

Commentary

## Drug consumption rooms: An overdue extension to harm reduction policy in the UK?

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### Abstract

This commentary examines the drug policy context of drug consumption rooms (DCRs) in the UK and describe the conclusions of an Independent Working Group (IWG) that was set up to evaluate the evidence of need in the UK, the international evaluation literature and legal, political and ethical concerns. Having considered this evidence, the IWG produced its report in May 2006, recommending a trial of DCRs in the UK, on the basis that DCRs offer a unique and promising way to work with problematic drug users in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society. However, despite support for the idea from a number of quarters, the UK Government has rejected this recommendation, citing previously deployed arguments that do not appear to be carry much weight in 2007. © 2006 Elsevier B.V. All rights reserved.

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### Drug consumption rooms: an overdue extension to the harm reduction policy in the UK?

While an increasing number of countries over the past 30 years have introduced drug consumption rooms (DCRs), the UK Government has so far withstood calls for pilot projects. There are now DCRs operating in eight countries: Australia, Canada, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland. However, the UK is obviously not alone in its resistance to the idea: the Danish Government recently rejected a proposal to introduce DCRs primarily on the basis of the International Narcotics Control Board's position that they are 'against the drug conventions' (Danish Government, 2003). This commentary examines the drug policy context in the UK, explores the arguments that the Government has used against

the introduction of DCRs and describes the conclusions of an Independent Working Group that was set up to consider the issue.

Throughout the 1980s and 1990s the UK was in the vanguard of countries that have sought to combat drug-related problems through harm reduction measures (Stimson, 1995). The UK's first and only major epidemic of HIV among injectors occurred in Edinburgh and Dundee in the early 1980s (Robertson, Bucknell, Welsby, et al., 1986; Robertson, Bucknell, & Wiggins, 1986; Stimson, 1995). This was met by the local development of a range of harm reduction measures, including syringe exchange, an approach that was given greater momentum, support and legitimisation by the oft-quoted report of the Advisory Council on the Misuse of Drugs (ACMD), *AIDS and Drug Misuse* (1988). The ACMD, a body of independent experts charged with the task of providing advice to the Government on a range of drug policy issues, was forthright in its conclusions, recommending that: 'the opportunity to take preventative action must be seized now if the tragedy of Edinburgh is not to be repeated throughout the UK'.

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While initially met with silence, the ACMD's recommendations were eventually taken up by government departments and money made available for syringe exchange, methadone treatment and outreach services (Stimson, 1995). In the UK over the past 10 years, there has been an increasing emphasis in the Government's drug strategy on harm reduction, particularly on reducing drug-related deaths and the transmission of blood-borne viruses (Home Office, 2002; National Treatment Agency, 2005)

Despite this generally favourable policy context, the UK Government has proved resistant to the idea of DCRs. In 2002, the Home Affairs Select Committee, a cross-party group of politicians charged with examining aspects of Home Affairs policy, recommended to Government that:

...an evaluated pilot programme of safe injecting houses for [illicit] heroin users is established without delay and that if, as we expect, this is successful, the programme is extended across the country. (Home Affairs Committee, 2002a, p. 44)

This proposal was rejected by the Government for a number of reasons, including a perceived lack of evaluation evidence, legal concerns, likely media and public hostility, cost and the likelihood of DCRs proving a magnet for dealers and disorder.

In 2004 the Joseph Rowntree Foundation supported the establishment of an Independent Working Group (IWG) on DCRs, chaired by Dame Ruth Runciman, to consider the evidence and issues in this area. The final report was published in May 2006 (IWG, 2006). A number of key areas were examined: the evidence of need in the UK, the international evaluation literature (which had increased considerably since 2002) and legal, political and ethical concerns.

#### *Evidence of need*

The IWG's examination of need showed that the UK experiences considerable problems associated with injecting drug use: consistently reporting the highest number of drug-related deaths in Europe since 1996 (EMCDDA, 2005), high rates of nonfatal overdoses, increasing prevalence of HIV and HCV and widespread problems with abscesses, cellulitis and other injecting-related health problems (Health Protection Agency et al., 2005; Hunt, 2006a; Judd et al., 2005; Powis et al., 1999). Such problems are particularly prevalent among the substantial population of homeless users in the UK, mostly based in hostels or rough-sleeping. Although hard to quantify in the UK, these problems are likely to have a large impact on society in terms of health care costs. Recent research found that 6.9 per cent of all the patients attending an emergency department in South West England had attended for drug-related reasons (Binks, Hoskins, Salmon, & Bengner, 2005).

In addition, injecting drug use often takes place in public places, where it is frequently witnessed by local residents and associated with discarded injecting equipment and other litter

(IWG, 2006; Rhodes et al., 2006). Two studies were commissioned to inform the IWG's deliberations. Taylor et al. (2006) described the negative impact of problem drug use on perceptions of safety and public amenity in local communities and in this issue Hunt, Lloyd, Kimber, and Tompkins (2006) report on a survey of needle exchange users that shows injecting in public places is common among this sample and if extrapolated to the wider population of needle and syringe exchange users, suggests that each month, tens of thousands of injecting episodes take place in public places in England alone. This is likely to be associated with large numbers of discarded syringes and other drug-related litter. A recent survey in England found that 147,345 used needles were collected by Local Authorities over the year 2003/2004 (ENCAMS, 2005).

The IWG therefore concluded that there were a range of needs in the UK which could be addressed, potentially, by DCRs. The IWG then went on to consider the evaluation evidence.

#### *Evidence of DCR impact*

The DCR evaluation literature is growing both in terms of size and rigour, with important recent developments from Australia and Canada that address some of the methodological limitations of earlier research. In particular, community-based IDU and DCR service user cohort studies in Canada have allowed the impact of DCRs to be quantified with greater confidence (e.g. Kerr et al., 2006; Wood et al., 2004).

Evaluations have addressed the impact of DCRs on a range of outcomes, including drug-related deaths, health of users and public nuisance (e.g. Hedrich, 2004; Hunt, 2006b; Kimber, Dolan, Van Beek, Hedrich, & Zurhold, 2003). At the community level, the impact of a DCR on drug-related deaths has proved difficult to determine—partly due to the inevitably partial coverage of injecting events but also due to the relatively low incidence of drug-related deaths (Hall and Kimber, 2005; Hedrich, 2004). Nevertheless, analysis of trends in drug-related deaths in four German cities found DCRs to have significantly reduced deaths (Poschadel, Höger, Schnitzler and Schreckenberger, 2003, cited in Hedrich, 2004). Moreover, the IWG was impressed by the simple fact that, while millions of potentially dangerous injections have taken place within DCRs over the past 20 years, often involving users with serious health problems, there has been only one recorded death from anaphylaxis (a severe, whole-body allergic reaction) rather than overdose (Kimber et al., 2003). The IWG therefore concluded that DCRs certainly prevent deaths, although how many is unclear. The degree to which DCRs are able to have a demonstrable effect on local overdose deaths will depend on the number of such deaths occurring and the proportion and nature of local injecting episodes that a DCR is able to 'capture'. This clearly carries implications for accessibility and opening times.

DCRs appear to be effective in providing medical care and referring users to other health and social services, thus

contributing to the health of users (Hunt, 2006b). It is likely that DCRs can also contribute to reducing the transmission of blood-borne viruses, but this is difficult to show conclusively. Nevertheless, Hedrich (2004) summarises positive evidence of reductions in sharing rates and more recent research (Kerr, Tyndall, Li, Montaner, & Wood, 2005) further strengthens our confidence that DCRs exert a positive impact in this area. Evidence from a number of studies, but most convincingly from the evaluation of the Vancouver project, shows that the implementation of a DCR can lead to a reduction in public injecting, discarded syringes and drug-related litter (Hedrich, 2004; Medically Supervised Injecting Centre Evaluation Committee (MSICEC), 2003; Wood et al., 2004).

Fears that DCRs could attract large numbers of users from outside the local area appear to be misplaced: the evidence shows the large majority of DCR users to be local people (Hedrich, 2004; MSICEC, 2003; Wood et al., 2005). There can be problems with dealing and public order but research has shown good interagency cooperation to be an effective way to minimise such problems (Hedrich, 2004). In this connection, operational models vary considerably between countries: some having more open eligibility criteria (e.g. in Germany and Australia) and others being more targeted and restrictive (e.g. in the Netherlands and Switzerland). In this way, local policy makers have been able to determine whether they prioritise throughput and coverage or high need—notably among homeless drug users. Such policy choices may have some bearing on concerns about ‘honey-pot’ effects and will certainly relate to the general impact of DCRs.

#### *Barriers to implementation in UK*

The IWG also looked at the main barriers and concerns standing in the way of implementing DCRs in the UK. A key issue in the UK – and in Denmark – has been the problem of compliance with the UN Drug Conventions (1961, 1971, 1988). On the basis of a commissioned legal analysis (Fortson, 2006) the IWG concluded that the Conventions need not act as a significant block to the introduction of DCRs in the UK. While commentators differ in their interpretation of the relevant sections of the three Conventions, it is clear that DCRs contribute towards a number of their aims. While the Conventions focus primarily on the control of drug production and trafficking, they also exhort signatories to treat, rehabilitate and reintegrate drug users (Fortson, 2006). As the United Nation’s own legal advisers on the Conventions have pointed out in the context of whether or not DCRs contravene the Conventions:

It might be claimed that this approach is incompatible with the obligation to prevent the abuse of drugs. . . It should not be forgotten, however, that the same provisions create an obligation to treat, rehabilitate and reintegrate drug addicts, whose implementation depends largely on the interpretation by the Parties of the terms in question. If, for example,

the purpose of treatment is not only to cure a pathology, but also to reduce the suffering associated with it (like in severe-pain management), then reducing IV drug abusers exposure to pathogen agents should perhaps be considered as treatment (UNDCPLAS, 2002, p. 5).

So, to the extent that a DCR contributes to the treatment (broadly defined), rehabilitation and reintegration of drug users, it can be argued that it is fulfilling a number of the Conventions’ objectives.

The IWG also saw considerable significance in the fact that DCRs have been set up in seven countries which have signed the three Conventions and one (Switzerland) that has signed the first two. Admittedly, these countries have had to survive periodic admonitions from the International Narcotics Control Board (INCB) in the form of official letters and negative comments in the INCB’s annual reports but otherwise, there appears to have been no great threat to their statehood. In Switzerland, for example, a legal analysis undertaken on the issue concluded that, as there is no explicit guidance in the Conventions on the question of whether DCRs contribute to rehabilitation and reintegration, the decision is best left to experts and policy makers (Swiss Institute of Comparative Law, 2000). In Germany, legal analysis led to the conclusion that DCRs did not constitute a punishable offence according to German law or the Conventions, provided that the sale, acquisition or passing on of drugs is not tolerated and that hygienic, stress-free and risk-reduced drug consumption is ensured through adequate care and control (Körner, 1993, cited in Hedrich, 2004). In Australia and Canada, DCRs have been set up as pilot projects, thus falling under the 1961 Convention’s exception to prohibition for ‘. . . medical and scientific research only, including clinical trials. . .’ (Article 2(5)(b), Single Convention on Narcotic Drugs, 1961).

United Kingdom law also does not appear to present any insurmountable obstacles (Fortson, 2006). Nevertheless, possession of a Class A drug is an offence under the Misuse of Drugs Act (1971) and the piloting of a DCR in the UK would therefore depend on the local police force agreeing not to search or arrest users in, and on their way to, the project. Indeed, local consensus and good cooperation between all the key agencies would be essential. A clear set of locally agreed rules governing issues such as sharing of drugs and the help provided to injectors within a DCR would also be a necessary prerequisite. Under these conditions, the IWG concluded that DCRs could be piloted within the UK without legislative change. Some legal risks would remain but these could be addressed by primary and/or secondary legislation that might be introduced at a later date, when the potential legal dangers are better understood.

#### **Conclusion**

Over a 20-month period, the IWG considered a broad range of evidence, including specially commissioned

research reviews and primary research; visits to DCRs in Europe, Vancouver and Sydney; evidence from local partnerships already working towards introducing DCRs in the UK and a meeting with a diverse, national group of drug users. The IWG concluded that there was sufficient evidence of need and sufficient evidence of effectiveness to merit the piloting of DCRs in the UK. It recommended that pilot projects are set up initially in well-run and well-resourced needle and syringe exchange programmes. As public injectors – a key target group for DCRs – already attend such services in large numbers, the impact on local communities and businesses of adding an injecting room is likely to be minimal. Integrating DCRs within currently operating needle and syringe exchange provision is also likely to maximise cost efficiency.

Overall, the IWG concluded that DCRs offer a unique and promising way to work with those whose drug use is most problematic in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society.

The IWG's report was published in May 2006 and received considerable attention in the British media. Support for the IWG's recommendations was expressed from a number of quarters, including an editorial in *The Lancet*:

After 4 years, and thousands of needless drug-related deaths, a thorough trial of DCRs is a requirement the Government cannot afford to refuse a second time'. (*The Lancet*, 2006, Vol. 367, p. 1792, June 3, 2006)

However, the UK Government did refuse this second invitation. Referring to the Government's rejection of the Home Affairs Select Committee recommendation in 2002, Vernon Coaker, Parliamentary Under Secretary at the Home Office responded thus:

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.

The last of these reasons, acquisitive crime, did not appear among the arguments against the idea put forward by the Government in 2002 (*Home Affairs Committee*, 2002b, p. 226–227) and the available evaluation evidence has shown DCRs to be neither associated with an increase or decrease in acquisitive crime (*Hunt*, 2006b, p. 28). While problems can be experienced with localised dealing and anti-social behaviour, the evidence considered by the IWG shows that such issues can be dealt with through good interagency cooperation. Indeed, none of the arguments employed by the UK Government to rebuff the idea in 2002 appear to carry much weight in 2007.

If there is to be a rational approach to addressing the harms associated with problem drug use in the UK, such an approach should include the piloting of DCRs. Only in this way will it be possible to assess the effectiveness of the approach in

the UK context: in terms of internal *modus operandi*, targeting, location, interagency working, integration with existing services and, in time, cost.

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