a DCR, with Glasgow City Health and Social Care Partnership currently identifying a site and the Irish Health Service Executive undergoing a tendering process for the service since the passing of the Misuse of Drugs (Supervised Injecting Facilities) Bill.

In 2015, Glasgow saw a significant HIV outbreak among people who inject drugs, with 47 new diagnoses compared to a previous annual average of 10 (see Figure 3) (Tweed and Rodgers, 2015).

In response to this outbreak and accumulating evidence of poor health and injection-related harm among people who inject drugs in Glasgow city centre, a local needs assessment was commissioned by NHS Greater Glasgow and Clyde (NHSGGC), which aimed to investigate how the city could better meet the needs of this population (Tweed and Rodgers, 2015). A number of priorities for health service provision were identified, with public injecting named as a risk factor for:

- Bloodborne viruses
- Overdose and drug-related death
- Other injecting-related complications, such as abscesses, wounds, and deep vein thrombosis

Seven recommendations came out of the needs assessment, the most novel being that the city should pilot Heroin Assisted Treatment (HAT) and a DCR. A short-life working group was convened to address NHSGCC's recommendations and proposed that a business case be made for a co-located DCR and HAT service. A co-located service was the preferred model as it was considered the most likely to improve the health of the target population, benefit communities and businesses currently adversely affected by public injecting, maximise the potential for service efficiencies, and take forward the recommendations of the health needs assessment (Millar, 2016a).

HAT involves prescribing medical grade heroin, administered under strict controls, to people who have failed to benefit from OST. Randomised control trials have tested HAT against oral methadone and injectable methadone, concluding that treatment with supervised injectable heroin leads to significantly lower use of street heroin than does supervised injectable methadone or oral methadone (Strang et al, 2010). Glasgow interviewees explained that a DCR will run in tandem to HAT as not all persons will be ready to accept HAT. The service places

higher demands on the person as, to be eligible, there must be evidence of previous unsuccessful treatment episodes and the person must attend the service, initially, three times a day and during specified periods that the service is open. HAT is also a highly cost-effective treatment (Strang et al, 2010) but is costly to operate, and potentially not affordable for the service to be offered widely.

The working group has since provided a further update on the development of this co-located service, with all recommendations approved by the Integrated Joint Board (Millar, 2016; 2017a; 2017b; 2017c). The group is currently identifying a site (Millar, 2017b) and is working with the Scottish Government to ensure that the appropriate legal context is in place to support the implementation and sustainability of the DCR (see section 4.3).

Ireland has experienced high drug-related harms in comparison to other EU countries, but these harms have been concentrated in Dublin, which has disproportionately high levels of opioid use, drug-related deaths (Long and Lyons, 2010; EMCDDA and Health Research Board, 2017) and HIV rates. Ireland has seen a significant rise in HIV, with increases of 81% in 2015 among people who inject drugs, with the majority of the new diagnoses occurring in Dublin (HPSC, 2016)

Public injecting is also highly prevalent in Dublin city centre. In 2013, Dublin city centre treatment provider Merchants Quay identified that 14% of people who use its needle and syringe programmes generally injected in public places, which can be extrapolated to 375 people (Jennings, 2013). A drug mapping project undertaken by the Ana Liffey Drug Project identified 1,750 individual pieces of drug-related litter in the North Inner City area over a two-week period in 2016 (ALDP, 2017).

All of these drug-related harms have taken place within the context of rising homelessness across Ireland, which, again, has been concentrated in Dublin (Department of Housing, Planning and Local Government, 2017).

In response to these persisting and increasing drug-related harms, and the publication of new international evidence on DCRs, Dublin-based drug and alcohol treatment provider, the Ana Liffey Drug Project, launched a strategic planning process which aspired to:

- *‘Advocate secure stakeholder support and plan for the establishment of a Medically Supervised Injecting Centre (MSIC) by September 2013.*
- *Subject to above and necessary legislative amendments, pilot a MSIC in Dublin offering a practical and safer alternative to public injecting by December 2014’ (ALDP, 2012)*

As a consequence of championing by the Ana Liffey, Senator Aodhán Ó Ríordáin and Minister for State Catherine Byrne, the Misuse of Drugs (Supervised Injecting Facilities) Act 2017 was enacted by the Dáil Éireann in May 2017, which provides ‘for the establishment, licensing, operation and regulations of supervised injecting facilities for the purposes of reducing harm to people who inject drugs’ (House of the Oireachtas, 2017).

The innovations taking place in local areas ‘close to home’ offer counterparts new opportunities to consider how a drug consumption room could be introduced in a UK context.

Chapter 5

Feasibility

5. 1. Impact

5.1.1. Location

A DCR should be a local intervention that responds to the needs of the local drug-using population. However, this does mean that a DCR has to be accessible to that local drug-using population, as people typically use their drugs soon after purchasing them and thus will not travel far to use a DCR (Tweed and Rodgers, 2015; Millar, 2016). A challenge faced by one locality was that it could not make the case that its drug-using population was sufficiently concentrated enough for the facility to offer a return in investment.

In Glasgow, NHSGGC firstly identified that there was a cohort of people who publically injected in Glasgow city centre who would benefit from a DCR established in that area. These estimates came from applying published prevalence estimates of public injecting (Hunt, 2006) to recent data from local needle and syringe programmes. The data concluded that there were between 400 and 500 individuals who may be injecting in public places in the city centre on a regular basis (Tweed and Rodgers, 2015, p.28).

The Health and Social Care Partnership then used a combination of quantitative and qualitative data collection methods to evidence that a DCR would be used by the targeted population, if it was placed in the city centre. Questionnaires were distributed to needle and syringe programmes in Glasgow city centre and adjoining areas. Among other questions, the questionnaire asked if the respondents would use a DCR in Glasgow city centre and 79% reported they would.

Within the questionnaire, respondents were asked if they were happy to be contacted again and this sample were invited to a DCR focus group hosted by the Scottish Drug Forum (SDF). To increase the number of participants on the day, SDF volunteers ventured into Glasgow city centre and asked people who were on the streets to come in and give their views. A £20 voucher was provided to those who gave up their time to participate, and lunch, tea and coffee were offered on the day.

Unanimously, the focus group agreed that a DCR should be provided. Though attendees said they would not travel to use the service, the people invited to the focus group were sampled from Glasgow city centre and adjoining areas, which will be the proposed location of the DCR (Millar, 2016).

By consistently sampling from the drug-using population in Glasgow city centre for all data collection, the Health and Social Care Partnership was able to make the case that a DCR would be sufficiently used if it was located in Glasgow city centre.

In Dublin, the Health Service Executive identified a location that would ensure the site was sufficiently used by surveying known street injectors, mapping drug-related deaths, ambulance service and fire brigade callouts, and identifying drug-related litter hotspots. Its working group concluded that Dublin city centre would see the facility offering significant return on investment (Health Business Services, 2017).

Recommendation:

PWUD are unlikely to travel to use a DCR and the locality would need to demonstrate that there is a concentrated drug-using population. The use of quantitative and qualitative methods, which collect data from a range of stakeholders and only sample within the targeted local areas, can build the case that the facility will be sufficiently used in the identified location.

**“YOU COULDN'T JUST WALK UP
BUCHANAN STREET AND SEE
INJECTING EQUIPMENT”**

5.1.2. Visibility of Drug Use

'The precarious situation in Germany's largest open drug scene – the Taunusanlage in Frankfurt am Main – had resulted in almost 200 deaths in public spaces at that time and increasingly concerned the citizens, politicians and city government'
(AK Konsumraum, 2011)

There are multiple community needs that a DCR can address, but responding to open drug scenes has been a key driving force for their establishment in other countries. Open drug scenes affect the wider community rather than just PWUD, who have historically had little opportunity to impact public policy. Although a study has evidenced that the UK experiences high rates of public injecting (Hunt, 2006), interviewees described an incidence where a proposal for a DCR struggled to gain traction as the public drug consumption that was occurring in the area was not as evident as it had been in areas such as Frankfurt or Vancouver. One would need to know where to look to find evidence of it.

Glasgow interviewees acknowledged that, although there are possibly hundreds of people using drugs in public places in the city centre, there is not an obvious open drug scene, with drug use more hidden than that experienced by its international counterparts.

'You couldn't just walk up Buchanan Street and see injecting equipment, but if you walked up one of the alleyways not far from there then you very well might... if you're not going out to look for it then you probably won't see it. You certainly see a lot of homeless people, people begging, people intoxicated but to actually visibly see injecting equipment and people injecting in public, like has been seen in Vancouver, it just isn't the case. I guess for some people they have no idea that the problem actually exists, it's a very hidden thing'

Kirsten Horsburgh,
National Naloxone Coordinator,
Scottish Drug Forum

The Ana Liffey agreed that a similar situation exists in Dublin.

'If you were to walk around Dublin city now you may not see any drug-related litter on the streets, however, if you were to turn and go 30 feet down an alleyway, you might or might not find a syringe, but you will find other types of drug-related litter... I've shown people what to look for and it has been said to me it's like one of those magic pictures where the image gradually emerges and the image that appears is shocking... '

Tony Duffin, CEO,
Ana Liffey Drug Project

However, multiple drug-related harms can persist without having a highly visible presence and need was also evaluated by a wider criteria than just the presence of an open drug scene. Moreover, what was highlighted by both localities was that the decision to progress the establishment of a DCR had been grounded in a local needs assessment rather than international comparisons.

Recommendation: The presence of obvious, open drug scenes has been a key driving force for their establishment in other countries which the UK, arguably, does not experience to the same extent. However, the case can be made that needs persist even if a drug-using population is relatively hidden. Moreover, the decision to establish a DCR should be guided by a local needs assessment, rather than international comparisons of need.

5. 2. Funding

5.2.1. Funding Streams

Recent budgetary cuts to drug and alcohol treatment are of significant concern. In December 2016, the Government announced that local authorities will receive £84 million less for public health in 2017/18, which has followed a £77 million reduction in 2016/17, and a £200 million cut in 2015/16. On average, local areas have seen drug and alcohol treatment cut by 30%, though some areas have seen cuts of up to 50% (Drummond, 2017) . There is limited additional resource in drug and alcohol treatment and some interviewees were apprehensive that the opportunity cost of investing in a DCR would result in further disinvestment from treatment provision, putting further lives at risk. The ACMD has advised that its primary recommendation for reducing drug-related deaths is for the Government to, at the very least, maintain investment in OST of optimal dosage and duration (2016, p.3).

The Glasgow Health and Social Care Partnership has acknowledged that treatment budgets are under strain and, thus, the DCR has not been funded by a diversion of existing mainstream treatment budgets. Interviewees commented that, instead, resources are being realigned from services targeted towards the population who are likely to use the DCR, for example, homeless addiction services. It was emphasised that resource will be diverted from these existing services without diminishing core provisions.

New money is also being allocated to the service through a contingency fund, which will finance the pilot service for three years (Millar, 2017b). Contingency funding was deemed to be an appropriate funding stream due to the emergence of urgent issues, notably drug-related deaths and new diagnoses of HIV.

'Most of the funding currently identified is from that contingency fund, the other is the redirection of current resource, but resources that are already at the moment aligned to this population. So its supplanting the current resource with more, in order to deliver a bigger agenda for that population'

Dr Saket Priyadarshi,
Glasgow Associate Medical Director
at Addiction Services NHS GGC

Funding for the Dublin DCR was identified through Ireland's Department of Health central budget. Interviewees commented that there was little difficulty in raising additional funds for the DCR as the cost was not substantial when taken out of a national budget. No diversion from existing treatment budgets occurred.

Recommendation: Treatment budgets are under significant strain and further significant diversion would have a detrimental impact on provision. In Glasgow and Dublin, there is no evidence of DCRs being funded from a diversion of treatment budgets. Alternative funding streams can include centralised funding, contingency funding or resources realigned from existing services targeted towards the population who are likely to use the DCR, without diminishing core provisions.

5.2.2. Cross Divisional Savings

A DCR can lead to substantial savings across different departments by, for example, reducing drug-related disorder, improving public amenity and reducing the burden on emergency health services. Studies have attempted to estimate the societal cost savings, most commonly through predicted reductions in HIV (Andreson and Boyd, 2010; Bayoumi and Zaric, 2008; Pinkerton, 2010). One interviewee raised the concern that, in some local areas, budgets do not account for these cross divisional savings. Other departments may feel the benefits of the DCR but not make any financial contribution to its operation.

The Health and Social Care Partnership has recognised the cross divisional savings a DCR can offer as, during the course of the three-year pilot, NHSGGC will evaluate where the service provides benefits and savings to other parts of the health and social care and wider system, which subsequent funding packages will reflect. Thus, the city is taking an invest-to-save approach, with an evaluation that includes a cost benefit analysis.

'If this evaluation demonstrates the [DCR] does improve the health of service users and reduces pressures on associated services, there would be a case to redirect resources from those services to fully fund the service from year four'

Dr Saket Priyadarshi, Associate Medical Director, Addiction Services at NHS Greater Glasgow and Clyde

For Dublin, the Department of Health will continue to fund the facility if the evaluation merits the continuation of the project. As the funding comes from a national health budget, different divisions within the Department of Health will feel the costs and benefits.

Recommendation: DCR funding packages can reflect cross divisional savings by coming from a centralised, cross departmental budget. Alternatively, funding packages can be informed by evaluations which indicate where savings are felt once the service is established.

5.2.3. Cost-Effectiveness

NHSGGC has estimated that the operating costs for a DCR will amount to £1,000,000, a figure which will be confirmed once the site is identified. The Ana Liffey has estimated a similar operating cost for the Dublin DCR. Both service designs have been modelled on the Sydney Medically Supervised Injecting Centre.

International evidence demonstrates that DCRs are a highly cost-effective service which can result in substantial savings (Bayoumi and Zaric, 2008; Pinkerton, 2010; Salmon, Van Deek, Amin, Kaldor and Maher, 2010).

The Glasgow HSCP have calculated that A+E and acute admission costs for the estimated 350 who inject drugs in the Glasgow city centre, amounts to 1.7 million. The average medication-only cost per patient receiving HIV treatment is currently £6,403 per annum; this figure does not include the costs of clinic appointments, laboratory monitoring, or treatment for any complications arising. In February 2017, there were 78 confirmed cases in the outbreak of HIV from the start of 2015 and the outbreak is ongoing. If these costs were realised for the individuals affected by the outbreak, then this would equate to £28 million lifetime costs; including £500K per annum medication costs (Millar, 2017a). The evidence indicates that investment in a drug consumption room could reduce spending in these areas.

However, one interviewee raised the concern that it would be challenging to allocate such a significant amount of resource to a relatively small cohort of people, especially with the availability of more affordable interventions such as Naloxone, needle and syringe programmes and OST.

The 2015 Glasgow local needs assessment did conclude that 'the quality of service provision for people who inject drugs in Glasgow compares well to other areas of the UK and to international standards' (Tweed and Rodgers, 2015, p.19). The needs assessment also made

recommendations to further improve and invest in this provision, such as increasing the opening hours of needle and syringe programmes.

However, the needs assessment identified that PWUD drugs in Glasgow city centre had, for years, consistently been at the epicentre of outbreaks and other harms, despite investment in prescribing services, needle and syringe programmes, and during times of high retention in drug and alcohol treatment. As 'previous attempts to address the problem of public injecting in Glasgow have not curtailed the harms experienced by this population', NHSGGC recommended that new and innovative approaches were required to meet their needs (Tweed and Rodgers, 2015, p.6)

'It obviously wasn't working... I think that's why changes need to be happening because people are still dying... people don't even know how to inject properly and they're causing themselves damage, people are losing limbs and contracting bloodborne viruses, and there needs to be something that people can access, because a lot of the people who are using in the city centre, they've been through services one million and one times and it's never worked and there's a good reason that it's never worked, I think it's just about trying something else and there's evidence there that it is successful'

Claire Muirhead, Chair of South Community Recovery Network and Lived Experience

By attracting marginalised groups, a DCR can deliver a 'Making Every Contact Count' approach, where services can utilise day-to-day interactions to encourage behaviour change that has a positive effect on individual health and wellbeing (Health Education England, 2017).

The Glasgow needs assessment also indicated that no existing initiatives have been able to resolve long-standing local community concerns surrounding public injecting and drug-related litter (Tweed and Rodgers, 2015). A Freedom of Information request revealed that in 2016/17,

Glasgow saw a 68% increase in call-outs to the local authority for the removal of drug-related litter (Glasgow City Council, 2017).

'I've examined the issue of the needles being dispensed and not being returned. From that experience, I fully understand the public health reasons for issuing fresh needles in order to reduce the transmission of bloodborne diseases like HIV. Throughout this period, my concern has been focused on the risks passed on to the population at large if needles are just going to be discarded in public places. There doesn't seem to be any way around the problem of needle discard, other than looking at a consumption room and taking the drugs taking away from back lanes, streets, waste ground, and into a suitably equipped and monitored premises...[Currently] the cost of needle discard falls to other people, it falls to housing associations, it falls to the council, it falls to emergency services, it falls to all kinds of other groups and sometimes in ways that are not calculated.'

Alison Thewliss,
MP for Glasgow Central

Thus, the establishment of a DCR is not just about investing in a relatively small cohort of people, it is about investing in the wider community by reducing drug-related litter and incidences of public drug injecting.

Dublin interviewees commented that questions regarding cost and cost effectiveness had not played a central role in Ireland. A criticism the proposal did face was that PWUD would have their needs better met through investment in treatment. However, investment in treatment would have had limited impact as the problem of public injecting in Dublin city centre had persisted for more than 30 years and existing services were not addressing it. Treatment can meet the needs of some people, but there are others who are not interested or ready to enter treatment and a DCR can fill this gap in provision.

Recommendation: A locality will have to justify why resources should be allocated to a relatively small cohort of people, especially with the availability of more affordable interventions. The case can be made that a DCR can bring benefits not provided by other interventions, as it can successfully build relationships with hard to reach groups who are not engaging in current provision. Existing interventions are also failing to address drug-related litter and public injecting, which is a significant burden in some communities. Thus, the establishment of a DCR is not just about investing in a relatively small cohort of people, it is about investing in the wider community by reducing drug-related litter and incidences of public drug injecting.

5.3. Acceptability

5.3.1. Community Engagement

Residents living in 'hotspots' of public drug consumption are likely to have concerns that a DCR will create more drug-related disorder and may object to proposed site locations, though evidence indicates that DCRs reduce the impact of drugs on communities. Most interviewees felt that there would be significant challenges in engaging the local community as the proposal would invoke 'nimby-ism' (Not In My BackYard) .

The Glasgow Health and Social Care Partnership is currently identifying a site. Once this is done, a community engagement process will take place.

Dublin is at a more advanced stage, with the Health Business Services recently releasing an invitation to tender. The tender specification includes the recruitment of a Community Liaison Worker Officer whose role will be to engage local businesses, communities and residents in a meaningful manner and set up a system for local monitoring. This would involve regular meetings with local stakeholders and reporting back to Ireland's Operational Governance Committee. This specification is in accordance with EMCDDA guidance that 'consultation with local key actors is essential to minimise community resistance' (2017a, p.5). The invitation to tender

also advises that local opinion before and after the opening of the facility should be recorded and reported on (2017). International evidence indicates that levels of community support for a drug consumption room increase after they are established (Thein, Kimber, Maher, Macdonald and Kaldor, 2005).

Recommendation: Despite evidence demonstrating that DCRs have a beneficial impact on local communities, residents are likely to have concerns that a DCR will create more drug-related disorder. If a DCR succeeds in delivering on its promises, it is likely that levels of community support will increase, as evidenced elsewhere. Until that time, the community should be continually engaged in the proposal and clear communication channels with the local authority should be provided. The recruitment of an individual with a designated position to do so could be an effective way of maximising engagement.

5.3.2. Media Engagement

It is likely that a DCR proposal would, initially, be perceived as contentious as the authorities would be providing a premises where people can use illicit drugs. Most interviewees cited concerns that the media reaction to the proposal would entrench misconceptions surrounding DCRs and obstruct positive public engagement with the facility.

Yet the response from the media to the Glasgow DCR has been overwhelmingly positive so far. NHSGGC has explained that this reaction was a consequence of the media engagement undertaken by its communications department and strong support for the initiative among partner agencies, people with lived experience and experts at the local level.

NHSGGC managed the publication of each of the Integrated Joint Board updates by working closely with the Health and Social Care Partnership to create detailed and accurate press releases for the media. The press releases were first sent to all stakeholders, ensuring that they were aware of the most recent service developments if contacted by the media. To keep the media engaged with the process, newsworthy content was included in the press release, as well as the key elements of the Integrated Joint Board update. NHSGGC also formulated a list of FAQs for media outlets to refer to, ensuring that information was transparent and easily accessible (Health and Social Care Partnership, 2016).

The DCR proposal received mostly favourable coverage from media outlets, with The Times and The Herald taking positive editorial stances. Others chose not to report on the issue. The Daily Mail was the only news outlet which was strongly critical of DCRs, yet was unable to find local stakeholders who were opposed to the initiative. NHSGGC commented that solidarity at the local level created a strong foundation for subsequent engagement with the media.

Media engagement began at an earlier point in Dublin as the process was driven to a greater degree by moral and political acceptability. The Ana Liffey was advised that DCRs were a newsworthy item and that it could create its own news stories to move DCRs up the agenda and manage perceptions of acceptability. The organisation planned for five interactions per week on DCRs on online media and also sought out opportunities for TV, radio and opinion pieces.

‘Radio has been a good communication platform for these purposes; listeners want to hear the human story and radio has given people who are affected a voice and a level of anonymity that has given them some comfort. Listeners can hear the person’s story, hear their heartache and the tragedy of the story.’

Tony Duffin, CEO,
Ana Liffey Drug Project

The charity strongly advised that advocates should engage with the media as not doing so would leave a void that could be filled with detraction and misinformation.

Recommendation: Media engagement is essential for facilitating community acceptance of DCRs and advocates are advised to seek out media opportunities to promote DCRs. Radio interviews are cited as a highly persuasive communication tool, with the voice of lived experience and families powerful in early work and for softening the way for informed discussion. Local commentators and stakeholders should be engaged in the proposal prior to the media release to ensure that the locality presents a united front. Press releases should be detailed, newsworthy and shared and drafted with all partners. Any additional information and FAQs should be in an easily accessible format.

5.3.3. Political Support

Drug policy is an area which politicians can be reluctant to speak about, with the UK Drug Policy Commission concluding in its final report that 'there is little political space for informed debate about policy options' (UKDPC, 2012, p. 134). Interviewees commented that, from their experiences, politicians can be reluctant to publically declare their support for alternative drug policies.

However, the opposite has occurred in Glasgow and Dublin. When Glasgow's intention to pilot a DCR was announced in October 2016, there were no public objections from Scottish politicians. Glasgow interviewees advised that politicians needed to feel safe in supporting a DCR, which can be encouraged by their peers publicly supporting the proposal.

'We decided we were going to put a line out from me in the office to say that I was supportive of the proposal, and why. In speaking to them [councillors] they were quite pleased and surprised that I had done that. The councillors on the Integrated Joint Board seemed concerned that this proposal was going to be a difficult thing to sell to the public... I'm quite glad that there has been cross-party holding of the line on it, because all it takes is for a couple of people to start objecting and throwing their hands up for this important intervention to falter.'

Alison Thewliss,
MP for Glasgow Central

Efforts were also made to depoliticise the proposal by framing it as an evidence-based intervention that was responding to rising and changing need, rather than being driven by a drug reform agenda.

'Across the world when we look at this, it's quite often high profile politicians and public leaders who have taken this

through. In the UK, there doesn't seem to be an appetite. Alison Thewliss has been very helpful and supportive but we don't have anybody in high office, or a Secretary of State or a Prime Minister or a high profile cabinet member taking this through. Actually it's been the bravery of very senior officers in our Health and Social Care Partnership who have taken this through, given it the authority for it to be taken as far as it has here. And a very systematic step by step explanation of the evidence base and the business case to the Integrated Joint Board, so that we can make the case with as little emotion as possible and just saying this is the right thing to do for the city centre'

Dr Saket Priyadarshi,
Associate Medical Director, NHSGGC

The structure of the Integrated Joint Board was able to mitigate any automatic political objections as half of the board was comprised of councillors who were engaged early in the process, presented with the evidence and jointly tied into decision-making.

The position of the Scottish Government has been accommodating to local decision-making in Glasgow, with Public Health Minister Aileen Campbell stating in June 2016 (Allen, 2016):

'The Scottish Government has no plans to introduce drug consumption rooms or heroin-assisted treatment on a national basis. This is a matter for Glasgow City Alcohol and Drug Partnership and NHS Greater Glasgow and Clyde health board. We would encourage the health board to ensure it consults with communities before making any decisions. We constantly look at new developments in drugs policy to see how effective they are and we would encourage an independent evaluation of any such facility.'

The Scottish Government is also supporting the Glasgow Health and Social Care Partnership to ensure that the appropriate legal context is in place to support the implementation and sustainability of the DCR (see section 5.4).

Interviewees commented that the Scottish Government could be accommodating to the policy developments in Glasgow as the Government had been fully informed of the process, with one of its representatives sitting on the DCR short life working group.

Similarly to the Scottish Government, the UK Home Office has stated that it 'has no plans to introduce drug consumption rooms'. However, its statement on DCRs adds that, 'it is for local areas in the UK to consider, with those responsible for law enforcement, how best to deliver services to meet their local population needs'. It can be inferred from this that the Home Office has become more accommodating to local agency surrounding DCRs, though far less explicitly than the Scottish Government.

A greater public debate has been had in Ireland where political champions played a more prominent role. Minister of State Aodhán Ó Ríordáin and Catherine Byrne were able to use their influence to secure safe passage for legislation which made it legal for the DCR to be piloted. After being approached by the Ana Liffey, Senator Aodhán Ó Ríordáin was the first political advocate for the facility and framed the proposal primarily as a humanitarian response.

'I was trying to put a group of people at the heart of a public policy initiative and I think people could see what I was trying to achieve. That was the ideology behind it, the sole purpose of it... In politics, if you put people at the centre of what you're trying to do, and particularly extremely vulnerable people, then people accept you're bona fide. It's not as if it's politically advantageous, it's not as if it's a sector who are voting or have power, they don't have huge access to mainstream media. So when you're advocating on behalf of... that sector who don't have a voice, then I think people will accept you... I would like to think that ran through in the things we were saying... There didn't seem to be anybody saying it was a bad idea, some voices on the extremes, but nobody in mainstream advocacy or lobbying.'

Senator Aodhán Ó Ríordáin,
Dublin Bay North

By the time the DCR legislation was being publicly debated in Ireland, interviewees observed that media outlets struggled to find politicians who were opposed to the idea.

Recommendation: Politicians are more likely to be supportive of drug consumption rooms if they are championed by their peers and framed as an humanitarian, evidence-based intervention, rather than as a wider call for drug reform. It is also advantageous for structures to be in place which ensure politicians are involved and consulted with throughout the planning and development process and prior to key political decisions.

**“IF YOU TALK THEM OFF THE
LEDGE THEN YOU CAN TALK
TO THEM ABOUT THE ISSUES
THAT HAVE GOT THEM ON
THERE IN THE FIRST PLACE.
BUT YOU HAVE TO STOP THEM
FROM DYING OR GETTING
A VERY SERIOUS DISEASE”**

5.3.4. Recovery Agenda

A DCR was considered unfeasible in one UK location due to criticisms from stakeholders that, by providing a premises for an individual to use illicit drugs, a DCR was inconsistent with the recovery agenda, which has put a greater emphasis on supporting individuals to lead a drug-free life (HM Government, 2010; 2017).

The Glasgow proposal highlights that the service is recovery-orientated as it will be:

- *Engaging a population with complex needs in effective addictions treatment and care*
- *Promoting recovery-orientated support such as peer support and mutual aid*
- *Providing opportunities to address and improve adverse life circumstances such as housing, welfare rights and wider medical needs. The facility will be offering wrap around services on the same premises and referral pathways into wider support services (Millar, 2017b).*

'A lot of people who are using in the city centre, they're not engaged in treatment services and trying to actually get them access to the kind of services that they're needing, providing a nurse for wound care, BBVs and other issues is difficult... I walk through the city centre all the time and there's never a day goes by where I don't recognise a couple of people who are sitting, begging in the city centre, using in the city centre, and all these people want is for somebody to actually talk to them. You know just go in, friendly face, somebody who remembers their name'

Claire Muirhead, Chair of South Community Recovery Network and Lived Experience

The Dublin DCR has similar recovery-orientated provisions in place by offering medical interventions, crisis interventions, counselling interventions (if requested) and referrals into social services, housing and treatment. It is also expected that the service provider should offer at least a brief intervention on each attendance (Health Business Services, 2017).

However, Dublin interviewees advised that the success of a DCR should be judged on its primary purpose, improving health outcomes among PWUD.

'If someone's on the edge of a building and they're about to jump off, that person may have housing issues, may have addiction issues, may have mental health issues, may have a whole bunch of issues, but your fundamental job is to stop them jumping off the ledge. Do everything you possibly can and if you talk them off the ledge then you can talk to them about the issues that have got them on there in the first place. But you have to stop them from dying or getting a very serious disease and that's what the SIF is. So I'm not overplaying it, you have people all over who use these centres for years... but they don't get diseases and they don't overdose and die, in a very lonely, pretty depressing environment, and that's all it's designed to do'

Senator Aodhán Ó Riordáin,
Dublin Bay North

Recommendation: The recovery agenda, which has come to prominence in UK drug addiction provision, places a greater emphasis on supporting individuals to lead a drug-free life. DCRs are a recovery- orientated service as they improve engagement with addictions treatments and care, offer recovery- orientated support and address adverse life circumstances. However, the primary remit of a DCR is to reduce harm and save lives.

5.4. Operation

5.4.1. Legality

The legality of DCRs was cited as one of the most significant feasibility hurdles. The UK Government's recent position on DCRs has become more accommodating to local agency (see Appendix 6.4), but this change in position does not address persisting legal barriers.

There are laws which would dictate how a DCR would operate and can be accommodated through management procedures, for example, not allowing service users to inject one another. There are then laws which would be difficult to overcome through service design. These are (Fortson, 2017⁵):

- *Simple possession of the drug in question (e.g. traces on paraphernalia or drugs that are abandoned)*
- *Assisting or facilitating the drug user's continued possession of the drug*
- *The conundrum of whether acts of drug preparation by the user constitute the 'production' of the drug*
- *Whether the occupier/manager of the DCR permits or suffers (with knowledge) the user to 'produce' the drug on the premises*
- *Anti-smoking laws*

When Glasgow officials agreed to formally consider a DCR, two legal opinions were provided by two separate Queen's Counsel to consider different legal routes. The legal opinion was privately commissioned and so is not available for public viewing, but was reportedly similar to legal opinions published by the Joseph Rowntree Foundation (2006), but see the updated paper by Fortson (2017).

The chosen legal route for the Glasgow DCR was originally a discretionary model, rather than seeking to change legislation. There is flexibility

within the law for the police to take a reasonable approach to law enforcement, exercising discretion in the public interest. The Health and Social Care Partnership viewed the discretionary model as a short-term solution to allow the operation of a pilot facility. If the evaluation of the service concluded that it was necessary and desirable in the longer term, a more permanent legal solution would have been sought through legislative change (Millar, 2017b). A change in prosecution policy was judged to be the more appropriate legal route in the first instance, as it would allow the facility to be established in less time than it would take to change legislation (Millar, 2017b).

Guidance was sought from Scotland's Lord Advocate, the chief legal officer of the Scottish Government and the Crown in Scotland for both civil and criminal matters that fall within the devolved powers of the Scottish Parliament, to allow an exemption from the relevant sections of the 1971 Misuse of Drugs Act (Millar, 2017b).

The Lord Advocate did not approve an exemption in prosecution policy but has given a clear steer on the next stage in the legal process to allow Glasgow to proceed. This will involve working with the Scottish Government, which officials are already doing. NHSGGC has commented:

'We are delighted to have the support of the Scottish Government to ensure the appropriate legal context is in place to support the implementation and sustainability of a Safer Drug Consumption Facility in Glasgow. We will work with the Scottish Government now with regards to the legislation change required.'

Dr Saket Priyadarshi, Glasgow Associate Medical Director at Addiction Services NHSGGC

The Dublin DCR model is operating through legislative change since the passage of the Misuse of Drugs (Supervised Injecting Facilities)

Bill 2017. Irish drug laws are comparable to UK drug laws, with both countries passing a Misuse of Drugs Act in the 1970s, which include laws that would challenge the operation of a DCR. The Misuse of Drugs (Supervised Injecting Facilities) Bill 2017 addresses the legal barriers which the operational design could not surmount.

To begin the process of changing the law, the Ana Liffey invoked the help of the Voluntary Assistance Scheme, a service run by the Bar of Ireland which offers pro bono legal assistance to vulnerable sections of society who often encounter difficulties in accessing the legal system. The Voluntary Assistance Scheme agreed to formulate a legal opinion for the Ana Liffey and draft DCR legislation, putting together a panel of barristers, including two senior counsel and six junior counsel. The expertise of the panellists included civil law, healthcare law, drug law, drafting legislation, debt delegating legislation, obligations of medical professionals, planning and DCR operational procedure. Through the legal opinion, the Voluntary Assistance Scheme was able to indicate what laws would challenge or prevent a DCR being established. The case could then be made that, if the draft legislation was enacted, all of the legal problems identified in the legal opinion would be remedied.

In April 2015, Senator Aodhán Ó Ríordáin was appointed as Minister of State at the Department of Health, with responsibility for the National Drugs Strategy. Senator Ó Ríordáin agreed to lobby the Supervised Injection Bill during his time in office and succeeded in securing the agreement of the Government to begin processing the legislation in December 2015. When Senator Ó Ríordáin lost his seat in the 2016 General Election, the legislation continued to be progressed by Minister for State, Catherine Byrne, who succeeded in passing the legislation in May 2017.

Amending legislation was the preferred legal route as it was felt that a discretionary model would be unlikely to withstand a legal challenge and legislation would give the DCR the strongest legal standing.

For the UK to provide DCRs with legislative protection, Fortson advises that amendments could be made to the 'Misuse of Drugs Regulations Act' or the UK could follow Ireland's model of passing a 'Misuse of Drugs (Supervised Injection Facilities) Act'.

Other UK jurisdictions could follow a legal discretionary route by making an application for guidance from the Crown Prosecution Service for England and Wales or Public Prosecution Service for Northern Ireland. Such guidance would be susceptible to changes of policy and senior personnel within the police or prosecution service and is also vulnerable to legal challenge as the guidance would not have the force of law. However, the courts will not lightly interfere with the exercise of discretion that is reasonable and rational (Fortson, 2017).

A discretionary model could operate without legal guidance from the prosecution service and instead rely solely on multi-agency support, with local stakeholders signing a document regarding the establishment and running of the DCR – whether styled as a 'protocol', 'terms of engagement' or 'comfort letter'. Though feasible, such a protocol would be exposed to the potential for political, legal and administrative challenges (Fortson, 2017⁶).

Recommendation: There are legal barriers which would challenge the operation of a DCR in the UK. However, there is flexibility within the law for the police to take a reasonable approach to law enforcement, exercising discretion in the public interest. A DCR could operate through a discretionary model, pursuant to guidance given by the police and prosecution service. Such guidance would be susceptible to changes of policy and senior personnel within the police or prosecution service and is also vulnerable to legal challenge as the guidance would not have the force of law. However, the courts will not lightly interfere with the exercise of discretion that is reasonable and rational. Alternatively, a discretionary model could operate without legal guidance from the prosecution service and instead rely solely on multi-agency support, with local stakeholders signing a document regarding the establishment and running of the DCR. Though feasible, such a protocol would

be exposed to the potential for political, legal and administrative challenges. A legislative route entails a longer process but is a more stable and permanent legal solution. However, evaluations of a facility, operating on a discretionary model, could be used to build the case for legislative change.

5.4.2. International Community

The international community plays a role in determining the legality of DCRs. In recent years, the International Narcotics Control Board (INCB), the body responsible for monitoring adherence to the United Nations Conventions, has expressed concerns about DCRs, but accepts that they can be consistent with the conventions if they 'reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking' (2016, p.91). INCB position statements from previous years have concluded that 'consumption rooms are in violation of the provisions of the international drug control conventions' (2012, p.100). One interviewee commented that the unfavourable position of the UN had coloured discussions surrounding the feasibility of establishing a DCR.

However, the INCB position no longer cites concerns and now simply states:

'For "drug consumption rooms" to be consistent with the conventions, they must aim at effectively reducing the negative consequences of drug abuse and lead to treatment and rehabilitation, without condoning or encouraging drug abuse and drug trafficking' (INCB, 2017)

Interviewees from Glasgow and Dublin both confirmed that there has been no interference in proceedings from international bodies. Instead, both local areas found that the international community was a useful space for learning and guidance.

The Glasgow process significantly benefited from its National Naloxone Coordinator travelling to Sydney to bring back operational and evidential learning from the Uniting Medically Supervised Injecting Centre, in video and report format (Horsburgh, 2015).

'I was able to bring back the learning from Sydney to key stakeholders and show a video about the service as well, which really helped people's understanding of it. Certainly, I would say it definitely helped inform their opinions on it and bringing back that evidence was really useful. I also presented the evidence to the group that were working on the [local needs] assessment in Glasgow and was able to answer a lot of the questions they had on injecting facilities... If you've never been in an injecting room or don't really know much about it, it's quite difficult to get your head around, so being able to answer a lot of those questions was valuable and hopefully helped inform some of the learning for the needs assessment.'

Kirsten Horsburgh, National Naloxone Coordinator, Scottish Drugs Forum

Similar work was undertaken by Ana Liffey, whose CEO Tony Duffin travelled to Sydney in March 2015 to meet with Dr Marianne Jauncey, the Medical Director at the Uniting Medically Supervised Injecting Centre, and other stakeholders involved at a policy level. Ana Liffey advised that it was essential for a local area to visit a facility if they were considering establishing a DCR, to address queries regarding operational guidance and stakeholder engagement.

'[In a] press conference we were asked questions about how [the DCR] would run, and if I hadn't been there two months previously, I couldn't have answered the questions as well as I did...I think you can train people up, you can have people visit you, you can do a course; but, if you've worked in a DCR, then you can refer back to those memories and experience to give a better informed answer.'

Tony Duffin, CEO,
Ana Liffey Drug Project

Recommendation: The UN currently advises that DCRs are justifiable if they reduce the negative consequences of drug abuse and lead to treatment and rehabilitation, without condoning or encouraging drug abuse and drug trafficking. The international community has been a useful source of expertise to assist the developments in Dublin and Glasgow. By building relationships with their international counterparts, stakeholders can address questions regarding operational procedure and stakeholder engagement.

5.4.3. Policing

Though legal barriers can be surmounted, the area surrounding the facility would still need to be policed and the success of a DCR relies to a large extent on collaboration and strong working relationships with the police. Uncertainty over how a facility would be policed was cited as a significant obstacle in one locality.

In anticipation of facility's establishment in Glasgow, a policing sub-group of the DCR short life working group has been established, chaired by Police Scotland, to advise on relevant public order issues and to develop working accords (Millar, 2017c). Local police and service accords across the world have been reviewed and the Health and Social Care Partnership is considering which model of practice should be used, with any modifications if necessary.

Interviewees explained that it is expected that the police will continue with their normal policing activities, but there will be an understanding that they will not specifically target people who are travelling to the DCR. It is also anticipated that there will be established referral pathways between the police and the facility as the police are likely to discover people who would benefit from the facility, during their normal policing activities.

Dublin is in a more advanced legal position than Glasgow as legislation has been passed

which clearly indicates what sections of the 1977 Misuse of Drugs Act do not apply to a DCR service user. The legislation also grants the police powers to enter a DCR.

Police discretion is still required, though Marcus Keane, a lawyer and Head of Policy at the Ana Liffey, explained that this model is likely to not be a significant departure from existing practice:

'If I'm a police officer and I come across somebody I reasonably suspect to be in possession of a substance, I could in theory arrest them for possession. However, just because I can do it, doesn't mean I have to do it. The police do not arrest everybody who they suspect to be guilty of some crime - if they did they would be completely inefficient and ineffective. The reality is that effective policing involves the use of discretion, not just in drugs law, but in many other areas also. In terms of a DCR, can police officers pull up outside and just wait to pick people up? Yes, of course they could, but they could do that anyway with many already existing locations. It's not as if there aren't people with drugs in the city centre as it stands and that we don't know where those people with drugs go.'

Marcus Keane, Head of Policy,
Ana Liffey Drug Project

During the pre legislative scrutiny for Ireland's Misuse of Drugs (Supervised Injecting Facilities) Bill, the police did see challenges ahead in how a DCR would be policed but promised 'it will do all it can to assist in ensuring the initiative succeeds in achieving its objectives. Currently the police are visiting and observing the policing in jurisdictions where supervised injecting facilities have been in place for some time.

Once the provisions of the Bill are enacted, the police will 'inform its personnel regarding

the appropriate manner in which to address the law enforcement and policing issues which will arise following the opening of a supervised injecting facility. It will also facilitate the inclusion of relevant information in policing plans and operational orders'. The police have advised that clear legislation makes it less likely that 'any law enforcement issue will impact negatively on achieving a successful outcome to the initiative' (Joint Committee on Health, 2016).

The police are committed to the success of the project, with Assistant Police Commissioner Pat Leahy, advising:

'Up and down main streets there are people who have heroin on them. Anything that can improve lives, I have to support. I cannot see any other way than treatment is the answer. We have to be mature about this' (The Journal, 2017).

UK police forces have recognised the need to take a holistic approach to drug issues, which 'supports the work of local agencies that aim to get users into treatment rather than pursue arrests for minor offences' (DEFRA et al, 2005, p.7). Greater Manchester Police has stated that the force policy on those returning used needles to needle syringe programmes is that:

"unless there are other attendant circumstances, officers will not arrest a person who is attending a needle exchange scheme, for the purpose of exchanging a needle." It is recognised that a written instruction cannot cover all the circumstances likely to be encountered, however, officers should act according to the 'intent' of the policy, that is 'not to arrest a person who is merely attending a centre to exchange a needle' (DEFRA et al, 2005, p.7)

In the context of needle and syringe programmes, it is recommended that an agreement or protocol is established between police and local agencies regarding the possession of used needles and their return, as it may be that trace amounts of illegal drugs are still present (DEFRA et al, 2005,

p.7). Discretion is commonplace in policing and similar protocols could be put in place for DCRs.

Recommendation: The success of a DCR relies to a large extent on collaboration and strong working relationships with the police. It is likely that police procedure will not be a significant departure from existing procedure for policing drug services but forces would benefit from observing models of practice in countries where DCRs have been in place for some time. Clear guidance or legislation would make it less likely that any law enforcement issue would impact negatively on the facility.

5.4.4. Service Providers

A DCR could be provided by the NHS but it is likely that part of the service, if not all of the service, will be commissioned to a third sector treatment provider. An operator who is supervising the use of illicit drugs on site is likely to be managing overdoses more regularly than in any other drug-related services. One interviewee doubted that there would be interest from third sector providers to run the service, as they would be taking on and managing too much risk.

Contrary to this expectation, there have been high levels of interest from third sector providers in Glasgow and Dublin. It is intended that the Glasgow model will have three phases to the service:

- Phase 1: Reception
- Phase 2: Drug consumption room area
- Phase 3: Aftercare area / additional support elements

The June Integrated Joint Board update suggests that there is the potential for phase one and three to be provided by third sector organisations, with NHSGGC providing phase two. The update comments that 'a number of partners from the third sector have expressed

interest in contributing to services provided within the proposed services' (Millar, 2017b, p.2).

The Dublin DCR may be run by a third sector provider with an invitation to tender sent by the Health Business Services in early September (2017). Bids were submitted from a range of third sector organisations and it is expected that the chosen organisation will be announced in December.

Ana Liffey would argue that the risks a third sector drug addiction service would face when running a DCR are not new and may, in fact, be fewer in nature.

'Addiction services take those risks all the time, working with people who use drugs. People aren't allowed to be in possession of drugs, people aren't allowed to use drugs on site. Are people in possession of drugs, do they use on site? Of course they do on occasion, so, addiction services are managing those risks at the moment - as are many, many services in all jurisdictions, so this is a safer way to work with people who use drugs. It brings it out of the toilets, out of the bedrooms of the hostels, into a space where people are talking to each other – removing the stigma and the reducing the risks to all.'

Tony Duffin, CEO,
Ana Liffey Drug Project

Though the risks will be familiar to third sector providers, in Ireland there is also additional statutory protection for exempting liability, similar to Good Samaritan legislation, which protects the actions of persons who act in good faith.

Liability of licence holder (section 9), Misuse of Drugs (Supervised Injecting Facilities) Bill 2017:

'A licence holder or any person acting under the direction of the licence holder shall not be liable for any act done or omitted to be done in a supervised injecting facility, in relation to the provision of assistance or advice to, or care of, an authorised user and no person shall have a cause of action in respect of that act.'
(House of the Oireachtas, 2017)

However, Ana Liffey advised that a provider should not bid to run a DCR unless there was a strong desire from within the organisation to do so.

'Ideally, the whole organisation wants to do this... You've got to want to do this, right across the organisation. You've got to be excited about the idea of running the [DCR], you've got to have the competency to do it and the desire to do it.'

Tony Duffin, CEO,
Ana Liffey Drug Project

In the UK, numerous treatment providers have announced their interest in being the provider of a DCR, including CGL, Blenheim CDP and Collective Voice (on behalf of its members). Any service provider which does offer this service would benefit from positive media coverage and would be in a favourable position for future DCR tendering contracts, by having the unique experience of having run one elsewhere.

Recommendation: The risks that come with supervising the use of illicit drugs on site are not dissimilar to existing risks taken by drug addiction services, which currently manage the consequences of unsupervised use of illicit drugs on site. Additional statutory protections can also be put in place which exempt liability, similar to Good Samaritan legislation. There have been high levels of interest by the third sector in being the service provider of a DCR in Dublin, Glasgow and elsewhere in the UK.

5.4.5. Opening Hours

A DCR brings many benefits to the local area where it is established but these benefits are most felt during the times that the service is open. Once the service closes, service users may continue to use drugs outside of the facility and potentially in a public setting. One locality struggled to arrive at a solution which could meet the expectations of local stakeholders and could feasibly be provided.

In Glasgow, the opening hours of the DCR will be 9am-9pm. These times were decided upon as they 'reflect known patterns of drug use within

the city and complement the availability of other supports, for example the requirement to be in hostel accommodation by 10pm' (Millar, 2017b, p.6). Though it is likely people will still use drugs outside of these times, the opening hours will be meeting the need of the majority of PWUD in Glasgow city centre. Glasgow stakeholders advised that there are no ideal opening hours as the times should be guided by the local needs assessment. Equally though, this need has to be balanced against financial constraint and what the local area is capable of providing.

Dublin opening hours were informed by a consultation with people who inject drugs in a street setting, with the invitation to tender suggesting that times are broken into brackets of 6:00-10:00, 14:00-17:00 and 20:00-22:30. Essential opening times are 6:00-10:00, to meet the needs of the vast majority of injectors who use at the beginning of the day (Health Business Services, 2017). Ana Liffey commented that in Dublin, there is typically less need to have a DCR open throughout the night as service users would be sleeping and, if they did need to use, they would wake up, use where they are sleeping and then go back to sleep (see Appendix 6.2 and 6.3 for further details on Glasgow and Dublin service designs).

Recommendation: It is likely that drug consumption will continue outside of service hours, however, to minimise the extent to which this occurs, opening hours should be informed by a stakeholder consultation which identifies the times of greatest need. Equally though, recommendations have to be balanced against financial constraint and what the local area is capable of providing.

“DRUG CONSUMPTION ROOMS ARE NOW A VIABLE POLICY OPTION AND SERIOUS CONSIDERATION SHOULD BE GIVEN TO THEIR INTRODUCTION”

Chapter 6

Conclusion

The evidence indicates that DCRs can address rising drug-related harms and the developments in Dublin and Glasgow demonstrate their potential feasibility for a number of locations in the UK. DCRs are now a viable policy option and serious consideration should be given to their introduction.

The unique element of a DCR that needs to be accommodated is its legal operation as there are some persisting legal barriers which would be difficult to overcome through service design. Legislative change offers a more stable and permanent legal solution but DCR pilots operating on a discretionary model could be used to build the case for legislative change.

UK drug laws also operate within the context of UN conventions. DCRs are consistent with current UN interpretations, as long as they aim to effectively reduce the negative consequences of drug use and lead to treatment and rehabilitation, without condoning or encouraging drug use and drug trafficking.

However, the majority of cited concerns and barriers were not novel. They are frequently faced when commissioning drug addiction services and have repeatedly and successfully been answered and addressed. To ensure that a service has sufficient impact, a needs assessment should be undertaken, which identifies the location and opening hours that would see the service being sufficiently used, balanced with other considerations. This assessment can also make the case that a DCR is the most cost-effective solution to the drug-related harms experienced by the locality and can ground the business case within the needs of the local community, rather than on comparisons with other countries. The financial burden does not have to fall on one sector and funding for a DCR can be sourced through: central budgets, contingency funding, diversion from services targeted at the population who are likely to use the DCR, for example homeless addiction services, or diversion from services

which would see savings as a consequence of the DCR being established. Politicians, media and local residents may raise objections to a DCR, and an engagement process would need to be targeted at each of these groups. The case can be made that a DCR is consistent with the recovery agenda as, through the provision of a harm reduction service, the facility is offering recovery opportunities. New protocols would have to be formulated for police, but it is likely that this will not be a significant departure from existing procedure for policing drug services. Equally, the risks that come with supervising the use of illicit drugs on site are not dissimilar to existing risks taken by drug addiction services, who currently manage the consequences of unsupervised use of illicit drugs on site.

Stakeholders can learn from innovation in Glasgow and Dublin but can also turn to existing practice, realising that the way forward may not be a significant departure from well trodden paths. In some ways, DCRs are a sizable shift in existing provision but, mostly, they are simply an extension and do not require a 'reinventing of the wheel'. By following in the footsteps of Glasgow and Dublin, but also turning to what is already known, localities will be best placed to replicate their progress and success.

Chapter 7

Appendix

7.1. Methodology

To find out current concerns and barriers that would prevent the establishment of a DCR in the UK, Volteface conducted 15 interviews with people in England and Wales who have advocated for DCRs, attempted to establish DCRs, or raised concerns surrounding their provision. Interviewees were contacted directly or sourced through Volteface's network of contacts, with snowball sampling used to recruit further participants. Interviewees have been named in the acknowledgements, but were asked to anonymously contribute what they felt were the concerns which would prevent the establishment of a DCR.

Interviewee contributions were collated and taken to 10 stakeholders in Glasgow and Dublin who have been named as playing a role in progressing the establishment of a DCR. The questions asked to Glasgow and Dublin interviewees were dependent on their specialisms, meaning different interviewees were asked different questions.

As Glasgow is the UK locality which has made the most progression towards establishing a DCR, it is the most relevant case study for other UK localities to turn to for guidance on feasibility. Dublin is a particularly relevant case study, compared to recent DCR developments in other Western European countries, as the UK and Ireland have drug laws which prohibit similar activities, both introducing a Misuse of Drugs Act in the 1970s. The UK and Ireland also have a unique influence on one another due to a shared history and have seen a similar shift towards the decriminalisation of drug use (BBC, 2016a; Department of Health, 2017). Both countries have also seen people who use drugs experience persisting and increasingly poor health and injection-related harm (Long and Lyons, 2010; ACMD, 2016; EMCDDA and Health Research Board). Moreover, learning from Dublin is more accessible for UK counterparts as the two countries share a common language.

As Glasgow and Dublin are working in different contexts and are at different stages in progressing the establishment of a DCR, they differ in how much they can comment on identified concerns.

7.2. Glasgow Service Design

Service type: Injecting and inhalation

Length of pilot: Three years

Staffing per shift: To be confirmed

Annual cost: Estimated £1 million, final cost is dependent on site

Eligibility criteria: Those aged 16 and over who are consuming illicit drugs. Proof of age or pregnancy status is not required at registration. However, staff will be vigilant and trained to respond appropriately to anyone who appears ineligible to use the service.

Opening hours: 9am-9pm, 7 days a week

Service design: 12 drug consumption booths, including a reception and aftercare area

Provider: Reception and aftercare area provided by third sector, DCR area provided by the NHS.

Operating procedures: Booths are for individual use only. Sharing or preparation and injection of one client by another is not permitted. Both of these practices constitute offences of "supply" under the Misuse of Drugs Act and under section 23 of the Offences Against the Person Act. Alcohol consumption or cigarette smoking will not be permitted in the facility.

Additional services: Supplies of take home naloxone and injecting equipment, including the supply of foil to promote transition from injecting, will be available to clients on leaving the facility. Further preventative and supportive health, social care and peer support, including advice and referral to specialist treatment options can be accessed in the after-care area (Millar, 2017b).

7.3. Dublin Service Design

Service type: Injecting only

Length of pilot: 18 months

Staffing per shift: Assessment area requires a minimum of one receptionist and one/two security person(s) at all times. The security person will manage front of service and stop people congregating.

Annual cost: Estimated to be €1 million

Eligibility Criteria: Eligibility guided by clinical decision, including access for under 18s and pregnant women

Eligibility Criteria: Eligibility guided by clinical decision, including access for under 18s and pregnant women.

The injecting and clinical area requires three nurses to be on duty at all times, two registered nurses and one clinical nurse manager reporting through an appropriate nursing governance structure. A doctor is required to be on duty a minimum of five days per week, and for an overall minimum of 30 hours in total with their time split between the available sessions appropriately. The 'chill out' area requires a minimum of two project workers to provide support in relation to accessing 'wrap around' services.

Opening hours: The facility will open from 6:00-10:00 to meet the needs of the vast majority of injectors who use at the beginning of the day. The facility will also be open in the afternoon with suggested timings being 14:00-1700 and

20:00-22:30 hours daily. Staggered or sessional opening is required to facilitate use prior to individuals returning to hostels at night. The service will open seven days a week (Health Business Services, 2017).

Service design:

1. An assessment and intake area where basic details of the service user can be obtained and the person is welcomed. Information on the DCR, house rules (for example no dealing, sharing of drugs) and information on sterile injecting is provided and a basic health needs assessment is carried out. The area is of sufficient size to prevent 'on-street congregation' of people waiting to use the facility. The area is equipped with a reception desk and can seat between 10 to 15 people.
2. A clinical area comprising of six injecting booths where sterile injecting equipment can be distributed and supervised injecting can occur in a space protected from public view. Resuscitation equipment is available and the individual is monitored in case of overdose or adverse reactions. The area is equipped with a desk and chairs for nursing staff and a lockable cupboard for medical consumables.
3. A relaxation or 'chill out' area where people can relax and be monitored for about 30 minutes post- injection. The area is equipped with a self-service coffee/tea machine, comfortable chairs and small tables for service users. Space is available for project workers to interact with attendees and access to clinical rooms is readily available.

Provider: Fully managed by a third sector provider or by the Health Service Executive

Operating procedures: The service will provide for adult (18+) established drug users who are on the premises of the supervised injecting facility with the permission of the licence holder, for the purposes of consuming drugs by injection only, during its normal opening hours. The facility

shall not be used for the consumption of drugs in any other manner, and such consumption of drugs by any other means (for example smoking) is strictly prohibited. Sharing or dealing drugs is not permitted at the facility.

Additional services: Clinical rooms for medical interventions, crisis interventions, counselling interventions (if requested) and where referrals for social services/housing/treatment can occur. Specific medical clinics (e.g. bloodborne viral testing, vaccinations and wound and abscess care) will be available each day to allow individuals access to appropriate medical care. Naloxone training and distribution, and injecting equipment provision will be offered to individuals on leaving the facility.

7.4. A UK History of Drug Consumption Rooms

While there is some history of unsanctioned DCR operation in the 1970s (Jolly, 2017), formal discussions did not start until 2002.

2002: The Home Affairs Select Committee recommends that “safe injecting houses” (DCRs) should be piloted.

‘We recommend that an evaluated pilot programme of safe injecting houses for heroin users is established without delay and that if, as we expect, this is successful, the programme is extended across the country... We recommend that Section 8 of the Misuse of Drugs Act 1971 is amended to ensure that drugs agencies can conduct harm reduction work and provide safe injecting areas for users without fear of being prosecuted’ (Home Affairs Committee, 2012, p.113).

The recommendation is rejected by the Government which concludes that DCRs:

‘should not be introduced in this country whilst we have no evaluations of those developed in other European countries. We would only consider contributing to a

ny evaluation through the World Health Organisation in view of the uncertain legal status of injecting rooms. We would not wish to consider any research initiative that could cause the UK to undermine the UN Conventions as that would not set a positive example to other signatories’ (Select Committee on Home Affairs, 2002).

2006: The Joseph Rowntree Foundation Independent Working Group on DCRs concludes, on the basis of a detailed review of feasibility and evidence, that ‘DCRs offer a unique and promising way to work with the most problematic users, in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society. The IWG therefore recommends that pilot DCRs are set up and evaluated in the UK’ (2006, p.108).

The leader of the Conservative Party, David Cameron, responds by commenting that ‘I certainly wouldn’t rule them out because anything that helps get users off the streets and in touch with agencies that can provide treatment is worth looking at’ (The Guardian, 2006).

However, the Independent Working Group’s recommendation is rejected. Parliamentary Under Secretary at the Home Office Vernon Coaker comments:

‘The reasons for rejecting it in 2002 are as valid today—the risk of an increase in localised dealing, anti-social behaviour and acquisitive crime’⁷

(Womack, 2006).

April 2013: The Independent Drugs Commission for Brighton and Hove recommends that ‘the Safe in the City Partnership should convene a working group to explore the feasibility of implementing a form of consumption room, targeting those who are hard to reach and not engaged in treatment, as part of the range of drug services in the city’ (2013, p.10).

October 2013: The Home Office states that “The Government has no plans to allow drug consumption rooms, which [would break] laws whereby possession of controlled drugs is illegal” (The Independent, 2013).

May 2014: The Drug Consumption Room Feasibility Working Group concludes that a DCR in Brighton would not be feasible as there is insufficient local community need and a lack of support for a local accord (Wilkinson, 2013).

October 2014: A Home Office review of international comparator approaches to drug misuse and addiction recognises the evidence of DCRs but does not recommend their implementation as ‘the UK does not experience open drug scenes of the kind which prompted the creation of the DCRs we saw in Switzerland and Denmark’ (Home Office, 2014, p.18).

October 2016: The Glasgow City Integrated Joint Board approves the development of a full business case for a pilot DCR (BBC, 2016b).

July 2017: The UK Government responds to the December 2016 ACMD recommendation that ‘consideration is given – by the governments of each UK country and by local commissioners of drug treatment services – to the potential to reduce DRDs [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’ (ACMD, 2016, p.40).

‘The Government has no plans to introduce drug consumption rooms. It is for local areas in the UK to consider, with those responsible for law enforcement, how best to deliver services to meet their local population needs. We are committed to taking action to prevent the harms caused by drug use and our approach remains clear: we must prevent drug use in our communities, help dependent individuals recover, while ensuring our drugs laws are enforced’ (UK Government, 2017).

The Government position no longer states that DCRs are illegal. The change of wording from its 2013 statement is also poignant, with it now stating that, ‘the Government has no plans to introduce drug consumption rooms’, rather than ‘the Government has no plans to allow drug consumption rooms’. The most recent statement also alludes to the fact that decision-making surrounding DCRs should be devolved to the local level

Endnotes

1. Various terms are used for the facilities, including drug consumption rooms, drug injection rooms, safe injecting centres, supervised consumption sites, safe injecting facilities, supervised injection facilities, safer consumption facilities, medically supervised injecting centres and enhanced harm reduction centres. Drug consumption room will be the preferred term for this report as it is widely used and encompassing of all terms. In the media, DCRs are commonly and incorrectly referred to as 'shooting galleries', facilities where users are expected to pay to use drugs on site, are unsanctioned by a national or local body and where medical supervisions is slight to non-existent (Fortson, 2017, p.3). Clients come to a drug consumption room with drugs they have already purchased, the facility does not supply them and operational procedures do not allow drug dealing on site.
2. EMCDDA report that 90 DCRs operate in Europe (2017a). One DCR operates in Sydney, one operates in Montreal and four operate in Vancouver.
3. This research preempts the EMCDDA's recent recommendation 'to identify and review the barriers to the establishment of drug consumption rooms in areas with high numbers of people injecting drugs in public places' (2017b, p.56).
4. Cardiff has not recorded drug-related litter prior to 2013/14. Erroneous data points have been deleted from Belfast and Leeds as it was evident that reporting procedures were not accurately capturing data. Drug-related litter in Liverpool is recorded annually, rather than by financial year. For the sake of clarity, the year beginning each financial year has been included.
5. Directly draws on the legal opinion written by Rudi Fortson QC, detailing the legal issues of setting up a drug consumption room. Fortson's document is intended only for guidance and discussion and he advises that anyone contemplating setting up a drug consumption room should first seek independent professional guidance (2017).
6. For more guidance, please see Fortson (2017)
7. It should be noted that localised dealing, anti-social behaviour and acquisitive crime were not cited in the Government's rejection of the Home Affairs Select Committee recommendation in 2002. The evidence does not suggest that DCRs lead to an increase in drug dealing, drug trafficking or drug-related crime in the surrounding environment.

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