The Report of the Independent Working Group on Drug Consumption Rooms

This report of the Independent Working Group on Drug Consumption Rooms provides a detailed examination of whether DCRs should be introduced in the UK.

In the past, the UK Government has rejected calls for the introduction of DCRs, partly due to the lack of research. However, there is now a much larger evidence base drawn from projects around the world. The IWG was set up to take an objective look at this growing evidence base and to consider whether DCRs would have a significant impact on the particular problems that we face in the UK.

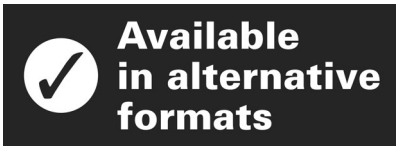
The report reviews the policy context in the UK and how the idea of DCRs articulates with past and current drug policy. It then examines in detail the particular harms associated with injecting drug-use in the UK, both in terms of the harm to users but also the impact on communities. By looking at what the research shows us about the effectiveness of DCRs, the report then goes on to consider whether they might carry the potential to reduce the problems caused by drugs in the UK. After considering a range of potential barriers and concerns, including legal considerations, a number of recommendations for the future are made.

On the basis of this detailed review of the evidence, the IWG concludes 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.

About the Independent Working Group

The IWG was chaired by Dame Ruth Runciman, and included senior police officers, academics, health professionals and a practicing barrister. Over a 20-month period the IWG reviewed the published evidence, commissioned new research, heard from relevant witnesses and visited DCRs abroad.

JOSEPH ROWNTREE
FOUNDATION



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Overview

The Independent Working Group on Drug Consumption Rooms was set up to take an objective, evidence-based approach to a sensitive question: should problematic drug users be provided with a place to go to use their illegally obtained drugs in a clean environment, supervised by medically trained staff? In order to address this question, the Independent Working Group (IWG) spent 20 months assessing the evidence. It commissioned comprehensive reviews of the research on the harms associated with drugs in the UK and the effectiveness of drug consumption rooms (DCRs) abroad, and authoritative papers on the national and international legal situation. Where there were gaps in the evidence base, research projects were commissioned and the IWG heard evidence from drug users' groups and people involved in developing local plans for DCRs in the UK. Members also visited a number of DCRs abroad to find out how they operated in practice.

The IWG found that, since the inception of the first DCR in Switzerland in 1985, there has been a growing acceptance of the worth of this approach in Europe, with six European countries having introduced them (Germany, Switzerland, Holland, Spain, Norway and Luxembourg). DCRs have also been introduced in Vancouver, Canada, and Sydney, Australia. There are now thought to be in the region of 65 DCRs operating in 40 cities around the world.

While the benefits of DCRs have been accepted by an increasing number of governments abroad, the UK Government has hitherto resisted calls for projects to be implemented here. In 2002, the Home Affairs Select Committee's recommendation to introduce pilot DCRs was turned down by the Government for a number of reasons, including the lack of evaluation evidence. Since then, the evidence base has grown considerably and the IWG therefore set itself the task of examining this evaluation literature in detail and addressing each of the Government's arguments against the Select Committee's recommendation. In addition, the IWG reviewed the problems associated with drug use in the UK and

thereby sought to establish whether we could expect DCRs to have an impact on the particular situation in this country.

We found that a number of the serious problems associated with drug use in the UK, such as overdose deaths, blood-borne viruses, other infections associated with injecting and syringes discarded in public areas, would all be addressed by DCRs. While one could not expect DCRs to eliminate such problems completely, provided they were well designed and well run the IWG would expect DCRs to have a significant impact on them.

Having reached this conclusion, we then turned to the barriers that stood in the way of actually setting up DCRs in the UK. While the legal barriers initially seemed formidable, on closer examination the UK's obligations with regard to the United Nations drug control treaties are far from clear and appear to leave room for the establishment of DCRs, particularly if they contribute towards the welfare, rehabilitation and reintegration of users. We saw it as significant that eight countries, all signatories to international drug control treaties and, in other respects, committed supporters of the UN, have introduced DCRs.

Domestic legislation includes a number of areas where those involved with DCRs, either as users or employees, might be vulnerable to prosecution. However, we have concluded that the risk of this happening can be considerably reduced through the establishment of a set of clear rules governing behaviour within (and in the immediate area surrounding) a DCR. Moreover, we do not believe that the establishment of a DCR should take place without the approval and close involvement of key local agencies, including the police and the Crown Prosecution Service. If these criteria are met, we are confident that the benefits that should accrue, in terms of lives saved, improvements in the health of users and reductions in the impact of public drug use on communities, would justify any residual risk.

The IWG therefore recommends that pilot DCRs are set up in the UK, founded on local accords between the key agencies. We recommend that, at least initially, pilots should consist of injecting rooms only. We believe that well-run needle and syringe exchange projects offer a promising location for them, as allowing users to inject safely on the premises is a natural progression from giving them clean injecting equipment but expecting them to inject elsewhere. The IWG strongly recommends that these pilots are rigorously evaluated.

To summarise our case: problematic drug use causes significant suffering in the UK. We have large numbers of users with little option but to inject drugs in toilets, alleyways and public parks, causing damage to themselves and distress and risk to the people living and working in these areas. We also have the highest number of drug-related deaths in Europe. We believe that well-run DCRs would have a beneficial impact on these and other problems associated with drug use in the UK. They should not be regarded as a radical policy option but, rather, as a rational and overdue extension to the Government's established harm reduction policy and one that is being introduced in an increasing number of countries experiencing problems such as our own.

1 Introduction

The idea of providing drug users with a place to go to use their illegally obtained drugs is highly contentious and one that has aroused much passionate debate. It is an idea that lends itself to extreme responses: on the one hand, many have rejected it out of hand because it appears to sanction, condone and even encourage a dangerous, illegal and anti-social behaviour; on the other, some appear to embrace the concept as the ultimate answer to 'the drug problem'. The Independent Working Group on Drug Consumption Rooms was set up to take an open-minded approach to this issue and to conduct a dispassionate, evidence-based analysis of this hotly contested question.

At the time of writing, there are approximately 65 drug consumption rooms[1] (DCRs) in operation around the world but not one of them in the UK. The UK Government has so far rejected the idea and has discouraged local agencies from developing DCRs. In 2002, the Government chose not to accept the recommendation of the Home Affairs Select Committee that pilot projects should be set up, partly on account of the lack of evaluation evidence from abroad. However, over the past four years, much more evidence has been published about the effectiveness of DCRs operating in other countries. Moreover, a new breed of DCRs has appeared over this period, with large-scale, well-resourced, medically supervised projects having been recently set up in Sydney and Vancouver. It therefore seemed the right time to revisit these issues and to take a much more detailed look at the evidence base than has previously been managed.

While there is considerable variety in the size, nature and function of DCRs, it may be helpful to provide a brief description of a 'typical' project, to give readers a grounding in what they involve.

Drug consumption rooms are typically placed in urban areas, close to established drug markets. Users are often required to be registered to use the facility and will arrive and give their details to a receptionist. They may then wait a short time before being allowed to go into another room. This room will contain a number of booths or injecting spaces with a chair and a clean table or ledge. All of these will be observable by employed staff. On entry, users are given a sterile syringe and other items such as a tourniquet, sterile water for dissolving the drug prior to injection, etc. The user then goes into the injection area, prepares the drug and injects himself. Should he have problems injecting the drug, a trained member of staff can give advice but cannot physically help with the injection process. Should he collapse, the staff member can go to his assistance. Afterwards, there is usually a place to sit and relax before leaving the building. Other medical, nursing, welfare or counselling staff will often be on hand to talk to those that want help and refer them to other services where appropriate.

DCRs have been set up in Germany, Switzerland, the Netherlands, Spain, Norway, Luxembourg, Australia and Canada. While there is some history of earlier, unofficial injecting rooms for drug users, the first official DCR was opened in June 1986 in Berne, Switzerland (Hedrich, 2004). By 2003, 12 consumption rooms were in operation in seven Swiss cities. DCRs were first set up in Germany and the Netherlands in the mid 1990s and in both cases projects spread quite rapidly, so that by 2004, 25 DCRs were operating in 14 German cities and 22 rooms in 12 cities in the Netherlands (Hedrich, 2004). The Spanish experience is more recent, with the first DCR there set up in 2000, and DCRs in Australia, Canada, Norway and Luxembourg were set up more recently still. The most recent DCRs were set up in Oslo and Luxembourg in 2005. Portugal introduced national legislation which paved the way for DCRs in 2001[2], but it is only comparatively recently that a proposition has been put forward to set up a DCR in Lisbon. A decision to proceed with this project is likely in the near future[3]. However, the UK Government is not alone in resisting calls for the introduction of DCRs; the Danish Government also recently rejected such a proposal (Danish Government, 2003).

Definitions and misconceptions

A confusing range of terms has been applied in this field: 'supervised injecting centres', 'safe(r) injecting rooms', 'fixing rooms', 'medically supervised injecting centres', 'drug consumption rooms' and, of course, the term so often used in the past, 'shooting galleries'. However, it is vitally important to make some clear distinctions here.

In this report, the term 'drug consumption room' (DCR) is used to cover any room specifically set up for the supervised, hygienic consumption of pre-obtained, controlled drugs. This distinguishes DCRs from 'crack houses', 'shooting galleries' and other premises used for the potentially unhygienic consumption of drugs bought at the same location.

Some DCRs in Europe allow the smoking or inhalation as well as the injection of drugs. However, the evaluation literature concentrates in the main on DCRs that only allow injecting of controlled drugs, supervised by trained staff able to intervene in the case of overdose. This is also the main focus of this report, reflecting the chief concern in the UK with injecting drug use, which is associated with the most serious harms.

A final – and important – definitional distinction concerns the *prescription* of heroin. A trial of supervised heroin prescription is currently under way in England, whereby users go into a medical facility, receive their drugs and inject them on the premises. Such programmes have been running for some time in the Netherlands and Switzerland, with positive results (Stimson and Metrebian, 2003). This is a distinctly different situation to a DCR. The drugs are legal and prescribed and the user will have had a history of trying other treatments before receiving a heroin prescription. Before receiving a heroin prescription a user will most likely have been treated with methadone (a heroin substitute) and, while failing to

give up illegal drugs, will have kept in contact with their treatment agency. Such 'trusted' users are therefore far less chaotic than the typical DCR clientele seen abroad, many of whom are homeless and experiencing a broad range of social and health problems.

The Independent Working Group

The idea of DCRs has repeatedly cropped up in the public debate on drugs over the past five years and in December 2003 the Joseph Rowntree Foundation set up a seminar to discuss the issue. A wide range of experts from universities, government departments and drug agencies attended this seminar and there was thought to be sufficient merit in the idea to justify further exploration of the issues. As a result, the Independent Working Group (IWG) on Drug Consumption Rooms was set up and had its first meeting in May 2004. Since then, it met regularly over a 20-month period to consider the evidence and issues relating to DCRs.

Members were selected in part because they were respected experts in their particular fields but also because they were thought to be individuals who would take a dispassionate and evidence-based approach to the issue. It should be emphasised that, initially, few of the members had a predefined position on the question of whether DCRs should be introduced in the UK and people's thoughts on the subject changed considerably over the course of the IWG process and the consideration of the evidence.

The Terms of Reference (see Appendix 1) defined the aims as follows:

1 To take an objective and evidence-based approach to the following question, drawing on both the national and international literature: 'Is there the potential for DCRs to have a significant impact on the private and/or public harms associated with drug use in the UK?'

2 Should the IWG decide that there is such potential:
   - to consider the pros and cons of different models
   - to identify the legal, political and practical obstacles to implementation and seek solutions
   - to make recommendations for the development and evaluation of appropriate demonstration projects.

3 To publish an accessible report summarising the evidence, the arguments and the recommendations.

The paramount importance of the evidence base was fundamental to the approach taken by the IWG, reflecting not only the Chair's and members' desires but also the JRF's general approach of thoroughly researching social issues before making any pronouncements on policy. Substantial and authoritative reviews of the evidence were commissioned wherever possible and these papers are separately published on the JRF website (http://www.jrf.org.uk/bookshop/details.asp?pubid=749). Two research projects were funded to inform the IWG in areas where there was an almost complete absence of information and relevant questions were also included in a community survey being conducted as part of another study. In addition, IWG members have between them visited DCRs in the Netherlands, Switzerland, Germany, Australia and Canada. Evidence was also obtained from witnesses who have been involved in considering local plans for DCRs around the UK and a drug user consultation was held, involving 13 representatives from drug user groups around the country.

The central question addressed by the IWG was whether there was the potential for DCRs to have a significant impact on the private and/or public harms associated with drug use in the UK. This raises issues about what is meant by 'potential' and 'significant impact': what was the height of the evidence 'hurdle' that DCRs should be expected to clear? Given the considerable political sensitivities surrounding the issue and the potential for

DCRs to do harm rather than good, the IWG is clear that there would need to be strong arguments and compelling evidence before such an approach could be recommended. However, the IWG is also mindful that a different level of evidence is required in considering the worth of 'piloting' the approach (setting up experimental projects that would be carefully evaluated before making any strategic decision). A recommendation for piloting would require a lower evidence threshold than a recommendation for national implementation.

The IWG's considerations were divided into two phases. First, it addressed the central question of whether DCRs had the potential to have an impact on drug use. The main sources of evidence drawn on to reach this decision were twofold: first, the current level of need, among both drug users in the UK and the communities affected by drug use; and, second, the international evidence on the effectiveness of DCRs. It was thought important to make this decision first, before proceeding to consider the barriers to implementing DCRs in the UK. We did not want the fact that DCRs might be very difficult to set up under current circumstances to cloud our judgement of whether DCRs were or were not an intrinsically good idea. The second phase focused much more on the practicalities: the pros and cons of different models and the legal, political, ethical and practical obstacles that stood in the way of implementation.

Structure of the report

The next chapter deals with the UK policy context. Following the logical order in which the IWG considered the various issues, Chapters 3 and 4 focus on the evidence of need and the evidence of effectiveness respectively. Chapter 5 identifies and discusses the legal, ethical, political and local concerns surrounding DCRs and Chapter 6 focuses on how pilot projects might be developed and evaluated in the UK. Chapter 7 contains the IWG's conclusions and recommendations.

2 The policy context

In 2002, the Home Affairs Select Committee (HASC) published its report on the Government's drug policy. One of its key recommendations was 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)

The Home Office's evidence to the HASC had already made clear the Government's opposition to DCRs on a number of grounds (Home Affairs Committee, 2002b, pp. 226–7):

- 'International legal position means that the rooms could be (but have not been) open to legal challenge.
- The Government could be accused by the media and others of opening "drug dens".
- No guarantee that public or political tolerance will be the same as Switzerland.
- Will directly increase health service costs as they would be a new service provision requiring additional capital and revenue costs.
- Still leave the possibility of unsafe injecting during the hours they are closed.
- There may be problems in some areas on occasion with drug dealers congregating near to venues, leading to reduced local tolerance for the presence of injecting rooms in their neighbourhood.

- Likely to raise the issue of policing low-level dealing in the vicinity of injecting rooms.'

The Home Office statement went on to explain that 'the current Government position is that injecting rooms for illicit drugs should not be introduced in this country whilst we have no evaluations of those developed in other European countries' (Home Affairs Committee, 2002b, p. 227). Consistent with this position, the Government's response to the published HASC report was that it would develop its policy of supervised consumption for those *prescribed* heroin but not for those who have not been prescribed heroin.

Some of these themes were repeated in a later interview with the then Home Secretary, David Blunkett:

> Where there are 'shooting galleries' I am ruling those out because at the moment we need much stronger evidence that firstly, they would ease the problem and secondly that they wouldn't cause such a backlash and undermine our progressive step-by-step policy in terms of prescribing. And thirdly, that people wouldn't try and develop these as a type of attraction.
> (Druglink, 2003, p. 10)

Some six months after the first meeting of the IWG, in November 2004, the Home Office commented on plans for a proposed mobile DCR in Cardiff in the following terms:

> The UK will not contravene or undermine UN conventions or the Misuse of Drugs Act. We believe facilities for supervising the consumption of illegal drugs would fall foul of these. Therefore, no authority could be given to the piloting of initiatives to supervise the consumption of illegal drugs.
> (http://news.bbc.co.uk/1/hi/wales/4053921.stm)

These same words were used more recently as part of the Government's progress report on action taken on the HASC's drug policy recommendations (House of Commons, 2005):

> We need to be careful to distinguish between facilities to supervise the consumption of prescribed drugs and new initiatives to supervise consumption of illegally acquired drugs. The supervision and consumption of prescribed drugs in front of trained staff is a well-established practice in England.
>
> However, the UK will not contravene or undermine UN conventions or the Misuse of Drugs Act. We believe facilities for supervising the consumption of illegal drugs would fall foul of these. Therefore, no authority could be given to the piloting of initiatives to supervise the consumption of illegal drugs.
>
> Several countries are piloting injecting rooms for illegal drugs and early evaluation does seem to indicate that such facilities can prevent overdose fatalities and reduce harm to drug misusers. However, such facilities do vary in style and content and most evaluations have not adequately looked at the impact of such facilities on local communities. Evaluation reports suggest that they can act as a magnet to drug misusers and dealers and require very careful management to minimise dealing and violence.

There is therefore a clear set of objections that underlay the Government's original rejection of the idea of DCR pilots in 2002 and some of these have been reiterated in more recent commentaries. Most of these objections will be reconsidered in more detail in Chapter 5, after the research evidence has been assessed. However, the Government's central concern about the weakness of the evidence base will be briefly dealt with here because of its relevance to the need for the IWG. A considerable number of evaluation and research papers have been published

since the HASC report, of which perhaps the most important is an extensive and authoritative review of the evidence carried out by the European Monitoring Centre for Drugs and Drug Addiction[1] (Hedrich, 2004). A number of important publications have also emerged from the well-conducted evaluations of the new facilities in Sydney and Vancouver, including a very detailed and authoritative evaluation report on the Sydney Medically Supervised Injecting Centre (MSIC). As the more recent government response to the HASC recommendations appears to acknowledge, the evidence base is certainly much stronger in 2006 than it was in 2002. Indeed, as has already been stated, this has been a strong imperative for setting up the IWG.

The Government's drug strategy

The historical context

In the past, the UK has been in the vanguard with regard to the introduction of harm reduction measures and, as a consequence, has been remarkably successful in controlling the spread of HIV infection among people who inject drugs. The UK's first and only major epidemic of HIV among injectors occurred in Edinburgh and Dundee in the early 1980s. By 1985 and 1986 there was increasing concern in government and in drugs services that HIV might rapidly spread to the rest of the UK's injectors (Stimson, 1995). There followed the rapid introduction of a range of harm reduction measures. This included syringe exchange, the social marketing of safer drug use and expansion of methadone prescribing, coupled with improved access to services and treatment, voluntary testing and counselling for HIV and outreach to drug users in the community.

These developments were given momentum by the report of the Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse:*

> We have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse ... We must therefore … work with those who continue to misuse drugs to help them reduce the risk involved in doing so, and above all the risk of acquiring or spreading HIV. (ACMD, 1988, para. 2.1)

In international terms, HIV prevention among injecting drug users in the UK has been a public health success story: the prevalence of HIV declined through to 1992, and the proportion of injectors with HIV has stayed around 2 per cent or less over much of the period 1993 to 2004 (but with an indication of a recent rise: Hope *et al.*, 2005). To put this in context: there are many cities around the world where the proportion of injectors with HIV is in the range of 40 to 60 per cent. A key to this success has been government commitment and allocation of resources to harm reduction. The UK led the world in demonstrating the feasibility, acceptability and effectiveness of harm reduction.

The current Drug Strategy

Over the past ten years, there has been an increasing emphasis in government strategies on reducing the harms associated with drug use. The lead aim of the Updated Drug Strategy 2002 is 'Reducing the harm that drugs cause to society – communities, individuals and their families' (Home Office, 2002a, p. 6). This focus is reflected in the priority accorded to reducing drug-related deaths by 20 per cent by 2004.[2] Since then, the number of drug-related deaths has become a key element of the Drug Harm Index, which has been developed to measure the Government's Public Service Agreement target of reducing drug-related harm (MacDonald *et al.*, 2005). There is an even stronger emphasis on harm reduction in the recent updated *Models of Care* report from the National Treatment Agency (NTA, 2005), which advocates 'a far greater emphasis on the need to reduce drug-related harm including risks

of BBV infection, overdose and other infections at all points in the treatment journey'.

As will be described, two of the central aims of DCRs are to prevent overdose and reduce the transmission of blood-borne viruses. If they were successful in this capacity, they would contribute to two major aims of government policy.

As well as seeking to reduce drug-related deaths and the transmission of blood-borne viruses, the Government's Drug Strategy seeks to improve the general health of drug users and improve access to treatment. Again these are two areas where, were DCRs able to deliver on their aims, they would contribute to the achievement of some of the Government's strategic goals.

Scotland

The Scottish strategy, *Tackling Drugs in Scotland: Action in Partnership*, has a similar emphasis on harm reduction, aiming to reduce drug-related deaths and the health risks associated with drug use and the sharing of injecting equipment. However, the issue of drug-related deaths has recently received particular attention, following the highest ever recorded number of such deaths in 2003. A number of official inquiries and reports followed. The report of the Association of Drug Action Teams on strategies to prevent drug-related deaths explicitly referred to the potential for 'safer injecting rooms' to prevent deaths (Association of Drug Action Teams in Scotland, 2005). This was picked up by the Scottish Advisory Committee on Drug Misuse in its report on the issue, where the recommendation was made that the Scottish Executive 'closely monitor developments taking place outwith Scotland such as supervised consumption rooms' (Scottish Advisory Committee on Drug Misuse, 2005, p. 12). In a recent response to the SACDM report, the Scottish Executive has agreed to monitor the use of DCRs abroad (Scottish Executive, 2005).

The European Union

The *EU Drugs Action Plan (2005–2008)* makes no explicit reference to DCRs but has a strong focus on harm reduction, with objectives covering the need for access to harm reduction services, programmes to prevent the spread of blood-borne viruses and interventions to prevent drug-related deaths. The Action Plan states that the 'reduction of drug related deaths [is] to be included as a specific target at all levels' (Council of the European Union, 2005, p. 13).

The United Nations and the International Narcotics Control Board

The UN position is complex. The British Government is a signatory to the three UN Conventions governing drug trafficking and other aspects of international and domestic drug policy. However, the general language used in these Conventions, and the broad range of possibly relevant sections contained within them, makes interpretation difficult (Fortson, 2006a, 2006b[3]). Accordingly, commentators have taken a variety of different positions on the implications of the UN Conventions for DCRs. The International Narcotics Control Board (INCB), the independent body responsible for monitoring member states' compliance with the Conventions, is confident that DCRs do indeed contravene them. Each year it produces a report summarising relevant developments around the world and each year since 1999, the INCB has expressed its opposition to DCRs. However, this has not prevented eight countries, each of which has signed at least two of the Conventions, from developing DCRs. These issues are considered in more detail in Chapter 5, which examines the legal impediments to setting up DCRs.

IWG conclusions

The IWG recognises and welcomes the fact that the UK Government's Drug Strategy has increasingly focused on harm reduction, alongside other priorities. This emphasis on harm reduction means that the objectives of DCRs actually chime well with the Government's current drug policy.

When the idea of introducing DCRs was last considered by the Government in 2002, a proposal to pilot DCRs was rejected on a number of grounds, an important one of which was the lack of evidence. The past four years have witnessed a dramatic increase in the evaluation literature and there is consequently a need to reconsider what the evidence base can tell us about the effectiveness of DCRs. It is also important to consider the issue of 'need': whether the drug-related problems experienced in the UK are of a scope and nature that might be addressed by DCRs. The next chapter turns to this question.

3 Evidence of need

DCRs have been set up abroad in response to a range of concerns and needs. These can be categorised as *public* harms which affect communities, such as discarded syringes in public parks and toilets, and *private* harms which affect individuals, such as overdose death and blood-borne viruses.[1] The public nuisance caused to residents and businesses close to drug markets has been a crucial factor leading to the setting up of DCRs in Swizerland, Germany and the Netherlands (Hedrich, 2004). The story of Platzspitz or 'Needle Park' in Zurich, Switzerland, is an example of how public concern led to a sequence of events culminating, among other things, in the establishment of a DCR (MacCoun and Reuter, 2001). Large numbers of drug users began to use this park in the centre of Zurich during the 1980s. The increasing numbers of drug users and amount of drug-related litter in this public park eventually led to its closure, the relocation of users to the local train station and finally the setting up of a DCR. The focus on public nuisance has perhaps been strongest in the Netherlands, where local concerns about drug taking in public places have been pivotal in the decision to implement DCRs. Public order is clearly at the centre of the Dutch policy on DCRs (Hedrich, 2004).

The private harms, in particular overdose deaths, associated with drug use have also been a driving force behind the setting up of DCRs in other countries. These appear to have been key to the setting up of projects in Norway, Spain and Canada and were also influential in their establishment in Switzerland (Hedrich, 2004; Skretting, forthcoming). The context in which DCRs were established in Sydney, Australia, was more idiosyncratic: rooms used by sex workers were increasingly being rented to drug users as illegal shooting galleries. Drugs were also being supplied from these rooms and police corruption surrounding their control was uncovered as part of a wider inquiry into police corruption (van Beek, 2004). The Royal Commission report resulting from this inquiry recommended that consideration be given to the

establishment of 'safe, sanitary injecting rooms' (quoted in van Beek, 2004, p. 3).

In considering the question of the need for DCRs in the UK, the IWG finds it significant that, while there were known to be high levels of injecting drug use in particular areas of the UK, these did not appear to be associated with the sort of extensive public injecting that had been instrumental in the setting up of some of the European DCRs. A central question was therefore whether there was evidence of significant public injecting and associated nuisance in this country.

Recognising the other premise put forward for the establishment of DCRs, the private harms to the user, the IWG was also concerned to bring together the evidence on overdose deaths, the transmission of blood-borne viruses and other health harms caused by injecting drug use.

Extent of problematic drug use

Within the UK the information on the extent of problematic drug use[2] is far from complete. For example, research is currently only recently under way to provide the first ever estimates of the extent of problematic drug use at the national and local level within England. To obtain a measure of the extent of problematic drug use in the UK as a whole, therefore, it is necessary to knit together a range of prevalence estimates from different studies conducted at different times. The most up-to-date estimate of national prevalence relates to Scotland where it has been estimated that there were 51,582 problematic drug users in 2003 (Information and Statistics Division, 2004). The next most recent estimate relates to England where it was estimated that there were 287,670 problematic drug users in 2001 (Frisher *et al.*, 2004). An estimate for Northern Ireland has been produced for 2000/1 which placed

the figure at 828 (McElrath, 2002). Estimates for Wales were derived in 1994 (Wood *et al.*, 2000) and are now thought to be obsolete.[3] If it were assumed overall that the prevalence rate for Wales was the same as that for England (8.91 per 1,000 population aged 15 to 64) this would mean that the figure for the UK overall would be in the region of 357,000 problematic drug users. **The recently published report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) shows the prevalence of problematic drug use in the UK to be higher than for any of the other countries represented within the European Union** (EMCDDA, 2005).

An important developing feature of problem drug use in the UK is the increasing use of crack cocaine. Surveys have shown increasing levels of crack use in the UK and increasing numbers of crack users are presenting themselves to treatment services (Home Office, 2002b). Crack is frequently used alongside heroin: sometimes simultaneously in a single injection in the form of 'speed-balling' but more often as separate (but reinforcing) elements of a drug habit. While cocaine and crack cocaine are more often inhaled, they can also be injected and primary cocaine injectors tend to inject more frequently than heroin users (Friedman *et al.*, 1990; Mann *et al.*, 1992; McCoy and Inciardi, 1995) and report higher levels of risk behaviours (Health Protection Agency, 2005). Furthermore, users of both crack and heroin are associated with particularly high rates of offending among those arrested by the police (Holloway and Bennett, 2004).

The prevalence of injecting drug use is known to vary considerably around the UK and is also much more prevalent among particular groups, such as the homeless (Fountain *et al.*, 2003a, 2003b) and sex workers (McKeganey and Barnard, 1996; Ward *et al.*, 2000). Projects and initiatives therefore need to be tailored to the particular drug problems arising at the local level.

Private and public harms

It was clear from the IWG's initial discussions that DCRs had the theoretical potential to have an impact on both private and public harms. A review was commissioned to gather the relevant UK evidence (Hunt, 2006a).

Private harms

The key private harms were identified as: the risk of drug-related deaths and other emergencies; the transmission of blood-borne viruses; the other health risks associated with injecting; and untreated drug use. This section of the report addresses each of these in turn and concludes with a summary of what is known about homeless users and public injectors, overlapping groups that are at considerably greater risk of private harm and which are often targeted by DCRs abroad.

1 Overdose

As discussed in the last chapter, preventing overdose is an important aim of the current UK Drug Strategy and has been one of the primary goals of DCRs in countries including Germany, Australia and Canada.

'Overdose' most commonly occurs when heroin or other opiates depress the respiratory system, starving the brain of oxygen. It is now widely recognised that fatalities often arise when opiates are used in conjunction with other depressants, notably alcohol and benzodiazepines (Darke and Zador,1996). By bringing drug use under the direct supervision of trained practitioners, DCRs provide an environment in which early recognition of overdose and intervention are possible and deaths can be averted.

Since 1996, the UK has consistently reported the highest number of drug-related deaths in Europe (EMCDDA, 2005),

although the number has been declining in recent years. In much of Europe problem drug users have an annual risk of mortality of over 1 per cent, which is around 15 times higher than the risk for the general population of young adults (aged 15–44), potentially contributing over 10 per cent of young adult mortality (Hickman *et al.*, 2003; Bargagli *et al.*, 2005).

'Overdose' is not treated as a distinct category within mortality data published either by the Office for National Statistics or the National Programme on Substance Abuse Deaths – np-SAD (Office for National Statistics, 2005; Ghodse *et al.*, 2005). However, 'overdose' deaths contribute substantially to these and there is now an agreed protocol for monitoring drug-related deaths that excludes deaths that would largely be outside the province of drug services, e.g. paracetamol overdose.

Fatal and non-fatal overdoses are relatively common occurrences among heroin injectors. In 2003, there were 1,388 drug-related deaths in England and Wales, of which 591 involved heroin and morphine (Office for National Statistics, 2005). Using a different monitoring system, the National Programme on Substance Abuse Deaths reported a similar number of deaths in 2004: 1,372 (Ghodse *et al.*, 2005). In Scotland in 2004, there were 356 drug-related deaths, of which 225 were associated with heroin or morphine (General Register Office for Scotland, 2005); in Northern Ireland there were 21 deaths associated with heroin in 2000 (Registrar General, 2001). Non-fatal overdose is more common, with somewhere in the region of 20 to 40 per cent of injecting heroin users reporting ever having such an experience (Gossop *et al.*, 1996; Powis *et al.*, 1999). Non-fatal overdoses can be associated with brain damage and a range of other physical injuries. Both fatal and non-fatal overdoses frequently result in ambulance call-outs and treatment in hospital. However, there are no national statistics by which to measure the extent of this problem. While local data are available, the IWG emphasises the

need for standardised ambulance call-out statistics that can be collated at the national level. This is a significant weakness in the evidence base.

One of the central aims of DCRs is to intervene early on in overdose incidents, in order to prevent physical damage and death. Whether or not they are successful in achieving this aim is considered in the next chapter.

2 Transmission of blood-borne viruses

It is well known that the shared use of syringes and other injecting paraphernalia can lead to the transmission of blood-borne viruses, including HIV and hepatitis B and C. In order to combat the spread of HIV in particular, the provision of clean syringes has become a major part of drug policy over the past two decades. HIV prevalence among people attending drug services in 2004 was 3.9 per cent for those in London and 0.6 per cent for those elsewhere in England and Wales (Health Protection Agency, 2005), much lower than in many other Western European countries (EMCDDA, 2005). The number of new diagnoses of HIV infection among injecting drug users has been decreasing since the early 1990s (Health Protection Agency, 2005) but a recent study has found a higher than expected rate of HIV antibodies among newer injectors, suggesting that historically low rates may now be beginning to climb (Judd *et al.*, 2005).

There are indications of an increase in the prevalence of hepatitis C since the late 1990s. According to the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey, prevalence among more recent initiates (those who began injecting in the previous three years) in England and Wales has increased from 12 per cent in 1998 to 20 per cent in 2004 (Health Protection Agency, 2005). Prevalence among all users stands at 41 per cent (Health Protection Agency, 2005). The significance of this problem at the

policy level is illustrated by the existence of the Hepatitis C Action Plan (Department of Health, 2004), which focuses on how to respond to this 'silent epidemic'. If left untreated, hepatitis C can cause serious liver disease in some patients, including cirrhosis and liver cancer. The prevalence of hepatitis B is lower (around 20 per cent) but can likewise lead to liver disease and cancer and, in some cases, immediate death.

Between 1992 and 1997, needle and syringe sharing in England and Wales stayed at a relatively steady rate, with just below 20 per cent of current users reporting sharing in the previous month. In 1998, the rate increased to around 30 per cent and has since remained at around this level (Health Protection Agency, 2005).

Recent research suggests that between three-quarters and four-fifths of drug injections involve previously used needles, although this does not necessarily imply sharing (Hickman *et al.*, 2004b) as people may reuse their own needles.

Where users do become infected with blood-borne viruses, there are good reasons for them to be aware of this fact: it may encourage them to look after their own health and take extra measures to prevent transmission of the virus to others. The evidence shows that approximately half the drug users infected with the hepatitis C virus and a similar proportion of those infected with HIV appeared to be unaware of their infection in 2004 (Health Protection Agency, 2005).

While the majority of people can be prevented from contracting hepatitis B through a course of three vaccinations, many drug agencies do not routinely offer this service and less than half of injecting drug users have been vaccinated (Hunt, 2006a).

DCRs aim to prevent the transmission of blood-borne viruses by providing sterile syringes and injecting paraphernalia. They can

also aim to intervene if users try to share injecting equipment on the premises or try to divide up drugs using potentially infected syringe barrels. They may also provide opportunities for testing a particularly marginalised group of users for the presence of blood-borne viruses and vaccinating them against hepatitis B, either directly on site or through referring to other services.

Finally, there is also the potential to provide sexual health advice and condoms through DCRs, thus contributing to efforts to combat the transmission of blood-borne viruses through unsafe sex. While reference is made to sexual health advice in the Sydney MSIC evaluation (MSIC Evaluation Committee, 2003), there is generally limited information on this issue in the evaluation literature.

3 Other health risks

DCRs often target more marginalised drug users, who may be injecting in public places. In such situations it is often very difficult to maintain a clean injecting environment. Furthermore, the need to inject covertly, coupled with the onset of withdrawal symptoms, can often lead to injections taking place in poor light and great haste. Such circumstances increase the risk of failed injection attempts and bacterial or fungal infection through injection sites on the body.

Research suggests that even in the general population of injecting drug users (rather than those specifically injecting in public places), hand washing is infrequent and swabbing an injection site prior to injection almost equally rare (Health Protection Agency, 2005). Accordingly, one study (Stone *et al.*, 1990) conducted at an emergency department in Glasgow found that almost a third of the 488 drug users attending had either abscesses or cellulitis (inflammation of the skin caused by bacterial infection). A more recent survey of injecting drug users found that three-fifths reported a possible infection at an injecting site in the past year and a third reported an abscess, sore or open wound at an

injection site over a similar period. Half of those reporting such an infection had sought medical attention (Health Protection Agency, 2005). Another common problem stemming from poor injecting practice is damage to and collapse of veins. This can lead to more dangerous injecting in the neck and groin which, in turn, is associated with risk of deep vein thrombosis and impaired blood circulation to the brain.

More uncommon health problems associated with unhygienic injecting include wound botulism, tetanus and other clostridial infections (Hunt, 2006a).

As a result of such health problems (and overdose incidents), drug users are frequently treated in hospital. It was recently reported that 6.9 per cent of all the patients attending an emergency department in South West England had attended for drug-related reasons (Binks *et al.*, 2005). The majority of drug-related problems were acute injuries (often assault), overdose and the medical complications of drug use.

4 Untreated drug use

While not a 'private harm' in its own right, the continuation of problem drug use without treatment is likely to be associated with the problems listed above, along with many others. It is clearly the case that, at any one point in time, a large proportion of injecting drug users are not in treatment: recent research suggests as many as three in four (Hickman *et al.*, 2004b).

DCRs offer the opportunity to refer users to treatment agencies. They also offer the opportunity to provide support in some of the other areas of users' lives that are intimately connected with their drug use, such as accommodation, general health and counselling. There has been a strong emphasis on integrating treatment within wider systems of social support in the National Treatment Agency's

Treatment Effectiveness Strategy (NTA, 2005) and DCRs could provide the opportunity to deliver a similar socially integrative approach to those not yet in the treatment system.

5 Homelessness and injecting in public places

A substantial proportion of rough sleepers are also problem drug users: research showed that around half of a sample of 389 homeless people in inner London had injected in the previous month and 36 per cent were assessed as being dependent on heroin (Fountain *et al.*, 2003a, 2003b). Many more dependent drug users are likely to be based in hostels.[4]

There is also evidence that a significant proportion of users accessing treatment or admitted to hospital are homeless. The National Treatment Outcome Research Study (NTORS) showed that 7 per cent of its cohort of over 1,000 drug users starting a new episode of treatment were homeless (Gossop *et al.*, 2001). Similarly, the Drug Outcome Research in Scotland (DORIS) study identified 15 per cent of users initiating treatment as being homeless (McKeganey *et al.*, 2005). Neale (2001) found that 32 per cent of a sample of 200 users admitted to accident and emergency departments in Scotland following an overdose were homeless.

While there is limited research on the issue, it is clear that homeless users are at particularly high risk in regard to the health problems and dangers referred to above, as well as a range of other risks, such as the risk of being a victim of theft or violent attack. Research conducted in the early 1990s showed that homeless injectors were likely to use more drugs more frequently, were less likely to be engaged in treatment, were more chaotic and shared injecting equipment more often than the rest of the sample (Klee *et al.*, 1990; Klee, 1991).). Recently published qualitative work undertaken in the UK amongst homeless injecting drug users

with a confirmed diagnosis of hepatitis C has highlighted the health risks of public injecting. Users reported picking up and using needles which had been discarded on the street; preparing drugs with water drawn from toilets, puddles or discarded bottles; and using discarded cigarette ends as filters (Wright *et al.*, 2005).

By definition, homeless drug users are likely to be injecting in public places. Homeless users living in hostels are often not allowed to inject on the premises (although the IWG did hear evidence from its meetings with local projects and with users that this is not always the case). Users will therefore often have to leave their hostels in order to inject in the local vicinity. Those sleeping rough will inevitably be forced to use in public places. A recent survey sample of 113 homeless injecting drug users included a question on the location of their last injection. Sixty-four per cent reported that their last injection had been in a public place, mostly streets, parks and public toilets (Judd *et al.*, 2005).

While homeless people are more likely than others to inject in public places, there is some research to suggest that they are not the only group doing so. Of the 56 public injectors included in a study by Klee and Morris (1995), only 22 were homeless.

Recognising that the fieldwork for the latter study was conducted in 1992, the IWG was concerned that there was no more recent research on the key question of the extent and nature of injecting in public places. A study was therefore commissioned to address this issue. This research is outlined in the box (for a full account see Hunt *et al.*, forthcoming).

IWG research on syringe exchange users

This study focused on a sample of 398 drug users obtaining sterile injecting equipment at a number of needle exchange projects and pharmacies in Glasgow, Leeds and London. The sample was mostly male

Continued overleaf

(82 per cent) and white (91 per cent), with an average age of 34. Respondents were asked where they had injected over the past week and 42 per cent responded that they had injected at least once in public areas, including public toilets, streets and parks. The extent of public injecting was clearly related to accommodation status. While 98 per cent of the users sleeping rough (n = 46) had injected in a public place in the past week, this was true of 49 per cent of hostel dwellers (n = 132) and 24 per cent of those living in their own accommodation. Thus, rough sleepers were considerably more likely to inject in public places than any other group and hostel dwellers were twice as likely to do so as those living in their own home. However, the fact that nearly a quarter of the people living in their own home reported having injected in public in the past week is significant, given that they were the largest group attending the needle exchange facilities. Public injecting is therefore certainly not the sole preserve of the homeless.

The sample was also asked about the proximity of their main drug market to where they lived and just over half lived within half a mile. Just under a quarter lived around a mile from their main drug market; the other quarter two miles or more.

This research demonstrates for the first time that public injecting is very common among drug users accessing syringe exchange facilities. While there are inevitably problems with extrapolating from one study conducted in three cities to the national level, **it can be concluded with some confidence that, in England alone, there are tens of thousands of injecting episodes per month occurring in public places**[5].

A key, largely unanswered, question in this field is the degree to which being homeless or a public injector confers a greater risk of overdose. Klee and Morris (1995) found that public injectors had a high risk of non-fatal overdose. A similar conclusion was reached by the Advisory Council on the Misuse of Drugs (ACMD) in their report on drug-related deaths (ACMD, 2000). Having referenced a number of studies conducted elsewhere in Europe, they concluded that:

> We think that this non-UK literature probably carries relevance for this country, and here too homelessness and injecting outdoors are likely to be risk factors *[for drug-related death].* (ACMD, 2000, p. 25)

DCRs tend to target homeless users and other users who are injecting in public places. These are groups that appear to be at particularly high risk of drug-related health problems and overdose.

Lastly, it has become clear to the IWG that, beyond the health problems that can be reliably measured, there is a great loss of dignity associated with injecting drugs in run-down backstreets and alleyways. There is undoubtedly much mental anguish experienced by those users who need to use in such dangerous and depressing places. This seems additionally significant in that, without some level of self-esteem, it is hard to see such users making a realistic attempt to address their multiple problems, including seeking to overcome their dependence on illegal drugs.

Public harms

While the private harms referred to above primarily affect the individual concerned, they also affect others around them and will, in addition, have an economic impact in terms of ambulance call-outs and hospitalisation. The potential for DCRs to influence ambulance call-out rates and treatment following overdose will be addressed in the next chapter. More relevant here is the issue of the social impact of injecting in public places – including the associated drug-related litter.

Use of drugs in public places has a direct effect on those who witness actual drug-using episodes and a wider, more indirect effect in terms of the drug-related litter often left in public places, including syringes, swabs and the packaging that contains these tems. The

IWG is surprised by the dearth of information and research in this field, given the media coverage of such issues and the obvious public concern relating to discarded syringes and associated 'needlestick' injuries. The only substantial previous research is the Environmental Campaigns (ENCAMS) survey of drug-related litter which was carried out in 1998, 2001 and 2004 (ENCAMS, 2005). This showed a rapid increase in the annual number of needles collected in England over this period: from 3,570 in 1998/9 to 147,345 in 2003/4. While caution needs to be exercised in interpreting these statistics, given that local collection and recording procedures are inevitably variable and the proportion of local authorities responding to the survey has never been high, the recent report is confident in concluding that **'the quantity of needles found is increasing dramatically year on year'** (ENCAMS, 2005, p. 34). It is clear from this report that the problem is an increasingly widespread one, with growing numbers of rural and seaside authorities reporting finds. The sites reported by most local authorities were parks/playing fields, public toilets, residential areas, car parks and footpaths. Over the three-year period up to 2004 there had been 169 recorded needlestick injuries, the majority of those injured being local authority employees (ENCAMS, 2005).

While this survey is very useful in giving some sort of indication of the size and spread of the problem, it does not provide an understanding of the impact of discarded syringes and other drug-related nuisance on local communities and businesses. It was therefore decided to commission a research project specifically to address this gap in the knowledge base. Additionally, some items were included in a community survey which was conducted as part of another study (May *et al.*, 2005).

1 Community survey

A street survey was conducted with a total of 717 residents in four different sites as part of a JRF study of the impact of drug dealing on communities (May *et al.*, 2005). Some questions were included

in this survey to inform the IWG's deliberations. Of this sample, 17 per cent said they had seen someone injecting heroin or crack and 29 per cent said that they had found discarded needles. The communities where this research took place were selected because they were associated with drug dealing, so these findings could not be taken as representative of the wider population. However, even accepting this, IWG members found these figures to be surprisingly high.

2 The social impact of public drug use

This research (Taylor *et al.*, 2006) was carried out in four sites around the UK known to be associated with public use of drugs and involved interviews with local people, including council cleaners, toilet attendants, park keepers, local business employees and local residents. Interviews were carried out with 100 people, 61 of whom took the researchers on 'walkabout tours' of the local area, pointing out sites where they had seen people using drugs or found evidence of public drug use. It should be emphasised that this was a 'purposive' sample, selected because their jobs or place of residence meant that it was particularly likely that they had witnessed drug use or drug-related litter.

Drug-using locations were identified in alleyways, car parks, derelict open spaces, neglected property, cafés, toilets, gardens and stairwells. Half of the participants reported drug dealing, over a third had seen people injecting and nearly four-fifths had seen at least one used syringe. Twelve of the 100 participants had witnessed drug users who had collapsed and/or overdosed. Participants were annoyed by the drug litter and visible drug use – particularly if it occurred close to their own homes or where it could be observed by children.

They were also intimidated by groups of users 'hanging about' – and referred to finding vomit and excrement that they associated with drug users, some of whom were sleeping rough. Respondents

generally reacted to these issues with anger, disgust and fear. The relentlessness of these problems was often viewed as part of a wider social malaise, which included the sex industry, homelessness, begging and drug-related crime.

The authors conclude that public drug use and related litter are associated with significant levels of community concern, reflected in feelings of reduced safety, public amenity and quality of life.

IWG conclusions

The IWG was surprised by the lack of knowledge about some aspects of injecting drug use and its associated harms in the UK. Research had to be commissioned to address fundamental gaps in our knowledge about injecting in public places. However, the IWG has been able to draw a number of conclusions from the available evidence:

- The UK has a substantial population of injecting drug users.
- The UK has the highest number of drug-related deaths in Europe and has done since 1996.
- There is a high, and probably rising, prevalence of hepatitis C among drug injectors in the UK. Hepatitis B is also a cause for concern.
- While considerably lower than in many other countries, HIV prevalence is increasing again, including one early indication of a rise among injecting drug users.
- Many users infected with blood-borne viruses are unaware of their infection.

- While hepatitis B can be prevented through vaccination, fewer than half the population of injecting drug users have been vaccinated.

- Abscesses, cellulitis and other infections are common among injectors, leading to frequent hospital treatment.

- There is a substantial population of high-risk, homeless, injecting drug users, mostly based in hostels or rough sleeping. They inject frequently in public places and are therefore associated with a lot of public nuisance.

- A significant minority of injectors who live in their own home also inject in public places.

- People who inject in public places appear to be at high risk of health problems and overdose.

- Users forced to inject in unhygienic and dangerous public areas are likely to experience anguish, loss of dignity and low self-worth.

- Large quantities of used needles and drug-related litter are dropped in public places and this is a widespread problem across the UK.

- Discarded syringes, drug-related litter and drug users congregating on the streets significantly affect the lives of many people living in areas close to drug markets in the UK.

It would appear, logically, that concentrating injecting drug use within DCRs could stem some of this extensive damage to individuals and communities. However, the IWG is clear that identifying needs potentially addressed by DCRs does not in itself constitute a conclusive argument for the piloting of DCRs in the

UK. There would have to be evidence that DCRs are demonstrably effective in meeting these needs and, moreover, sufficient indication that they would be more effective than current interventions. The next chapter considers the international evidence relating to the effectiveness of DCRs.

4 Are DCRs effective?

As discussed in the last chapter, it is plausible that DCRs could have an impact on a range of private and public harms that are commonly experienced by individuals and communities in the UK. However, what is the evidence that they have such an impact? At the time of writing, somewhere in the region of 65 DCRs are operating in 40 cities in eight countries around the world. Not all of these facilities have been subjected to a thorough evaluation but an increasing number of evaluations have been published over the past ten years.

Evaluation of any project that aims to have a community-level impact on a clandestine behaviour like injecting drug use is fraught with problems. It is very hard to know how many injecting drug users are out there and even harder to contact a representative sample and interview them. If it is expected that a DCR will have an impact at a local community level, then local users will need to be contacted in this way. For this reason, among others, it is much more difficult to distinguish the impact of a DCR at the *community* level than it is to analyse its impact at the *individual* or *project* level.

As with all evaluations of community interventions, it can also be extremely difficult to ascribe changes in behaviour or health to the project itself. To take an example: if a DCR is associated with a lower reported level of needle sharing among its users, is this due to the DCR or another, competing explanation, such as a local outreach intervention or, alternatively, a wider trend in decreased sharing among the age cohort using the DCR? Various evaluation designs have been employed to try to distinguish between competing explanations but with varying degrees of success. The most recent evaluations focusing on the Sydney and Vancouver projects have employed particularly robust designs.

Other issues include the infrequency of some of the possible outcome variables, such as overdose death, which make it hard to be sure that an individual DCR has had an effect; and the

propensity for vulnerable people to answer questions in a way that they think may please project staff or researchers (particularly where a high-profile demonstration project has been set up).

Such problems mean that evaluation evidence in this area is inevitably *indicative* of whether a project is effective or not rather than *proof* of its relative effectiveness. However, when a number of evaluations appear to be showing similar trends, the evidence should be regarded as more convincing.

In considering this evidence, the IWG emphasises that these evaluations relate to DCRs operating in different countries with different drug-related cultures and problems. Their applicability to the operation of a DCR in the UK can therefore be questioned. Ultimately, IWG members conclude that such caveats would only be addressed through conducting properly evaluated pilots in this country.

The job of making sense of the evaluation literature has been greatly aided by the publication of an excellent EMCDDA review on the subject (Hedrich, 2004), which has been drawn on extensively in our work. This chapter is divided into five sections. The first four address the following key questions relating to effectiveness:

- To what extent do DCRs reach their target group?
- What is their impact on health?
- What is their impact on local communities?
- How do they compare to other interventions and are they cost-effective?

The last section brings together the evidence of need from the last chapter with this evidence relating to effectiveness and reaches

conclusions about the extent to which the UK might benefit from the introduction of DCRs.

Reaching the target group

1 User characteristics

The EMCDDA review states that the target populations of DCRs are:

> typically defined as high-risk problem drug users, especially regular or long-term users of heroin and cocaine, drug injectors, drug-using sex workers, street users and other marginalised, often not in treatment, groups.
> (Hedrich, 2004, p. 24)

As the review goes on to point out, the socially marginalised nature of this target group means that restrictive rules and regulations are not likely to be attractive. However, if DCRs are to operate within parameters that have official sanction and ensure the safety of their users, properly observed rules are a necessity. This is a conundrum that affects DCRs' ability to attract the most socially excluded users.

Another important issue affecting targeting is the potential for DCRs to introduce users to injecting drug use. It is possible that the existence of a safe environment for drug injecting might push someone hovering on the brink of injecting heroin for the first time to go over the edge. DCRs generally try to restrict their clientele to experienced drug users but this is actually very hard to ensure in practice. Age restrictions are usually put in place as one means of deterring this potential 'net widening' effect but, of course, different people start using drugs at different stages of their lives.

Turning to the research evidence, 15 'key studies' were drawn on by the EMCDDA review in its consideration of the target groups of DCRs. The typical DCR user is a male over 30 years of age, who is a frequent user of heroin and/or cocaine and has been injecting for at least ten years. A substantial proportion of a typical DCR's users will have been injecting in public places prior to using the DCR (for example, 39 per cent of the Sydney MSIC users had injected in a public place within the last month). There are, of course, exceptions to this picture, perhaps most notably those DCRs that are set up specifically to attract drug-using sex workers.

The first evaluation report of the DCR set up in Vancouver (Insite) was published after the EMCDDA review and showed that a similar profile of users were accessing the facility (British Columbia Centre for Excellence in HIV/AIDS, 2004). Seventy per cent of users were male and the mean age of the group as a whole was 39.

A significant proportion of DCR users are homeless but the actual percentage varies greatly according to the definition of homelessness and the DCR's location and purpose. Sixty per cent of the users in a DCR in Barcelona were defined as homeless, reflecting this DCR's targeting of marginalised users. By comparison, a recent survey of all German consumption rooms found that 5 per cent lived on the street (Hedrich, 2004). Twenty-two per cent of the Vancouver sample were defined as of no fixed abode or living on the street (British Columbia Centre for Excellence in HIV/AIDS, 2004). The extent to which a local DCR has been able to attract a substantial proportion of local, homeless drug users has not been addressed in the literature. However, some of the Dutch projects specifically target small groups of local, homeless individuals who are known to be causing significant amounts of public nuisance and, from IWG visits to such projects, they appear to be successful in achieving this aim.

Although, as outlined above, DCRs usually try to exclude experimental or intermittent injectors, studies in Switzerland have revealed that a small percentage (0.5–4.5 per cent) of DCR users report that they had their first injection in a DCR (Hedrich, 2004). This demonstrates that, so long as a DCR is accessible to a broad range of drug users, it is inevitable that a small number will first inject within the premises. Whether or not, in the absence of a DCR, such people would have injected a drug in any case is open to conjecture.

One of the main and, in the view of the IWG, completely understandable community concerns surrounding the setting up of a DCR is that it will attract even more users to the area – the 'honeypot' effect. Research has been conducted on the proportion of service users who live locally and has found that between 63 and 93 per cent report living in the local area, however defined (Hedrich, 2004). The number of people that are attracted to a DCR from outside the immediate area is likely to depend on several factors, including the DCR's policy; the local policing policy; the number of other DCRs in the locality; the location and nature of drug markets; and the availability of needle exchange, treatment and hostel facilities for users. These issues are considered in more detail in the later section on the impact of DCRs on local communities.

The potential for DCRs to refer users who have never previously addressed their drug use problem on to treatment agencies was identified in the previous chapter. The evidence on DCR attendees suggests that the potential does exist, with between 15 and 50 per cent never having been in treatment before (Hedrich, 2004). DCRs' actual effectiveness in referring users on to treatment is considered below under the section on health impact.

Finally, DCR users are usually able to gain access to a range of needle and syringe exchange, medical and social care, counselling

and housing services through co-operation between DCRs and other services.

2 Utilisation and coverage

Heroin and cocaine are the main drugs used, sometimes in combination, and the main mode of use is injecting. However, in the Netherlands, where the majority of heroin users inhale drugs, services have separate areas for those who inhale and those who inject. DCRs designated for the inhalation of drugs have recently been set up in Switzerland and Germany in order to promote less risky modes of drug use.

DCRs vary enormously in the extent of their use, depending on the number of spaces for users, the size of the local user population and the eligibility criteria. At one end of the scale, a weekly average of 50 supervised consumptions has been reported; at the other, the Vancouver project reported a weekly average of over 3,000 (Hedrich, 2004; British Columbia Centre for Excellence in HIV/AIDS, 2004). Studies in Germany and Switzerland show that many people use services on an average of five times a week. In the Netherlands, where projects usually focus on comparatively small groups of homeless users, average usage rates per person can be as high as six days per week (Hedrich, 2004). The Vancouver project was used by 3,036 individuals in a six-month period, during which 79,962 injections took place. The average individual usage rate was 11 visits per month (British Columbia Centre for Excellence in HIV/AIDS, 2004).

The location of a DCR is a vital consideration. In one study of German service users, it was found that, in addition to the provision of safe and hygienic conditions, one of the main reasons given by users for utilising a particular DCR was its proximity to a drug market. In another study of three DCRs in Frankfurt, it was

found that the extent of their use was related to their distance from the local drug market. Similar results have been found in Hamburg, where there was a policy decision to try to move users out of the city centre by relocating drug services, including DCRs, outside the centre. The relocated DCRs were used very little (Hedrich, 2004).

Opening times vary from many being open eight or nine hours a day to some which are open 24 hours a day. Extending opening hours at night can lead to more supervised injections, more users and different kinds of users. The extent to which services can stretch to cover nights and weekends is likely to be crucial in the degree to which they 'capture' a significant amount of local injecting.

On the question of the proportion of injecting episodes in public places that can be 'captured' by DCRs, Hedrich (2004) provides interesting case histories of the DCRs set up in Frankfurt, Hamburg and Zurich. In the early 1990s, each of these cities was faced by open drug markets and public drug use. In each case, a number of DCRs had to be developed in order to have a significant impact on public injecting: five in Zurich, four in Frankfurt and eight in Hamburg. This makes an interesting contrast to the situation in Sydney and Vancouver, where drug users and drug markets have been concentrated in quite small areas of the city. Single DCRs with very high turnovers appear to have been able to have an impact more readily in these circumstances.

3 Conclusions on reaching the target group

The research evidence from DCRs abroad suggests that they are largely successful in attracting considerable numbers of long-term users, many of whom are socially excluded and out of contact with treatment services and a significant proportion of whom will have never had any contact.

DCRs have generally been set up for local users with little evidence of 'honeypot' effects. Those who use DCRs regularly tend to be locals. DCRs are rarely used by novice injectors.

While this report focuses mainly on injecting drug use, a number of drug consumption rooms in Europe also provide a service for those wishing to inhale their drugs. It is at least logically possible that DCRs which do not offer space for inhalation might thereby encourage drug users into injecting – or, at least, reinforce this behaviour.

The success of DCRs in attracting users depends crucially on their location with proximity to drug markets being the key factor. Maintaining long opening hours is also vitally important.

Finally, there is evidence that, possibly where drug markets and public drug use are more diffuse, multiple DCRs may be needed in order to 'capture' a significant proportion of public injecting.

Impact on health

If a DCR is to have an impact on health, the literature suggests that it needs to provide four essential services:

1 ensure relatively safe and hygienic injecting in the facility

2 provide personalised advice and information on safe injecting practice

3 recognise and respond to emergencies

4 provide access to a range of other on-site and off-site interventions and support.

If these services are successfully delivered to a sufficient number of people, it is likely that the DCR can then have an impact on a number of health-related outcomes:

1 overdose

2 transmission of blood-borne viruses

3 other health problems, such as abscesses

4 rates of drug use.

This section is therefore divided into two: the first addressing the four services provided by DCRs, the second the four outcomes.

Service provision

1 Ensuring relatively safe and hygienic injecting

The many problems associated with the failure to inject safely and hygienically have been alluded to in the previous chapter and a central aim of DCRs is therefore to provide clean injecting equipment, a clean environment in which to inject, a clear code of conduct and some clinical supervision of the injecting process. House rules and regulations, such as the prohibition of the sharing of injecting equipment and injecting in the neck, are instituted and 'policed' through supervision of the injecting process. However, do these procedures work? Are DCRs successful in ensuring safe and hygienic injecting within their walls? There appears to be an assumption in the literature that all of the injections that take place in a DCR take place in a safe and hygienic manner (Hunt, 2006b). Thus it is assumed that, given the existence of clear policies to ensure this, all those injecting in DCRs do so safely. While this is, indeed, likely to be the case in the majority of DCRs, particularly

where injection is closely supervised, it is still possible that some unsafe injecting practices do take place in DCRs with lower levels of supervision. The IWG is of the opinion that future evaluations of DCRs should include more observation of their operation, including the process of supervision and the enforcement of house rules. This should be one focus of any independent evaluation.

Nevertheless, there can be no doubt that, in well-run DCRs, the large majority of injection episodes take place in relative safety and this is borne out by IWG members' visits to DCRs in the Netherlands, Germany, Switzerland, Canada and Australia. The degree of benefit will depend on the nature of the injecting episodes that would otherwise have taken place: if a homeless person injecting in a DCR would otherwise be injecting with someone else's syringe in a public toilet, using toilet water to dissolve the drug, then the health dividends are much greater than for a DCR client who would otherwise be injecting safely in their own home. It is clearly impossible to know with any certainty the type of injecting episodes that have been prevented when users inject in a DCR: users themselves may find it difficult to state how and where they would have injected had they not been visiting a DCR. Nevertheless, the evaluation of the Sydney MSIC included asking the 3,782 clients where they would have injected if there was no DCR (MSIC Evaluation Committee, 2003). Forty-two per cent reported that their next injection would have been in a public place. As we have seen, injecting in public places is associated with greater risks than injecting in other locations. Moreover, DCRs appear to be generally successful in attracting homeless users and other people who regularly inject in public places. It seems likely, therefore, that the impact in terms of preventing unsafe and unclean injecting episodes is great. Furthermore, it should certainly not be assumed that this preventive 'dividend' applies only to those who inject in public places. While Taylor *et al.*'s (2004) video-based research on 48 injecting events confirmed the fact that injecting indoors was associated with fewer risks than injecting outdoors,

there were still numerous instances of risky injecting practices in the flats where the majority of the injections took place. There may therefore be a preventive dividend for the majority of injection episodes that take place in a DCR.

Preventing individual instances of dangerous injecting is a somewhat limited goal. It is highly unlikely that an individual user will always inject their drugs within DCRs. While for some health aspects, such as damage to veins or the development of abscesses, capturing only a proportion of injecting episodes will still bring significant benefits, for other health aspects, such as hepatitis C, preventing contraction of the virus within the DCR may appear of limited value if all it takes is one instance of sharing injecting (or drug preparation) equipment outside the DCR to lead to infection. This begs the question of the extent to which DCRs can influence injecting practice beyond their walls. This is addressed in the next section.

2 The provision of advice

DCRs provide a unique opportunity to observe an individual's injecting practice and offer advice. By comparison to a syringe exchange project, for example, there is a much greater potential to establish a detailed knowledge of the particular habits and dangers that users have built up as part of their regular injecting practice, simply by directly observing them. This then gives the potential for tailored advice designed to reduce the risks associated with their injecting. DCRs also offer the opportunity to provide more general health-related information and sterile injecting equipment for users to take off the premises. DCRs therefore have much potential in this regard but is this potential realised?

As Hunt (2006b) points out, there is a lack of information in the literature on the extent to which DCRs provide such advice to users. However, some useful information comes from the

evaluation of the Sydney MSIC (MSIC Evaluation Committee, 2003). In nearly 14 per cent of the visits to the MSIC, advice on injecting and/or vein care appears to have been given to the user: a total of 7,732 occasions over an 18-month period. Project workers referred to this work in their interviews with the evaluation team. Despite most of the clients being experienced injectors, staff referred to their 'amazement at their [poor] injecting technique' and the need to 'de-ritualise some of the entrenched rituals of injecting' (MSIC Evaluation Committee, 2003, p. 30). Staff agreed that injecting techniques had generally improved as a result of their interventions, describing 'a huge impact from both a blood-borne virus point and a potential death issue … [There's] been an increase in hand washing definitely … also less bruising, scars and abscesses' (MSIC Evaluation Committee, 2003, p. 30). Several members of staff thought that this input was one of the main benefits conferred by the MSIC.

While evaluations seem to have largely failed to measure the nature and extent of advice given to users, many have addressed the question of whether users have changed their behaviour as a consequence of attending DCRs. However, there are significant methodological problems here and studies have taken various approaches to the question (Hedrich, 2004). Some have followed up clients over time to see how their behaviour changes. However, without comparison samples, it is hard to distinguish between changes that are a consequence of attending a DCR and 'natural' changes in behaviour that would have occurred in any case. Other studies have compared DCR users with other samples of users who do not use DCRs. The value of this approach is limited by the extent to which such samples are identical in all aspects other than their attendance/non-attendance at a DCR. Given the sensitivity of many of these health measures to factors such as homelessness, age and drug-use experience, it is hard to be sure of comparability. Other studies have simply asked users whether, in retrospect, they ascribe any changes in behaviour to the DCR. Here, the

researcher is dependent on the user's memory of their earlier use, rather than having a baseline measure, as well as having no means of attributing the change specifically to the DCR.

Bearing in mind such shortcomings, what does the evaluation evidence show? Earlier studies have indicated an increased knowledge and awareness of risk and a decrease in needle and syringe sharing among DCR clients (Hedrich, 2004). The methodological problems associated with these evaluations have precluded a stronger conclusion. However, the evaluation of the Vancouver project has employed a more sophisticated approach, drawing on previous epidemiological surveys of injecting drug users, and has shown that the introduction of the DCR was associated with reduced syringe sharing among those attending the project (Kerr *et al.*, 2005; Wood *et al.*, 2005).

There remains a real need for better evaluation in this area: both observation and other qualitative work on the provision of advice to injectors and quantitative designs focusing on behaviour change, which need to include both a longitudinal and comparative element.

3 Recognising and responding to emergencies

DCRs vary in the level of medical supervision that they provide. The MSIC in Sydney has nursing staff and/or a doctor present at all times, allowing immediate and early response to overdose incidents (MSIC Evaluation Committee, 2003). It also has a fully equipped emergency room and staff on site able to administer naloxone.[1] While most other DCRs have doctors and/or nurses working within them, there is variation in their ability to provide on-site intervention in emergencies and, in some cases, a greater reliance on ambulance call-outs to treat overdose cases (Hedrich, 2004). These issues are dealt with in the consideration of outcomes.

4 Other interventions and support

Aside from the functions already described, international surveys have shown a standard DCR service to provide needle and syringe exchange programmes, basic medical care, counselling and referral to a range of off-site services (Hedrich, 2004). As stated above, most DCRs have doctors on site either part-time or full-time and where they do not, most have nursing staff on site. Some services also provide food and drink, showers and laundry services. A small number of DCRs form part of integrated services which include hostel accommodation on the same site.

Medical consultation, wound care services and counselling are provided in between 5 and 10 per cent of visits to DCRs (Hedrich, 2004). The Sydney MSIC provided a total of 13,696 services (in addition to supervision of injection) to 2,186 users over an 18-month period. After injecting and vein care advice, the most common service provided was 'general counselling' but there followed a long list of the provision of other information, medical and social services (MSIC Evaluation Committee, 2003).

With regard to referrals to other services, rates vary significantly across DCRs, from 9 to 54 per cent (although direct comparison is difficult: Hedrich, 2004). The Sydney MSIC referred 15 per cent of its users to other agencies, many on more than one occasion. Fifty-five per cent of the 1,385 referrals were verbal; 45 per cent written. Forty-three per cent of all referrals were for drug treatment; 32 per cent for health care; and 25 per cent for social welfare. Of course, the act of referring a person to another agency does not mean that that person will show up and receive help. 'Referral cards' were sent out with the written referrals and over one in five of these were returned as confirmation of the MSIC client's attendance. With regard to treatment, 49 of the 300 written referrals (16 per cent) resulted in a user attending the agency to which they were referred. Methadone maintenance had the highest rate of successful referral (MSIC Evaluation Committee, 2003).

The Vancouver project made 262 referrals to addiction counselling services over a six-month period, with 78 referrals to withdrawal management programmes (British Columbia Centre for Excellence in HIV/AIDS, 2004).

It does not seem particularly impressive that of the 3,782 registered MSIC clients over the 18-month period, 49 (or 1.3 per cent) were known to have attended a drug treatment service. However, as the evaluators point out, these figures are likely to underestimate the rate of successful referral (MSIC Evaluation Committee, 2003). There was no mechanism for finding out the success or otherwise of verbal referrals. Moreover, referral cards may not have been handed over to agencies by users and may not have been sent back by agencies. The inevitably 'hit and miss' nature of referring users elsewhere argues for the maximum provision of services on site as well as the need for integrated rather than specialised DCRs (see Chapter 6).

In conclusion on service provision, it seems highly likely that DCRs provide much safer and cleaner injecting environments for the majority of the injecting episodes that take place in them. They also provide a range of additional services, including advice on safer injecting. There is the suggestion that some of this advice may influence injecting practice outside the DCR, including the sharing of injecting equipment. Other useful services are provided within DCRs, including medical and social services. Many referrals are made to other agencies but, unsurprisingly, a low percentage appears to be taken up. The next section examines the impact of DCRs on the key outcomes.

Outcomes

1 Overdose

Concern about drug-related deaths has been an important spur to the development of DCRs in many of the countries hosting them.

By providing safety-related rules, supervision of the injecting process and medically trained staff, it is hoped that overdose deaths can be prevented. Non-fatal overdose is also a significant issue, frequently associated with serious health implications for users and drawing on ambulance and hospital resources. DCRs provide the potential to intervene at an early stage in the overdose process and thus avert the need for hospitalisation.

The large majority of reported emergencies within DCRs are overdoses relating to heroin, but there are also small numbers of cocaine overdoses and epileptic seizures (Hedrich, 2004). The most frequent way in which heroin overdose causes immediate death is through respiratory depression, often in combination with other drugs, particularly alcohol (ACMD, 2000). DCRs can therefore prevent deaths through aiding users' breathing and administering naloxone.

As Hunt (2006b) points out, there are a number of stages at which DCRs could have an impact on overdose events:

- DCRs prevent emergencies from occurring in the first place.
- Emergencies are managed earlier than would otherwise have occurred.
- Emergencies are managed with lower-intensity interventions than would otherwise have occurred.
- DCRs reduce morbidity and mortality from emergencies.

Evaluating a DCR's preventive role in these respects is difficult: how does one know that, without an intervention, the emergency would not have escalated?

There is a considerable amount of evidence on the incidence of emergencies within DCRs. The rate of emergencies seems to vary

very widely: from 0.5 to 7 emergencies per 1,000 supervised injections (Hedrich, 2004).[2] Reasons for this wide variation are likely to include differences in the nature of the target group and different definitions of what constitutes an emergency requiring intervention. However, it is clear that dangerous situations that require intervention arise frequently in DCRs (as they do in any drug-injecting context). The Sydney MSIC had the highest rate of emergencies (seven per 1,000 injections) and 329 heroin-related overdoses were managed by the staff over the 18-month evaluation period.

Paradoxically, these high rates of non-fatal emergencies point to the efficacy of projects in preventing the more serious overdose events that might have occurred were these emergencies to have taken place outside DCRs.

The proportion of emergencies dealt with by DCR staff will depend on the extent to which medically trained staff and the necessary equipment are present (Hedrich, 2004). Ninety-eight per cent of the emergencies at the Sydney MSIC, which has a doctor or nurse present at all times, were dealt with by the staff. DCRs which do not have a doctor present have much higher ambulance attendance levels: up to 70 per cent of emergencies (Hedrich, 2004).

Following ambulance call-out, some users are admitted to hospital. The proportion of emergencies resulting in hospitalisation varies between 2 and 8 per cent for the three studies addressing the issue in the EMCDDA review (Hedrich, 2004).

It is therefore clear from the foregoing that not only are emergencies a fairly frequent event in DCRs but that these are responded to. How effective are these responses? The most obvious measure is the one where information is readily available: the number of overdose deaths. **There has only been one reported death in a DCR since the first DCR was introduced in**

1986: in December 2002 a drug user died from anaphylaxis (a severe, whole-body allergic reaction) in a German consumption room (Hedrich, 2004). Injecting drug use is a very dangerous activity and millions of injections will have taken place within DCRs over the 20 years since their inception. As Hunt (2006b) points out, this statistic offers powerful evidence of the safety of DCRs.

While it is therefore clear that DCRs largely prevent overdoses occurring while clients are injecting within them, a more testing question is whether a DCR can be shown to have an impact at a community level. However, the impact of a DCR in this respect will always be limited by the following factors (MSIC Evaluation Committee, 2003):

- A DCR can only prevent deaths during its hours of operation.
- A proportion of the local users will not use the DCR.
- Those that do use the DCR will inject elsewhere some of the time.

Nevertheless such analyses have been attempted in Sydney and Germany. The evaluation of the Sydney MSIC included a sophisticated set of analyses of the impact of the DCR on drug-related deaths. However, the community-level measurement of impact was undermined by the rapid decrease in the availability of heroin which occurred shortly before the MSIC opened (Bush *et al.*, 2004). This was associated with a rapid decrease in overdose deaths and made the measurement of the impact of the MSIC at community level impossible. Nevertheless, using the proportion of overdose ambulance call-outs in New South Wales that end in the death of the user and applying this figure to the 81 more serious overdose cases in the DCR (which were treated with naloxone), a conservative estimate was made of four lives saved per annum.

Evidence of community-level impact is provided by a 'time series' analysis of the impact of DCRs on overdose death rates in four German cities (Poschadel *et al.*, 2003, referenced in Hedrich, 2004). This research concluded that DCRs were 'statistically significantly related to the reduction of drug-related deaths' (Poschadel *et al.*, 2003, referenced in Hedrich, 2004, p. 52). Another analysis of German data, which applied estimated overdose mortality rates to the number of supervised consumptions, found that ten deaths per year were prevented by the German DCRs (Hedrich, 2004).

In conclusion on the prevention of overdose deaths, it is unfortunate in the context of the Sydney MSIC that this, the best test of the impact of a DCR hitherto, was undermined by dramatic changes in the availability of heroin. Other analyses are inevitably complex and hedged by caveats. Nevertheless, it is unarguably the case that DCRs save lives. How many is less clear.

The research base is unable to say anything concrete about the extent to which DCRs might prevent emergencies occurring in the first place – or intervene earlier to prevent the escalation of an overdose event (Hunt, 2006b). One issue here is that DCRs may prevent overdoses occurring on site by excluding from the facility people who are already intoxicated. Intoxication with alcohol is an important risk factor for heroin overdose (ACMD, 2000). It may be possible for DCR staff to persuade users to come back and inject when they are sober. However, it is likely that such users may simply go on to use their drugs elsewhere, in which case, should they overdose outside the DCR, these could hardly be regarded as overdoses 'prevented'. Relevant here is the fact that some DCRs intervene in overdose cases occurring locally on the streets. Where intoxicated users are excluded, it may be possible to 'keep tabs' on them outside the facility. Users at DCRs may also be asked what drugs they are injecting and may be discouraged from using

certain combinations of drugs (or prevented from using them on the premises). This may deter users from more lethal injections. Finally, DCRs offer the opportunity for users to take their time in measuring their dose, rather than rushing their injections in a poorly lit environment. Such possibilities require evaluation.

Preventing overdose incidents from escalating seems a very important goal and further detailed research here would be very useful. However, as Hunt (2006b) has pointed out, there is also the theoretical possibility that DCRs might contribute to emergencies by making users more inclined to risk using drugs that they know will be dangerous because they believe they will be safe within a DCR. Further careful evaluation of these issues is needed.

2 Transmission of blood-borne viruses

It is much easier to examine the impact of DCRs on self-reported needle and syringe sharing than it is to examine their impact on the transmission of blood-borne viruses. The Sydney MSIC evaluation found no impact on viral transmission, although this study was confounded by the Australian heroin drought, which had a marked effect on the entire drug scene throughout the duration of the evaluation.

The problems involved in establishing whether or not a project has had an impact on the transmission of viruses are considerable. The low incidence of blood-borne viruses means that it is very difficult to measure impact (MSIC Evaluation Committee, 2003) and the problem may therefore be primarily one of evaluation rather than programme failure: as the EMCDDA review concludes, 'it is likely that the direct and personalised safer use education in the setting of supervised consumption rooms contributes to a reduced risk of transmission of infectious diseases even outside the room' (Hedrich, 2004, p. 54). But this is very hard to show beyond doubt.

3 Other health problems, such as abscesses

As described above, DCRs frequently offer medical services on site and also refer users to off-site medical services. Given the large number of visits to DCRs, this can mean large numbers of treatments. The three Zurich consumption rooms delivered an annual average of 3,122 wound care services; for the Sydney MSIC, this figure was 847; and the DCR in Madrid provided medical services on an average of 3,902 occasions per year. The Sydney MSIC also referred clients to off-site health care services on 439 occasions over an 18-month period and health care referrals had the highest uptake rate.

As Hunt points out, 'given that many people who use DCRs are highly marginalized and with poor access to healthcare services, this evidence strongly suggests that DCRs fulfil an important function in providing primary health care … interventions to a very needy population' (Hunt, 2006b, p. 25).

4 Impact on drug use

As has been shown, DCRs provide psychosocial counselling on site and refer users to a range of agencies including treatment services. It could therefore be anticipated that DCRs might have a beneficial impact on drug use, both through referral to treatment and through impacting on some of the multiple social problems experienced by socially excluded users. Alternatively, it might be thought that the presence of a safe place to inject drugs might increase drug use.

A number of studies have examined this question and, as summed up by Hunt (2005b), most find a minority of people (up to 16 per cent) who report increased frequency of drug use since using the DCR and others who report decreased use (up to 22 per cent). With any population of drug users some will be increasing and

others will be decreasing their use and it seems likely that these findings may simply reflect the natural flux in patterns of use. A recent study of drug users in Vancouver found that the opening of the DCR was not associated with any measurable negative changes in injecting drug use. The only significant change was a reduction in the initiation of binge drug use following the introduction of the DCR (Kerr *et al.*, 2006).

In summary on health outcomes, it seems highly likely that DCRs prevent overdose deaths and allow earlier intervention in a substantial number of potentially fatal overdoses. The IWG attaches considerable importance to the following fact: **over the years, DCRs have supervised millions of injections of potentially dangerous illicit drugs, frequently involving users with serious health problems, and yet only one person has died.** It is difficult to measure the number of lives saved by an individual DCR and even harder to measure the impact of DCRs on drug-related deaths at the community level. However, the methodological problems involved here should not detract from DCRs' considerable success in preventing overdose.

DCRs are clearly successful in providing on-site medical care and referring users to off-site medical services. They are also likely to be having some impact on blood-borne viruses but this has not yet been shown. There is no convincing evidence that they impact on levels of drug use in either direction.

Impact on local communities

A central aim of DCRs is to reduce the amount of injecting that occurs in public places and to reduce the amount of associated, discarded injecting paraphernalia. However, as the EMCDDA (2005) review points out, plans to set up a DCR have often been met by resistance from local residents and businesses who fear

that it will attract more users to the area – and associated crime and drug dealing. What is the evidence on either side?

Reduction in public injecting

A range of evidence points to DCRs resulting in a decrease in injecting in public places (Hedrich, 2004). Interviews with DCR users in Rotterdam and Hamburg have shown that users report reduced rates of public drug use as a result of their attendance at the DCR. However, while DCR users may reduce their level of public injecting, many still continue to use in public. Research in Hamburg, which found that 37 per cent of respondents had used in public during the past 24 hours, identified withdrawal symptoms, in conjunction with long waiting times for access to the injecting room, distance from place of purchase and limited opening hours as the main reasons for so doing.

More convincing evidence of impact comes from Switzerland, where users of low-threshold drug services have been regularly surveyed in order to evaluate the Swiss AIDS prevention strategy (Hedrich, 2004). Survey data were collected from users in Biel and Geneva, before and after the introduction of DCRs. Before the introduction, 21 per cent and 18 per cent of users in Biel and Geneva respectively reported using mainly in public places. After the introduction of DCRs, these figures had fallen to a single individual in Biel and 10 per cent of users in Geneva. Forty-nine per cent of the users in Biel and 29 per cent of the users in Geneva referred to DCRs as their most frequent location for drug use.

The strongest evidence comes from the evaluation of the Vancouver project which involved an array of observational measures, including people seen injecting in public places. Comparing the six-week period before the establishment of the DCR with the 12-month period afterwards, there was a statistically

significant reduction in the number of users seen injecting in public places: from a daily average of 4.4 to a daily average of 2.4. This relationship held true when rainfall (which was expected to be associated with lower rates of outdoor drug use) and police presence were taken into account (Wood *et al.*, 2004).

Reduction in discarded syringes and drug-related litter

Until recently, research on discarded syringes and needles has proved largely equivocal. While, following the introduction of the DCR, a drop in discarded syringes was recorded in the area around the Sydney MSIC, it was unclear whether this could be attributed to the DCR or the decline in heroin availability. A slight increase in discarded syringes was recorded following the setting up of the DCR in Biel, despite a high return rate for needles and syringes given out. Researchers suggested that this might be due to an increase in cocaine use (and the associated increase in the frequency of injecting). Surveys of residents living near the Dutch DCR in Venlo showed a reduction in discarded syringes following implementation (Hedrich, 2004).

Again, the strongest evidence of the impact of DCRs on drug-related litter comes from the Vancouver study. Whereas a daily average of 11.5 discarded syringes were found before the opening of the DCR, this average figure dropped to 5.3 after its opening. Injection-related litter (syringe wrappers, syringe caps, sterile water containers and 'cookers') showed a drop in the average daily count from 601.7 to 305.3. Both these differences were statistically significant and independent of law enforcement activity and rainfall patterns.

Public nuisance: 'honeypot' effects, crime and dealing

As has already been described, research has found that the large majority of DCR users live locally, although the proportion of local

users will vary according to a number of factors: the DCR's policy; the local policing policy; the number of other DCRs in the locality; the location and nature of drug markets; and the availability of needle exchange, treatment and hostel facilities for users. As DCRs tend to be located near drug markets, their clientele is likely to reflect the profiles of users buying drugs in those local markets. In the case of a DCR where there is a large, local population of drug users (such as Vancouver), it should prove relatively straightforward to ensure, and to demonstrate, that the DCR has mainly provided a service to the local population of users. However, if a DCR is located close to a city drug market which is used by people migrating in from a wide area in order to buy their drugs (such as Frankfurt), a greater proportion of 'non-local' users is likely to be recorded. This does not mean that the DCR has necessarily attracted new users who otherwise would not have been in the area: many would have come in to buy their drugs in any case. In such circumstances, more sophisticated 'before and after' designs need to be used to evaluate the extent to which a DCR has acted as a magnet for users over and above the local drug market.

In considering the extent to which DCRs might act as a magnet to users who would otherwise not have been in the area, it is useful to consider the mindset of the average user. As the users who gave evidence to the IWG pointed out, an addicted injecting heroin user is likely to be primarily driven by the need to obtain their drugs. If they have the money, their first port of call will be a dealer. If there is somewhere nearby where they can safely use their drug (and obtain a clean syringe), then this is likely to be their next step. If they need to go any distance to reach such a place, their need to inject their drug is likely to lead to them using somewhere else (often a public area nearby). Consistent with this picture is the finding from a number of studies that DCRs located any distance from drug markets attract very few users (Hedrich, 2004). Thus, there appears little reason to assume that a DCR will act as a

magnet for users, drawing them in from other areas, so long as drug dealing is excluded from the premises and the immediate surrounding area. If a new drug market were to flourish around a DCR, this would be likely to draw in users who would otherwise have bought their drugs elsewhere.

However, there are two potential problems with this analysis. First, at the micro level, even if a new DCR does not lead to an increased number of users coming into an area from outside, it is likely to lead to changes in the flow of local users through the streets surrounding a DCR. The increased passage of users between the local market and DCR would mean greater exposure to drug users for some residents and businesses. Others (particularly those previously affected by injecting in public places) are likely to benefit. One way to prevent such problems is to set up DCRs within or alongside other drug services, such as syringe exchanges. In this situation, services are already attracting users and there is unlikely to be a significant net increase in local users.

Second, this analysis depends on market stability. Where markets are unstable, for whatever reason, users and dealers may shift location. This can lead to declining numbers using a DCR. These potential problems emphasise the need to undertake detailed monitoring and 'scoping' of local drug markets before siting a DCR and the need for good interagency working to ensure that problems can be responded to.

Some of these issues are borne out by the history of the first DCR in Hanover (Hedrich, 2004). This DCR was set up in 1997, one kilometre from the city centre drug market and 'open drug scene'. Three months into its operation the weekly number of injections had reached 300 but this figure fell sharply to 130 in the fifth month. Among the users' explanations for this fall was the distance from the drug market and police interventions on the route to the service. Changes in police practice were agreed (as well as some

amendments to procedures in the DCR) and this was followed by a return to the earlier levels of usage. At this point, there was no dealing occurring outside the facility and very little trouble between users and residents or the police. However, in subsequent years the police put increasing pressure on the local drug market, with the result that the area in front of the DCR became a new meeting place for users. By 2001, average weekly use had reached 800 and the relocated drug scene led to much more nuisance for people living in the local area.

There has been a strong focus on general drug-related nuisance in the Netherlands, where DCRs have been set up largely in response to such community concerns. Research has shown a positive impact, with the five studies comparing nuisance levels before and after implementation finding lower levels of reported nuisance after the DCRs were set up (Hedrich, 2004).

A study of all the consumption rooms operating in Germany found that the level of reported nuisance problems was related to the quality of co-operation between the police and drug services: where there was agreement about the need for DCRs and a shared understanding of their public health and public order functions, fewer public order problems occurred. In others such as Hanover, where this did not appear to be the case, problems did arise.

Recent evidence on the overall impact of a DCR on the local community comes from the evaluation of the Sydney MSIC, which included surveys of local public opinion. A recently published paper has compared the views of local people and businesses seven months before the DCR opened with those reported 17 months after it had opened. Results show that support for the MSIC increased significantly over this period and that residents' perceptions that DCRs attract drug users or make law enforcement difficult decreased significantly (Thein *et al.*, 2005).

One aspect of public nuisance not addressed in the literature is that of overdoses. Overdoses that take place in public places can be very upsetting for those directly and indirectly involved. As referenced in the last chapter, 12 of the sample of 100 in the research carried out for the IWG on the community impact of public injecting had witnessed incidents involving overdose or the collapse of users (Taylor *et al.*, 2006). Overdose deaths (whether or not they occur in public areas) are likely to become widely known about and can have a significant impact on the image a community has of itself. Thus, to the extent that DCRs prevent overdose incidents taking place, they may contribute to a community's sense of well-being. This issue is worthy of future research attention.

On the specific issues of crime and drug dealing, various studies have drawn on local police data to assess whether there is any impact of DCRs on acquisitive crime, including robbery. No impact on crime levels (in either direction) has been found. As DCRs do not seek to replace illicit drugs with prescribed drugs, this approach does not break the need for dependent drug users to commit crime in order to finance their drug use. However, 'integrated' DCRs, which directly or indirectly provide access to a range of other services such as treatment, housing and employment, may lead to a reduction in the need for illicit drugs and associated crime in individual cases.

A number of studies have reported some dealing in the immediate vicinity of DCRs. Because of the proximity of most DCRs to drug markets, it is hard to differentiate between dealing that would have occurred in the area in any case and dealing specifically associated with DCR users. Such problems can be addressed through DCR policies which prohibit dealing and 'loitering' near the premises and police action and surveillance to prevent users gathering in the immediate areas surrounding drug consumption rooms (Hedrich, 2004).

Conclusion on public harms

There is good evidence that DCRs can lead to a reduction in injecting in public places and some evidence that they can lead to a reduction in discarded syringes and drug-related litter. Crucial issues here are accessibility and opening times: the closer DCRs are to drug markets and the longer they are open, the greater their likely impact on public injecting.

Fears that large numbers of users might be attracted to DCRs who would not otherwise be in the area appear to be misplaced: the large majority of DCR clientele are local users. The degree to which a particular DCR attracts users from outside the immediate area is likely to reflect the nature of the local market. If the local drug market is used regularly by people outside the area, this will be reflected in the clientele of the DCR.

The degree of public nuisance experienced by local residents and businesses will depend on the dynamics of the local situation and is likely to vary over time. Research has also shown a key issue here to be the degree of co-operation and planning between local agencies. Variations in these local contexts have been associated with (often temporary) increases in DCR-related public nuisance in some areas but decreases in others.

While dealing has taken place in the vicinity of DCRs, this appears to be controllable through strict DCR rules and street policing. There is no evidence of either increases or decreases in crime consequent on DCR implementation, although this is unsurprising as DCRs do not provide prescription drugs and cannot therefore directly affect crime committed to obtain drugs. However, to the extent that DCRs are successful in providing access to structured treatment and other interventions aimed at social integration, they may have an indirect impact on crime levels.

How do they compare to other interventions and are they cost-effective?

Other interventions

The IWG is clear that DCRs need not only to be effective, but to be more effective than other similar interventions. This raises the question of which aspects of DCR provision are covered by other interventions. To the extent that DCRs provide clean injecting equipment, they serve a similar purpose to needle and syringe exchange programmes (NSPs). NSPs can also provide advice on safe injecting and thereby attempt to impact on users' health and overdose. In some cases, nursing staff also provide ancillary medical services such as immunisation against hepatitis B and wound care and may make onward referrals. Moreover, the client groups are broadly similar, with sizeable proportions of homeless and public drug users. However, the fact that in DCRs injections take place on site means that it can be virtually assured that injections take place comparatively safely (with sterile equipment and in less dangerous places on the body etc.). Supervised injecting also means that immediate intervention can be made in overdose incidents and the direct observation of injecting behaviour should result in more tailored, personalised advice on injecting. DCRs should also have a much greater potential to impact on public drug injecting and associated public nuisance by bringing injecting episodes inside the facility.

Outreach workers can also work with users to reduce the risks associated with their drug use, provide sterile injecting equipment and refer users on to other agencies but, as with the comparison with NSPs, by supervising injecting on site, DCRs are able to reduce risks in other ways. However, it should be noted that outreach workers would be able, potentially, to reach and work with those users not prepared to come into DCRs to inject. There may be, for example, a group of homeless users who do not want to

use in a DCR because they have been excluded from injecting there or simply because they do not want to. Outreach offers a method of reaching such a group.

Emergency services obviously respond to overdose incidents. However, there is always some delay, which can be critical, between recognition of an overdose incident and the arrival of trained staff. DCRs clearly offer the potential to respond more quickly to the overdose events that occur within them and, possibly, those taking place nearby.

From such considerations the IWG concludes that DCRs offer a number of services that cannot be delivered, or cannot be delivered as effectively, by other approaches.

Cost-effectiveness

Different operational models are likely to incur very different costs. Stand-alone demonstration projects seem most likely to be the most expensive models, whereas services integrated with other components of drug treatment seem likely to be cheaper.

The Sydney MSIC operating cost for one year was the equivalent of approximately £850,000 (MSIC Evaluation Committee, 2003, p. 214). The annual cost of the Canadian SIS trial was the equivalent of approximately £1,200,000, although this also includes the evaluation expenses (City of Vancouver Four Pillars Drug Strategy, 2003). However, these represent the very top end of the scale, being large, stand-alone demonstration projects. Cost data on European services, some of which operate on an integrated model, are not readily available. Nevertheless, the marginal costs of extending a service to include a supervised consumption facility must inevitably be much less than those arising from a specialised project such as the MSIC and SIS.

While it has been concluded from the research evidence that DCRs have an impact on a range of outcome measures, the size of this impact is much harder to ascertain. As a result, at this stage, it is impossible to say anything certain about cost-effectiveness. However, integrated DCRs that provide a service to large numbers of injecting drug users seem most likely to offer the best 'value for money', particularly in terms of overdoses avoided and the early treatment of injection-related infections.

Bringing together evidence of need and evidence of effectiveness

The IWG concludes that DCRs are effective in providing safe and clean injecting environments, advice on safer injecting and on-site medical and counselling interventions. Thereby, they have a significant impact on preventing the escalation of overdose incidents and there is convincing evidence that they prevent overdose deaths. They also contribute to the better health of users, provide opportunities to link with structured treatment and may well prevent the spread of blood-borne viruses. They clearly can reduce injecting in public places, discarded syringes and drug-related litter.

The IWG is mindful that all of these impacts depend crucially on precisely how DCRs are implemented. For example, DCRs are not likely to have an impact on public drug use if they are open for only a few hours a day. Likewise, evidence from Germany clearly shows that if a DCR is set up some distance from a local drug market, it is unlikely to attract many users and have much of an impact.

However, assuming DCRs were well designed and well implemented, would they have an impact on drug-related problems in the UK, as identified in Chapter 3? The IWG's response to this question is that they would almost certainly have an impact on some of these problems. The frequency of overdose, the prevalence of blood-borne viruses and other injection-related

infections, the amount of public injecting and the damage caused to communities in the UK would all be addressed, at least to some degree, by DCRs. While other already existent services also address some of these needs, it is clear that DCRs offer the unique potential to ensure safer, on-site injecting and thereby directly prevent health problems, overdose and drug-related nuisance.

The IWG considers that DCRs have a particular potential to impact on the serious health and social problems associated with two overlapping groups in the UK: homeless drug users and those that inject in public. The potential dividends in terms of reduced damage to communities, improved health and saved lives seem much greater for these groups. The possibility of designing DCRs that focus particularly on these groups is considered in Chapter 6. However, before turning to such issues, it is important to consider the social and legal obstacles that lie in the way of setting up DCRs in the UK.

5 Potential barriers and concerns

The IWG shares others' discomfort at the idea of letting people bring dangerous, controlled substances to a place where they are then allowed to inject them into their bodies. Such a scenario throws up a number of legal and ethical concerns: for example, would DCRs be against the law in this country? Would they contravene the United Nations Drug Conventions? Might they also serve to condone the use of controlled drugs? The IWG has also been aware that there are, undoubtedly, substantial political obstacles lying in the path of any experimentation with DCRs in the UK. It is a highly sensitive idea that is likely to cause alarm to many. Politicians may feel that it would be impossible to have a serious and open debate about this question, given previous media and public opposition to the idea of 'shooting galleries'. Such concerns were put forward by the Home Office in its evidence to the Home Affairs Select Committee (see Chapter 2). Finally, there are the local concerns. Could any local community be expected to host a new DCR with equanimity? While the international evidence reviewed in the last chapter may refute such views, there will inevitably be deep suspicions that a DCR will attract even more dealers and users to a local area.

This chapter explores these barriers and concerns, with separate sections below focusing on the legal, ethical, political and local barriers to the establishment of DCRs.

Legal barriers

Two papers have been commissioned which have greatly informed the IWG's consideration of the legal issues (Fortson, 2006a; 2006b). Readers are referred to these papers for a fuller account of the complexities in this area.

There are two key aspects to legal questions concerning DCRs: first, whether DCRs breach the three United Nations Drug Conventions; and, second, whether operating a DCR would put individuals at risk of prosecution under United Kingdom law.

The UN Conventions

There are three United Nations Conventions dating from 1961, 1971 and 1988 and the UK is a signatory to all three. These Conventions provide the framework for international co-operation in the drugs field. Their main focus is on drug production and trafficking but sections are included which focus on possession. The 1961 Convention (to which a protocol was added in 1972) was introduced, in part, to unify and simplify the nine international agreements that were already in place but also to extend existing controls to drug cultivation (Jamieson, 2001). Its main aim was to ensure that 'narcotics' could only be produced and supplied for medical and scientific purposes. However, it also required states to make the possession and purchase of narcotic drugs 'punishable' offences when committed intentionally (although there has been doubt over whether these measures were intended to cover possession *for personal use:* Independent Inquiry into the Misuse of Drugs Act, 2000). The 1972 protocol to the 1961 Convention strengthened controls over production and trafficking and emphasised treatment and rehabilitation as alternatives (or additions) to punishment (Jamieson, 2001; Fortson, 2006b). This latter emphasis was also reflected in the general provision within the 1961 Convention that 'parties' or signatories 'shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved' (Article 38, para. 1, p. 19). As Fortson (2006b) points out, the Conventions are not just about *control*, they also exhort signatories to *rehabilitate* and *reintegrate* drug users. The

1961 Convention also paved the way for the establishment of the International Narcotics Control Board (INCB), the watchdog responsible for monitoring compliance with the Conventions, which was then set up in 1968.

The 1971 Convention was a response to the increased use of drugs not covered in the earlier Convention, such as various stimulants, sedatives and hallucinogens, and imposed restrictions on these drugs similar to those introduced in the 1961 Convention.

The 1988 Convention sought to clarify some of the ambiguities in the earlier Conventions and to strengthen and supplement them principally in the context of illicit trafficking of scheduled substances. Most importantly in the present context, it specified that the possession, purchase or cultivation of illicit drugs *for personal consumption* should be criminal offences when committed intentionally. However, again, measures such as treatment, education, aftercare, rehabilitation and social integration may be substituted for (or added to) conviction and punishment (Jamieson, 2001). The welfare and rehabilitation of users is also emphasised elsewhere, with signatories being exhorted to 'adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs … with a view to reducing human suffering and eliminating financial incentives for illicit traffic' (Article 14, para. 4, p. 14). Furthermore, the UN's own legal advisers on the Conventions have pointed out in an unpublished paper that the 1988 Convention authorises signatories to base demand reduction measures on the recommendations of the United Nations. The resolution relating to demand reduction[1] is therefore relevant (UNDCP Legal Affairs Section, 2002). This resolution pledged 'a sustained political, social, health and educational commitment to investing in demand reduction programmes that will contribute towards reducing public health problems, improving individual health and well-being, promoting social and economic integration' (UNDCP Legal Affairs Section, 2002, p. 8).

There are therefore two themes running through the UN Conventions: on the one hand, there is a strong emphasis on controlling the production, distribution and possession of drugs, which has been the focus of most commentators. On the other, there is a clear and repeated emphasis on the rehabilitation and integration of drug users and, indeed, on the general health and welfare of all people (Fortson, 2006b). Given this second aim, there is latitude within the Conventions for the introduction of harm reduction measures that aim to improve the health of users and contribute to their welfare, rehabilitation and reintegration (Fortson, 2006a).

Turning specifically to the question of DCRs, in 2002 the Legal Affairs Section of the United Nations Drug Control Programme (now the United Nations Office on Drugs and Crime) produced an opinion for the INCB on the flexibility of the Conventions with regard to harm reduction approaches (UNDCP Legal Affairs Section, 2002). The question of whether or not DCRs contravene the Conventions was specifically considered in this paper:

> It might be claimed that this approach *[DCRs]* 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 *[such as HIV and hepatitis]* should perhaps be considered as treatment.
> (UNDCP Legal Affairs Section, 2002, p. 5)

The paper goes on to consider whether DCRs might be said to incite or induce the illicit use of drugs or aid, abet or facilitate the

possession of drugs, contrary to the Conventions. It points out that these matters could only count as criminal offences 'when committed intentionally' and contends that it is hard to assert that DCRs intentionally incite or induce illicit drug use or that they facilitate possession:

> On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug abusers, thereby reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counselling and other therapeutic options. (UNDCP Legal Affairs Section, 2002, paras. 27 and 28)

Thus the UN's own legal experts on the Conventions have concluded that DCRs do not necessarily contravene them. But this is manifestly not the view of the organisation for which this legal opinion was prepared: the INCB. As stated in Chapter 2, each year in its report summarising the world situation with regard to treaty compliance, the INCB expresses its belief that DCRs are contrary to the Conventions. The grounds for this view have varied a little over the years: in the 1999 report the primary view expressed was that DCRs facilitate drug trafficking (INCB, 2000, p. 26). In the 2000 report the main reference was to DCRs breaching the principle that drugs should be used solely for medical and scientific purposes (INCB, 2001, p. 66). In the 2002 report there was concern about 'aiding and abetting drug abuse (and possibly illicit drug trafficking)' (INCB, 2003, p. 70). By the 2003 report, there was a more measured appraisal, including the observation that the German DCRs were 'perceived as a success by a large part of the local authorities and the local population' (INCB, 2004, p. 78). However, the report went on to assert that there was little evidence that DCRs ensured that users underwent treatment or reduced drug-related deaths. Moreover, in that they allowed the abuse of illicit drugs, they were contrary to the Conventions (INCB, 2004, p. 78). The 2004 report (INCB, 2005) recognised that the

establishment of DCRs is a contentious issue and that some argue that they have positive effects. However, the INCB 'reiterates that drug injection rooms are against the central principle embodied in the international drug control treaties, namely that the use of drugs should be limited to medical and scientific purposes only' (INCB, 2005, p. 77). Finally, the 2005 report reiterates the INCB position that DCRs contravene 'the major principle of the treaties, namely that the use of drugs should be limited to medical and scientific purposes' and 'deeply regrets' the opening of the DCR in Norway (INCB, 2006, p. 84).

There is therefore considerable disagreement between the UN's legal experts and the INCB on these issues. What is clear from any reading of the 1988 Convention is that the unauthorised possession of controlled drugs for personal consumption should be a criminal offence under a signatory's domestic law when committed intentionally. However, beyond this, as Jamieson (2001) has pointed out, there appears to be 'considerable room for manoeuvre'.

Turning from the question of possession to the potential role of the DCR in 'publicly inciting or inducing others … to use narcotic drugs or psychotropic substances illicitly' and 'facilitating' the commission of a drug offence (Article 3, paragraphs (c) iii and iv), the Legal Affairs Section's arguments seem convincing with regard to inciting or inducing: it is hard to see how a DCR could be shown to do these things intentionally. While DCRs expressly aim to *facilitate* safe injecting, it is not their purpose to facilitate unlawful, unauthorised possession for personal consumption.

Perhaps a stronger argument of the INCB is that DCRs are contrary to the Conventions because they appear to run against the 'central principle' that 'the use of drugs should be limited to medical and scientific purposes only'. This phraseology appeared in the 1961 and 1971 Conventions but not the 1988 Convention.

The relevant paragraph of the 1961 document reads:

> A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the … possession or use of any such *[Schedule IV[2]]* drug except for amounts which may be necessary for medical and scientific research only, including clinical trials …
> (Article 2, para. 5(b))

The Official Commentary on the 1961 Convention makes it clear that this paragraph was introduced as a compromise, leaving the question of prohibition to the judgement of each party (see Fortson, 2006b). Furthermore, whether or not 'possession' as defined in the 1961 and 1971 documents referred to personal use as opposed to possession in the context of trafficking offences has been much contested (Jamieson, 2001). The 1988 document sought to clarify these issues and it did so without explicit reference to scientific or medical use (although it did reaffirm 'the guiding principles of existing treaties … and the system of control which they embody' (p. 1)).

Literal interpretations of the Conventions are difficult: there is, inevitably, a considerable degree of ambiguity conferred by the three historical layers of the Conventions and the many paragraphs relating to the same issues. The INCB's plea that DCRs are contrary to the Conventions might best be understood as implying that they are at odds with the *spirit* of the Conventions: in their own words, that the restriction of the use of controlled drugs is the 'central principle' (INCB, 2005). However, it could also be argued that *the* central aim of the Conventions is to bring about international co-operation on drug trafficking. Beyond this, there are many subsidiary aims and emphases, some of which seem to conflict.

As Fortson points out, 'Conventions, in common with many formal documents, need to be given a purposive interpretation' (Fortson, 2006b, p. 4). It is equally clear that different commentators will give different interpretations. The Conventions do not seem to represent an insuperable obstacle to the implementation of DCRs: 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 attests to this. An important question is therefore how other countries have rationalised the introduction of DCRs with their status as signatories to the UN Conventions.

Switzerland

In Switzerland, the Swiss Federal Office for Public Health commissioned two key legal analyses (Hedrich, 2004). The first of these, published in 1989 following the setting up of the first DCR, focused on the status of DCRs within national legislation. The second, which was not produced until 2000, focused on international law and the drug Conventions in particular. By this point, DCRs had been operating in Swizerland for 12 years. This paper[3] states that:

> No guidance at all is provided *[in the Conventions]* to the persons who must decide whether or not state-controlled public injection rooms are conducive to the rehabilitation and social reintegration of addicts, to the reduction of human suffering and to the elimination of financial incentives for illicit traffic. This is indeed not a legal question at all, in the sense that medical experts, social workers and health policy makers are much better equipped than lawyers to provide reliable responses.

The Swiss position therefore appears to be that because the Conventions do not provide explicit guidance on the question of DCRs, governments need to decide for themselves whether DCRs

would contribute to UN goals, such as reducing human suffering and trafficking.

Germany

In 1993 an analysis of the same question was undertaken by the Chief Public Prosecutor in Frankfurt (Körner, 1993, referenced in Hedrich, 2004). The conclusion was 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.

Since this time, federal legislation has been introduced which explicitly enables cities to apply to set up DCRs.

Canada

The main law governing drugs in Canada, the Controlled Drugs and Substances Act 1996, allows for exemptions from the Act if, in the opinion of a minister, 'the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest' (Fortson, 2006b, p. 2). In 2003, the Canadian health minister granted such an exemption for the establishment of a *pilot research project*, and therefore necessary for a 'scientific purpose'. As Fortson (2006b) points out, the Canadian Government therefore believes that it has complied with the Conventions: the operation of evaluated pilot DCRs effectively restricting use to scientific purposes.

Australia

In Australia, the Drugs Misuse and Trafficking Act 1985 was temporarily amended to enable the MSIC project to be piloted. Under this legislation, a DCR has to be licensed and the granting of that license is subject to a number of restrictions and conditions (such as proximity of the premises to a school). Sections 36O and 36P provide exemption from criminal and civil liability for acts

carried out in good faith and without recklessness or gross negligence. Section 36N enables users to be in possession of drugs in the licensed DCR.

Conclusion

The IWG concludes that well-run DCRs would not act contrary to the primary objects of the three United Nations Conventions. The extent to which DCRs might contribute towards meeting some of the Conventions' objectives concerning user welfare, rehabilitation and reintegration would depend on the extent to which other services were provided and referrals made. An 'integrated' model of DCR provision, which includes a range of health, treatment and social integration services, would seem to be most Convention compliant.

Signatory states have employed various techniques and arguments to rationalise the introduction of DCRs with their status as signatories to the Conventions. The danger here is that the operation and implementation of DCRs can be compromised by shoehorning them into the perceived (but we think misconceived) Convention-compliant construction of the relevant provisions. In any event, the IWG finds it unacceptable that a restrictive construction of the Conventions that places undue emphasis on scientific and medical use should result in countries setting up DCRs as perpetual experiments. In this context, the IWG emphasises that the Conventions were drawn up at a time when there was little or no awareness of harm reduction interventions such as DCRs. As a result, there is no clear guidance on the question of DCRs (De Ruyver *et al.*, 2002). There seems little point in repeatedly analysing these texts for indications and suggestions that might apply to DCRs: indeed, there is a sufficient lack of clarity to allow any commentator to reach the conclusion that they wished to reach at the outset. Given this, the IWG concludes that the Conventions should be interpreted as offering general guidance rather than specific precepts in this area, of which the need to

prevent trafficking and contribute towards the rehabilitation and social reintegration of users seems most pertinent.

Other international agreements

Fortson (2006b) has considered the argument that various international agreements, and in particular the European Convention on Human Rights (ECHR) enacted in the UK through the Human Rights Act 1998, might actually make the Government duty-bound to set up DCRs. However, the IWG accepts his view that this is unlikely to be an argument that would find favour in a United Kingdom court. Nevertheless, the emphasis in documents such as the ECHR and the UN's Declaration of Human Rights on the *dignity* of 'the human family' and the *right to life* do have a strong resonance in the context of DCRs.

Domestic legal obstacles

Fortson (2006b) explains how those who run and those who use in DCRs could be liable to a number of criminal and civil actions. A significant number of these stem from the Misuse of Drugs Act 1971 (henceforth the MDA).

The MDA

The following sections have relevance for DCRs (Fortson, 2006b):

- *Production and preparation:* Section 8 of the MDA prohibits managers and occupiers of premises from 'permitting or suffering' the production of controlled drugs in contravention of section 4(1) of the MDA. The preparation of a drug may or may not constitute 'production' under the MDA.

- *Unlawful possession and consumption:* Users are clearly in possession of whatever drugs they bring to a DCR and have therefore committed an offence. It is also likely that at various

points a member of staff in a DCR would come into possession of a controlled drug: for example, by finding a controlled drug that has been left behind (as happened in the Sydney MSIC: van Beek, 2004). With regard to project managers, following the Government's decision to repeal an amending provision to section 8(d) of the MDA, it only remains an offence for an occupier or manager of premises to 'knowingly permit or suffer' the smoking of cannabis or 'prepared opium' on the premises. Thus staff could not be charged under section 8 for permitting the use of heroin or cocaine on the premises.

- *Supply:* Any user who shares drugs with another user will have committed an offence of supply under section 4. If user A asks user B to inject him/her with heroin, then B is guilty of supplying the drug (subject to the case of *Harris* [1968] 1 W.L.R. 769). Such an act is also an offence under section 23 of the Offences Against the Person Act 1861, because heroin has been held to be a 'noxious thing'. Managers and 'occupiers' of DCRs would be committing an offence under section 8 if they were to 'knowingly permit or suffer' the supply or attempted supply of a controlled drug in contravention of section 4.

- *Paraphernalia:* Workers in DCRs would be restricted in the type of paraphernalia that they could legally provide to users. If they were to provide sterile cookers, razor blades, plastic film, aluminium foil or tourniquets they could be in breach of section 9A. It is unclear how many prosecutions have been brought under this section but the possibility of prosecution would remain.

The Offences Against the Person Act

Anyone injecting someone else with heroin (whether or not they have requested them to do so) is guilty of administering 'a noxious thing', contrary to section 23 of the Offences Against the Person Act 1861. There is doubt about the degree to which someone less

directly helping a user to inject might also be liable and this is an area that would benefit from clarification (Omerod and Fortson, 2005).

Manslaughter

If a person directly injects another with heroin unlawfully in a DCR and death of the latter results, the injector may be guilty of manslaughter. Moreover, a person may also be liable for manslaughter if they assisted another in the injection process. This is a complex area of law and one which is likely to be considered by the House of Lords in 2006 (Ormerod and Fortson, 2005). There is the potential for DCR employees to be charged with manslaughter if they act in circumstances that constitute assisting another in an unlawful injection process and death from heroin intoxication results. Prosecution in such a case may well not be brought on public interest grounds but a civil action might be mounted if there were evidence of negligence.

Negligence and civil action

Those running DCRs would be subject to the legal obligations, duties and requirements that affect other service providers. They would need to meet health and safety requirements and attempt to protect their employees from injury (particularly pertinent, given the potential for needlestick injuries). They might also be liable to civil action where things went wrong, e.g. when a user died or where a member of staff was injured in negligent circumstances.

Anti-social Behaviour Act 2003

If there were reasonable grounds to suspect that conduct in a DCR was causing serious nuisance or disorder, they could be closed down under the Closure Order procedure in the Anti-social Behaviour Act 2003. Closure proceedings are brought by the police, rather than civilians.

Implications and conclusions

There are therefore a number of potential legal obstacles to the establishment of a DCR in the UK. Some of these could be addressed through properly enforced rules, similar to those instituted in DCRs abroad. Such rules would need to prevent the sharing (and thereby 'supply') of drugs among users and users injecting each other. They would also need to carefully define and limit the level and nature of help offered to injectors by staff (including the provision of paraphernalia). Rules would need to carefully govern the safe disposal of needles, to prevent injury to staff or users, and the action that should be taken if suspected drugs are left behind by users. Clear procedures would need to be set out for responding to overdose incidents. Lastly, nuisance and disorder would need to be carefully controlled.

Ideally, were pilot DCRs to be set up, this would be with the approval and support of the Government. This would mean that a standard set of rules and minimum standards could be instituted and enforced. It would also mean that, at some stage, DCRs could be given statutory protection though primary legislation or by way of a combination of primary and secondary legislation. Were there not the political will in the UK to introduce primary legislation, it would be possible to modify the reach of the Misuse of Drugs Act 1971 by secondary legislation in order to provide a significant degree of protection from prosecution under this Act.

However, while such legislative change would provide a very safe basis for piloting DCRs in the UK, the IWG is not persuaded that this would be a necessary and unavoidable first step. Pilot DCRs could be set up with clear and stringent rules and procedures that were shared with – and agreed by – the local police (and crime and disorder partnerships), the Crown Prosecution Service (CPS), the Strategic Health Authority and the local authority. An 'accord' might be established that action would not be taken against the DCR, its

staff and, in normal circumstances, its users. The local police and CPS would need to agree that they would not charge users for possession offences within the DCR or on their way to the DCR. Of course, they would arrest users suspected of other offences in the usual way. Such local agreements have allowed DCRs to be set up in Frankfurt.

There are potential problems and risks associated with such an approach. The accord would be agreed between the particular individuals managing the local agencies at that time. A change of senior staff could lead to its collapse. There is also nothing to prevent local citizens or businesses from initiating a private prosecution. However, provided DCRs institute the type of rules referred to above and are properly insured, the IWG is of the view that risks and problems can be kept within acceptable limits.

Were the Government to withhold its support from the piloting of DCRs, the IWG does not think that this should preclude the development of such projects locally. Again, local agencies would need to work together and draw up an accord which defined their different roles. The potential for police forces to trial approaches at a local level that are not sanctioned by government is exemplified by the Lambeth cannabis policing pilot, where a senior police officer introduced a system of formal street warnings for cannabis possession offences in South London. The IWG sees no compelling reason why such an approach could not be taken with a DCR, although it would require the sustained commitment of a number of senior individuals across the key agencies. IWG members visited a number of projects on the continent where this type of ongoing, close liaison between the key agencies had been achieved through regular interagency meetings.

Ethical concerns

A likely concern for many is that the setting up of DCRs would condone the use of drugs in a more general sense. An important function of the law and of official policy is their symbolic value: they make a statement about what is acceptable and what is not acceptable in society. Should the state officially sanction DCRs, the Government's broader, and currently strong, opposition to Class A drugs could be eroded and this might have a knock-on effect on people's propensity to use Class A drugs. It might also be claimed that such a policy change would signal a general 'soft on drugs' approach which might encourage young people to experiment with drugs. This concern is echoed in the debate about the classification of cannabis: where there have been fears that the reclassification of cannabis from Class B to Class C 'sent the wrong message' to young people.

At this point, it is impossible to either verify or disprove such views: DCRs have not been introduced in the UK and evaluations in other countries have not attempted to address the question of the impact of such developments on broader drug-related attitudes and use. The IWG considers it unlikely that such an approach with dependent, injecting drug users will have a significant impact on the drug use of young people, who tend to have very negative attitudes towards such users (Fountain *et al.*, 1999). However, the best way to address this issue would be to include questions about the broader impact on attitudes and use in an evaluation of pilot projects. Community surveying could include samples of young people, to see whether there appeared to be any impact of a DCR in their locality.

Other concerns may revolve around DCRs acting as a 'Trojan Horse', allowing a legalising agenda to be smuggled into the drug policy fortress. This has certainly not been an aim of the IWG and it seems perfectly possible, as the last two decades have shown, for

the Government to develop harm reduction approaches within a broadly prohibitionist approach to controlled drugs.

More specific dilemmas are associated with the potential for DCRs to encourage drug injecting as opposed to other modes of use or encourage users to take greater risks. Our consultation with drug users provided the IWG with a difficult possible scenario: if one member of a couple usually injects and the other usually inhales, and if they usually purchase and use their drugs together, might the drug inhaler be tempted into injecting by visiting an injection-only DCR with his/her partner? There is at least a theoretical possibility that this could occur but it is unclear how common it would be for such a situation to arise. Other users involved in the consultation felt that this would be very rare indeed. Again, this issue would best be addressed through pre-piloting questionnaires, which would be able to assess the likelihood of such situations arising, and then careful evaluation of the operation of pilot projects.[4]

It would also, similarly, be hard to identify whether DCRs were encouraging non-injectors to inject for the first time. This issue has been addressed in some of the evaluation evidence and it appears rare for such circumstances to arise (Hedrich, 2004). A number of considerations are relevant here. On the one hand, it is plausible that users may wish to hide the fact that they were injecting a drug for the first time, making the research evidence somewhat questionable. However, on the other, there is evidence to suggest that injecting initiates are most often introduced into injecting by another user (Stenbacka, 1989; Crofts *et al.*, 1996; Hunt *et al.*, 1998). This would not be allowed in the large majority of DCRs and, given the technical difficulty of the task, it seems unlikely that a user would attempt their first injection without any assistance from others.

DCRs might also provide a false sense of security, encouraging users to try more risky amounts of a drug, more risky preparations (such as crushed tablets) or more risky drug combinations. Again, this would need to be a subject for evaluation, so far as such trends in use could be ascertained. However, the IWG considers the fact that only one person has been reported to have died in a DCR to point to either the low prevalence of such drug use behaviours or the success of DCRs in preventing deaths occurring when these behaviours did take place.

Finally, whatever the rarity of deaths in DCRs, there is still the possibility that a death will occur. If a user were to die in a UK DCR, could it sensibly be claimed that this policy had effectively allowed, or even aided, someone to take their own life? The legal position in this regard has been referred to above but people might well see this as an ethical issue. The IWG views the main consideration here to be that, provided proper procedures were in place and followed, it is highly likely that this user would have died wherever they were injecting. It is clear that, overall, DCRs make a considerable contribution to the *survival* of users.

Political concerns

When the Government last considered a recommendation to pilot DCRs, from the Home Affairs Select Committee, it voiced a number of concerns which were listed earlier in the report. Now that the evidence has been reviewed in the subsequent chapters, these issues are revisited:

- National and international legal issues: DCRs would 'contravene or undermine UN conventions or the Misuse of Drugs Act'.

As has been concluded above, the United Nations Drug Conventions do not provide clear guidance on whether DCRs are incompatible with UK treaty obligations. DCRs certainly contribute to some of the aims of the Conventions and may fall foul of others, depending on interpretation. The fact that eight signatories to the Conventions[5] have introduced DCRs, on a number of different grounds, testifies to the range of interpretations that are possible.

With regard to the Misuse of Drugs Act, as stated above, the IWG concludes that many of the potential contraventions could be sensibly addressed through a set of clear and well-enforced rules. However, the offence of possessing a Class A drug would inevitably occur within a DCR. The IWG believes that this issue could be dealt with through an accord agreed between the key local agencies, including the local police and branch of the CPS. This accord would ensure that, in normal circumstances, the local police would not charge users for possession offences within the DCR or on their way to the DCR.

- 'The Government could be accused by the media and others of opening "drug dens".'

The IWG accepts that some local and national media are likely to be critical of the idea and would attack the Government were it to support the introduction of DCRs. However, all drug policies are, quite rightly, contested by different groups and different commentators. The IWG considers the standard of media debate on drug policy issues to have improved over the past five years: while many will fundamentally disagree with the idea of DCRs, it is to be hoped that commentators will employ argument rather than invective. The IWG is keen to see a serious and well-contested public debate on the DCR question.

- 'No guarantee that public or political tolerance will be the same as Switzerland.'

The IWG accepts that one could not expect the same sort of response to the idea in the UK as that experienced in Switzerland. However, the IWG does not see any reason to expect that reactions in the UK would necessarily be more hostile than those experienced in Germany, Norway or Australia, countries that have introduced DCRs but which are not particularly associated with tolerant attitudes towards controlled drugs.

- 'Will directly increase health service costs as they would be a new service provision requiring additional capital and revenue costs.'

The cost of DCRs will depend on where and how they are implemented. If, as is discussed in the next chapter, they are introduced as adjuncts to current drug services, the marginal costs will be quite low. Moreover, one of the key arguments for piloting DCRs is the opportunity this would provide for a rigorous analysis of cost-effectiveness.

- 'Still leave the possibility of unsafe injecting during the hours they are closed.'

The degree to which DCRs are able to 'capture' unsafe injecting in a local area is a key measure of their success. Opening hours and location are important features likely to govern accessibility and use. The need to work with other agencies and services is also important in this context. IWG members found from their visits to DCRs abroad that, where there were more than one DCR in a city, projects were able to stagger their opening times and persuade users to move on to another DCR or a hostel at closing time.

- 'There may be problems in some areas on occasion with drug dealers congregating near to venues, leading to reduced local tolerance for the presence of injecting rooms in their neighbourhood.'

- 'Likely to raise the issue of policing low-level dealing in the vicinity of injecting rooms.'

These are, undoubtedly, potential problems but ones that have been successfully dealt with elsewhere through close partnership with the local police, who are encouraged to crack down on anyone suspected of dealing within a certain radius of a DCR. Differentiating between dealers and users is not a straightforward process, as recent research has shown (May *et al.*, 2005). Many dealers also use drugs and users often buy drugs together and share their drugs (which technically involves the 'supply' of drugs). However, in projects abroad, users in general are discouraged from 'hanging around' in the immediate neighbourhood and this is usually enforced by the local police.

- Could lead to damaging confusion between DCRs and heroin prescription.

As outlined in the Introduction, DCRs are clearly differentiated from heroin prescription in terms of both their operation and their target group. The IWG is fully supportive of the heroin prescription trial but emphasises that the chaotic, excluded users targeted by DCRs represent a very different group from the relatively stable, entrenched, long-term users enrolled on heroin prescription programmes.[6]

- '… we have no evaluations of those developed in other European countries.' There is a lack of evidence on 'the impact of such facilities on local communities'.

As we have seen, there are now a considerable number of evaluations from Europe, Australia and Canada. Many of these studies do address the question of impact on local communities and this has been given close attention by the IWG. As Hedrich (2004) concludes, the evidence shows that 'when managed in

consultation with local authorities and police, they do not increase public order problems by increasing local drug scenes or attracting drug users and dealers from other areas' (Hedrich, 2004, p. 83). However, where interagency working is poor, problems can occur. The most robust evaluation of the impact of a DCR on local residents and businesses at an aggregate level showed increasing support for the DCR and decreasing concern about attracting drug users from outside the area, when community views were compared before and after the DCR's implementation (Thein *et al.*, 2005). Moreover, if introduced as extensions to already existing, needle-exchange facilities (see next chapter), the impact on local communities may be kept to a minimum.

None of these concerns therefore seem to be insurmountable. A political decision to support the introduction of DCRs would undoubtedly attract opprobrium from some but, if the Government accepts the potential for DCRs to decrease the damage caused to individuals and communities by injecting drug use, politicians may have to grasp the nettle.

Local concerns

If DCRs were to be piloted in the UK, there may well be considerable local opposition to the idea. By providing something that users want, the fear is that a DCR would act as a magnet, drawing in users from other parts of the city or other areas of the country. This issue has been discussed at some length in the last chapter. As was concluded there, experience abroad has shown DCRs to be used largely by local users. The degree to which users from outside an area visit a particular DCR is likely to relate to the nature of the local drug market: if users from a wide area 'commute' in to buy their drugs, this will be reflected in a DCR's clientele. However, users are unlikely to travel any distance specifically to use a DCR, their primary motivation being to buy and use their drugs as quickly as possible.

It should be emphasised that many of the communities which might be targeted for a DCR already suffer significantly from drug-related nuisance, as the research undertaken by Taylor *et al.* (2006) showed. The IWG considers that a well-designed and implemented DCR offers the potential to *lessen* the overall impact of drug use on a community and whether or not this is the case would be one of the primary questions for an evaluated pilot. Great care would have to be taken in positioning a pilot DCR, involving careful mapping of the flows of drug users through a particular area. It seems to the IWG that the most acceptable place for a DCR is a harm reduction facility, such as a needle exchange, that already provides services for injecting drug users, thus limiting the additional impact on the local community.

Conclusion

The IWG is clear that the UN Conventions are not a significant block to the implementation of DCRs in the UK. DCRs would contribute towards many of the aims contained within the Conventions. Moreover, the relevance of the Conventions to modern harm reduction measures is highly questionable. United Kingdom law also does not appear to present an insurmountable obstacle. Provided a clear set of properly enforced rules are instituted and local accords are forged between the key agencies, the IWG concludes that DCRs could be piloted within the UK without legislative change. Risks would remain but the IWG has concluded that the potential benefits substantially outweigh these risks. At some stage in the future, should DCRs prove their worth, it would be important to introduce primary and/or secondary legislation in order to fully protect those involved in the management of the premises and those using drugs within them.

Many of the ethical concerns surrounding DCRs are best tested through a rigorous evaluation of trial projects. Others may simply

need to be discussed as part of the wider public debate on the worth of this idea, which the IWG hopes will follow publication of its report.

Political fears are perhaps the most important obstacle to the piloting of DCRs in the UK. The IWG is clear that the evaluation evidence warrants experimentation with this approach but it also recognises that policy has never been solely evidence-based. Supporting DCR pilots would undeniably represent a political risk but one that should ultimately yield benefits for users and communities. While the concerns voiced by the Home Office to the Home Affairs Select Committee represented significant issues, the IWG does not regard any of them as intractable problems.

6 UK pilots

This chapter looks at the operation of DCRs in more detail and draws some conclusions on what pilot DCRs might look like in the UK. It is divided into three sections. The first identifies three DCR models and a number of key domains in which they differ. The second considers which approaches might apply best to the British situation and how they might be implemented as pilot projects in this country. The final section focuses on the need for evaluation.

DCR models

Hunt (2006c) provides a good overview of the history, objectives and procedures associated with DCRs in seven of the eight countries which host them.[1] The purpose of this section is to explore in more detail how DCRs differ in terms of their aims, design and operation. In order to do this, three variants in DCR design and delivery are described which draw on both the IWG members' visits to various DCRs and the published literature. These are anonymised, composite projects which are not based on any one DCR and are offered as examples which bring out the main variations between projects.

Model 1

This DCR was set up in response to both health and public order concerns surrounding injecting drug use. It has one large injecting room and no smoking room. Around 300 people inject drugs at the project each day. On entering, there is a large room, with a number of chairs and a desk at which users register. Users are asked what drugs they plan to use and are asked to show their drugs to the workers at the registration desk. If there is a place free in the injecting room, a standard set of drug-injecting paraphernalia is handed to them from the registration desk. If the injecting room is full, users have to wait before picking up their paraphernalia and entering the room.

On going into the injecting room, users are shown to one of ten cubicles or booths, running along the length of one wall. Each contains a stainless steel surface fixed to the wall, a chair and a mirror covering the wall above the level of the stainless steel surface. These booths resemble a line of

Continued

toilet cubicles that have no doors. The users are therefore visible from behind as they use their drugs and a project worker is stationed in a position which gives the best view of the users in these cubicles.

On leaving the injecting booth, users go into a room with comfortable chairs, where they are encouraged to spend a short while before leaving the project. However, this room does not have the ambience of the 'living room' described in model 2. Users are not encouraged to stay for very long periods unless they appear to be heavily intoxicated. While some users are well known to project staff, others are infrequent visitors and there is not, therefore, the same type of contact between staff and users.

Because of the focus on injecting, and the sheer number of users, emergencies are common: on average, once in every 300–500 injections, making it an almost daily event. Members of staff are all trained to deal with such emergencies. Equipment for assisting breathing, including oxygen, is close at hand. Naloxone can also be administered by trained staff, although this is rarely needed.

Rules are kept to a bare minimum. Users are asked not to share out their drugs on the premises but doing so does not necessarily result in exclusion. Users are allowed to inject in their neck or groin but staff work with users to prevent this. Those receiving a prescription for methadone are allowed to use the project; under 18s and heavily intoxicated users are not. Any violence is taken very seriously and the majority of exclusions are for fighting. However, every effort is made to try to include users wherever possible, recognising that the most difficult people are often those most at risk of overdose.

There is good interagency working around drug-related issues in this city. The relationship with local businesses (there are no local residents) is managed through regular local meetings.

Model 2

This DCR has been set up primarily to reduce the local public nuisance associated with homeless dependent drug users. It works with a group of 35 local, highly marginalised, homeless drug users. Only members of this group are allowed to use the facilities, which include a smoking room, where heroin and cocaine are smoked, but no injecting room. Injecting drug use is comparatively rare in this city.

The project is based around a central, 'living room' area, where there is a café serving hot drinks and food and an extensive seating area with a television. The room is warm and clearly designed to provide an attractive place for homeless users to spend time off the streets.

Continued overleaf

When users wish to use their drugs, they go down a staircase to another part of the project where the drug consumption room is located. On entry, they come to a small office, where project staff ask to see their drugs and provide them with any sterile paraphernalia that they may need. Provided there is space, users are then allowed to enter the consumption room, which has large, internal windows in it, allowing a clear view from the small office. The consumption room is quite small (approximately five metres square) and there are two wooden tables and numerous chairs in the room. There are posters on the wall and an informal ambience. There are two plastic containers positioned at each end of the room for discarded paraphernalia and litter.

The consumption room tends to be busy, with between five and ten people smoking crack cocaine in pipes or 'chasing' heroin on strips of tinfoil. Sometimes at the weekend, as many as 25 people share this room and there is standing room only. Users are free to go to and fro between the living room area and the consumption room.

Project workers are on good terms with the users, seeming to know most of them well. This reflects the limited number of people using the project. Users have to have a pass before they are allowed to use the project. Only users known by project staff, the police and other agencies to be homeless and causing nuisance on the streets are given a pass.

Arguing and fighting are an occasional problem but very rarely have the police needed to be called. Overdose incidents do not occur thanks to the exclusive focus on smoking.

Relationships with other agencies are good and regular consultations are held with representatives from the local community.

Model 3

This project has also been set up in response to both public order and health problems. While many of the most marginalised local users are injectors, there is also a growing population of crack users – many of them sex workers. This project therefore provides both an injecting and a smoking room.

The consumption rooms were added to an already existent drug project on this site. This project therefore has a number of facilities other than the DCRs. These include a methadone treatment programme, a 'living room'/ café and ten beds providing overnight hostel-style accommodation. The consumption rooms are on the ground floor and have a separate entrance door from the rest of the project (although the facilities are all conjoined by a staircase). The injecting room does not have booths like those described

Continued

in model 1 but has a stainless steel ledge at waist height that runs around the room, creating a table at which users sit to prepare and inject their drugs. It is busy, with a daily average of 200 people using it, and a member of staff works in the room itself, providing advice and keeping a close eye on the users. The smoking room is less busy, but still used by around 50 users a day. It is viewed through a CCTV camera, the screen being watched at the entrance desk. The smoking room is similar to that described in model 2.

A number of rules are clearly displayed. Users must not share drugs on the premises or inject in the neck or groin. Violence or shouting is also against the rules. Failure to comply with rules frequently leads to temporary exclusion.

Once they have used in the consumption rooms, users are able to use the 'living room' area on the next floor. This provides coffee and snacks, and lunch is cooked each day with the involvement of users who are paid by the hour. As with model 2, users can go to and fro between the consumption rooms and the living area. The project is open for long hours and if users have nowhere else to go in the evening they can ask to sleep in the accommodation section. The methadone programme clients are kept strictly separate from the rest of the project.

As with model 1, the project is open to anyone but new arrivals must go through a registration procedure and all users are given a unique code. The smoking room has been successful in attracting local sex workers, many of whom use crack.

Key dimensions

These models illustrate some of the variety in the approaches that have been developed around the world. This reflects variations in the actual and perceived needs at national, city and more local levels. A number of key dimensions can be identified which underlie these differences. The location of a DCR on each of these dimensions carries important implications for how a project is designed and run.

Injecting vs smoking

While model 1 focuses only on injecting, model 2 focuses only on smoking and model 3 provides separate rooms for smokers and injectors. If a project focuses mainly (or solely) on smoking, there

will be considerably less risk of overdose incidents.[2] The degree of supervision and the standards of hygiene in a smoking room can therefore be lower. This can have important implications for the 'atmosphere' in such rooms: they can have a more informal feel. The injecting rooms are more clinical and, if large numbers of users are processed over the course of the day, medical emergencies are inevitably quite common. Such projects are clearly preventing overdose incidents from progressing to life-threatening stages.

Public order vs public health

Model 2 was set up with public order as the overriding priority. Models 1 and 3 have combined health and public order aims. If public order is the main aim, it becomes important to retain users for as long as possible within the project and to ensure that users have somewhere to go at all hours of the day. The day care approach exemplified by model 2 shows how this can be done.

Open access vs targeted

Targeted projects such as model 2 allow projects to run within a more clearly defined set of aims. However, users who fall outside the criteria and who may be in danger are excluded. Model 3 effectively excludes some users on account of the rules it imposes. Model 1 is the most open to all injectors.

Integrated vs specialist

Model 3 shows how a range of provision, including consumption rooms, can be kept under one roof. Model 1 is at the other end of the continuum, focusing almost exclusively on ensuring that users inject safely.

DCRs in the UK

What do these considerations mean for DCRs in this country? This section addresses each of the dimensions referred to above in turn.

Injecting vs smoking

As has been concluded in Chapter 3, the UK has a relatively large population of injecting drug users and it therefore seems logical that any initiative here would need to address injecting, which is associated with the most serious health risks. Nevertheless, as has also been discussed, crack smoking has increased in prevalence and is a serious problem that should not be ignored. Moreover, there are serious concerns surrounding current services' ability to attract primary crack users in the UK (Home Office, 2002b). A crack smoking room might provide one way to bring in crack users who are otherwise out of contact with services.

An important question here is the extent to which smoking and injecting rooms can be combined within a single project. In the Netherlands, where the majority of problem drug users smoke their drugs, having both types of room located next to each other appears to have worked well. In Germany and Switzerland too, projects are increasingly adding smoking rooms. Some of the users involved in the IWG's consultation referred to the importance of separating crack smokers from injectors. The difference in the effects caused by the drugs was thought to carry the potential to cause problems among mixed groups of users. Were pilot injecting and smoking rooms to be set up in the UK, there may be merit in positioning them in separate locations, especially if a particular subpopulation of crack smokers were to be targeted, such as sex workers or particular ethnic groups.

Public order vs public health

As we have seen in Chapter 3, the UK suffers from both public nuisance and public health problems associated with drug use. Both constitute important arguments for the introduction of DCRs in this country. However, while health problems will occur in any population of marginalised users around the country, there seems to be more variation in the level of public nuisance. In order to evaluate the extent to which DCRs can impact on public nuisance, it would be important to site DCRs in areas associated with high levels of such nuisance.

Open access vs targeted

Model 2 describes a highly targeted approach, whereby homeless users causing public nuisance are selectively given access to a project. Such an approach allows a project to tailor its design and procedures to the needs of the targeted group. In the case of model 2, this involved providing attractive day care facilities. If it were to be decided that UK DCRs should focus primarily on the most marginalised, homeless drug users, this type of approach seems sensible. However, as the IWG research on NSP clients revealed, a significant proportion of public injectors live in their own accommodation. In this particular study just under a quarter of the public injectors were in this category. As public injectors endanger themselves whatever their accommodation status (and also cause public nuisance), the IWG concludes that projects should target not only homeless users in this way but public injectors more generally.

Integrated vs specialist

DCRs in Europe have frequently been added to existing services rather than being designed as a stand-alone facility. The IWG sees great benefit in consumption rooms being part of wider services for drug users. First, every effort needs to be made to move users on

from their current drug use: where windows of opportunity arise for treatment, these need to be seized quickly. Having other services sharing the same site gives the potential to respond with greater speed. Second, a key aim of DCRs must be to further *integrate* marginalised users. Provision of advice on accommodation, benefits and employment should be an important part of such an approach. In Zurich, social reintegration is now seen as one of the foremost goals and there are close links with the city's housing services. Third, drug users suffer from a range of health problems, some associated with their drug use but others associated with their general lifestyles. Provided sufficient numbers of users are attracted, the provision of primary health care on site is likely to prevent problems escalating and divert users from expensive hospital treatment. Finally, as discussed in the previous chapter, appending DCRs to existing services is likely to have the least negative impact on local communities.

Structure, location and minimum standards

There are strong arguments for setting up DCRs within existing drug services. However, there remains the question of which services. The IWG has discussed at length the possibility of DCRs being appended to hostel accommodation. Where hostels do not allow drug use to take place on the premises,[3] residents are asked to leave the hostel in order to take their drugs. This will often mean that users end up injecting in public places nearby. We heard reports of fatal overdoses occurring as a direct result of hostel residents having to inject off the premises in dangerous and isolated locations. However, the IWG has also heard from local project workers that some hostels have recently started to allow drug use to take place within them. This is happening as a consequence of the Government's decision (discussed in the last chapter) to repeal a proposed amendment to section 8(d) of the MDA, as a result of which it only remains an offence for an occupier or manager of premises to 'knowingly permit or suffer' the

smoking of cannabis or 'prepared opium' on the premises. If hostel users are allowed to use drugs in their own rooms or dormitories, to some extent this may obviate the need for a DCR. Certainly, given the confusion surrounding hostel policies, the IWG does not think that it can recommend the piloting of DCRs in this context. However, it is strongly recommended that there is a review of hostel policies and practices in this area. Allowing users to inject in their own rooms may be the lesser of a number of possible evils but if users are allowed to inject alone and unsupervised behind a closed door, there remains a real risk of overdose fatalities.

The IWG sees greater merit in setting up DCRs as adjuncts to NSPs. As we have seen from the NSP user survey undertaken for the IWG, a considerable proportion of NSP users appear to inject in public places. It also appears from this research that NSPs attract considerable numbers of hostel users and rough sleepers. A busy NSP already brings a lot of users to its door and the addition of a DCR is therefore unlikely to make a great difference to the flow of users through a local community. Finally, the positioning of a DCR in this context would bring together harm reduction services under one roof. This prevents any 'contamination' effect of mixing approaches that aim to reduce the risks associated with illicit drug use with those aiming to stem their use or substitute their use with other drugs.

However, were DCRs to be set up within NSPs, the IWG would want to see their resources considerably boosted, in order to deliver the type of 'integrated' services referred to above. A recent survey of needle exchange services has shown great variation in the range of additional services provided by such projects (NTA, forthcoming). It would be imperative to situate DCRs in facilities which provide a range of services, including wound care and overdose prevention advice. The IWG also concludes that, while the main emphasis should be on making users safer, there should also be a commitment to helping users to move on to treatment if they are able to do so. The IWG does not accept that there is an

unbreachable divide between harm reduction and treatment or abstinence-oriented goals, and staff working in DCRs should have the flexibility to help their clients in a variety of different ways. While DCRs located in NSPs are likely to work with some of the most chronic, damaged and marginalised users, recovery will always be a possibility.

Given the potential for DCRs to prevent drug-related deaths, there is a strong argument for setting them up in areas associated with particularly high rates of drug-related death. It would be vitally important to inform users released from prison about the existence of such projects. It would also be important to set them up in areas with a good history of interagency working: particularly between the police and drug agencies. **IWG members were impressed by the extent of co-operation and trust that existed between agencies in the cities visited abroad.**

Finally, there would need to be a clear set of minimum standards forming part of the clinical governance arrangements for any DCR. These would need to be strictly adhered to and regularly audited. They would cover issues such as the minimum number of trained staff required to supervise injecting and intervene in drug-related emergencies.

Pilots

Given the above considerations, the IWG concludes that there are strong arguments for DCRs initially being piloted in NSPs. Should they prove to work well, this would provide a model which could be replicated relatively easily elsewhere. There are other DCR models that might be tried in the UK at some point in the future. The IWG believes that there is potential in the idea of introducing DCRs for smoking crack, which would aim to attract marginalised users who are currently not attending any other services. However, at this stage, this idea requires further research and exploration.

Evaluation

The IWG views it as imperative that these pilot DCRs would be properly evaluated. Detailed process and outcome evaluations would need to be conducted. Perhaps most important, and sometimes overlooked, would be the need to collect detailed data *before* pilots were to commence and comparative data from sites where DCRs were not to be introduced. These data should include a user survey, community survey (including local residents and businesses) and statistics on ambulance call-outs, hospital treatment and drug-related deaths. It would also be important to map the flows of users through the local area and to conduct a more qualitative assessment of the history and nature of drug use in the locality. Police intelligence on local drug markets will also be vitally important information which will help evaluators to judge how things may have changed after the introduction of a DCR but should also help in deciding on the location of the pilot project.

7 Summary, conclusions and recommendations

The initial aim of the IWG was to take an objective and evidence-based approach to the question of whether DCRs could have a significant impact on the private and public harms associated with drug use in the UK. It then went on to look at the barriers to setting up DCRs in the UK and the possible models that might be applied. In looking at these issues over a 20-month period, the IWG has identified a number of important findings and reached some key conclusions.

Key findings and conclusions

The policy context

- The IWG welcomes the increased emphasis in the Government's Drug Strategy on harm reduction and the existence of strategic aims that reflect this emphasis. A number of these aims are directly addressed by DCRs.

Harms associated with drug use

- The UK has a substantial population of injecting drug users and the highest number of drug-related deaths in Europe.
- There is a high, and rising, prevalence of hepatitis C among drug injectors. Hepatitis B is also a serious concern.
- While lower than in many other countries, HIV prevalence appears to be increasing among injecting users.
- Many users infected with blood-borne viruses are unaware of their infection.

- While hepatitis B can be prevented through vaccination, fewer than half the population of injecting drug users have been vaccinated.

- Abscesses, cellulitis and other infections are common among injectors, leading to frequent hospital treatment.

- There is a substantial population of high-risk, homeless, injecting drug users, based in hostels or rough sleeping. They inject frequently in public places and are therefore associated with a lot of public nuisance.

- Evidence from research undertaken for the IWG showed that 42 per cent of a sample of 398 needle exchange users had injected in a public area at least once in the previous week.

- A significant minority of injectors who live in their own home also inject in public places. One in four of the needle exchange users who lived in their own home had injected in public in the previous week.

- In England alone, the number of drug injections occurring in public places is likely to be in the order of tens of thousands per month.

- In addition to the physical risks to themselves, users forced to inject in run-down, unhygienic and dangerous public areas are likely to experience anguish, loss of dignity and low self-worth.

- Large quantities of syringes and drug-related litter are dropped in public places across the UK, causing considerable impact on local residents and businesses.

Are DCRs effective?

- DCRs prevent drug-related deaths by providing early intervention in potentially fatal overdose incidents.

- They are successful in providing on-site medical care and referring users to off-site medical services. The IWG is therefore confident that well-run DCRs improve the general health of users.

- DCRs can reduce sharing of injecting equipment and are *likely* to reduce the transmission of blood-borne viruses but the latter has not yet been demonstrated and is very difficult to prove.

- There is no evidence that DCRs either increase or decrease an individual's drug use.

- There is good evidence showing DCRs to be associated with a reduction in injecting in public places. They can also lead to a reduction in discarded used syringes and drug-related litter.

- DCRs do not appear to act as a magnet for users from outside the local area. Most of those who use DCRs are local drug users.

- DCRs are effective at attracting local homeless and other socially excluded drug users.

- There is no evidence that DCRs either increase or decrease levels of acquisitive crime. However, this is unsurprising as DCRs do not provide prescription drugs and cannot therefore directly affect crime committed to obtain drugs.

- To the extent that DCRs are successful in providing access to structured treatment and other interventions aimed at social integration, they may have an indirect impact on crime levels.

- Some DCRs have been periodically associated with local public disorder and dealing. These problems have been successfully dealt with through close co-operation between the key agencies, including the police, and strict rules governing behaviour in and around the DCR.

- While other services address some of the harms targeted by DCRs, the IWG concludes that DCRs offer the unique potential to ensure safer, on-site injecting and thereby directly prevent health problems, drug-related deaths and drug-related nuisance.

Would DCRs have an impact in the UK?

- The IWG concludes that well-designed and well-implemented DCRs would have an impact on some of the serious drug-related problems experienced in the UK.

Barriers and concerns

- The IWG does not regard the UN Conventions as imposing a manifest embargo on the implementation of DCRs in this country.

- There are a number of potential legal obstacles within United Kingdom law. Many of these could be addressed through properly enforced rules. However, some areas of risk would remain.

- The weight and implication of various ethical concerns are hard to judge impartially. The IWG would welcome debate on these issues. However, some of these questions are probably best addressed through evaluation of pilot projects.

DCR pilots

- There is a wide variation across the eight countries that have introduced DCRs in how they are designed and run.

- There are strong arguments for DCRs in the UK focusing on drug injecting, but being otherwise open access, targeting both public health and public order objectives and being run within existing services.

- Further thought needs to be given to the idea of DCRs which target primary crack smokers, a group often out of contact with services (such rooms might also include heroin smoking).

- Evaluation of pilot projects would be essential and would need to be properly resourced.

Recommendations

The Independent Working Group on Drug Consumption Rooms makes the following key recommendations:

- The IWG recommends that a number of pilot drug consumption rooms be set up in the UK. These projects should be founded on local accords between the key agencies and therefore need to be in areas where there is already considerable local support for the idea.

- Ideally, this piloting process would be supported and co-ordinated by central government. However, if the Government is unable to play this role, the IWG hopes that local agencies will be able to devise local schemes where it is in the public interest to do so.

- The IWG recommends that initial pilots should consist of injecting rooms only. Well-run needle and syringe exchange projects (NSPs) appear to offer a promising location for setting up DCRs in the UK and the IWG recommends that pilot projects are set up in this context.

- There are a number of other approaches that the IWG thinks are worthy of exploration. In particular, there appears to be considerable potential for developing DCRs for primary crack smokers, a rapidly growing population, the majority of whom are out of contact with services. This idea requires further research and development.

- DCR pilots should form part of an *integrated* local drug service, providing the opportunity for users to give up or reduce their drug use, as well as making their use safer.

- DCRs need to provide a sufficient number of trained staff to be able to intervene in drug-related emergencies, such as overdose events. They also need to be able to provide basic on-site medical treatment, such as wound care.

- There should also be access to, and where possible direct provision of, advice on accommodation, benefits and employment, hygiene and self-care. Washing and laundering facilities should also be provided.

- DCRs should be set up in areas experiencing significant problems with public drug use and overdose deaths. They should also be set up in areas where there is genuine support for the idea across the relevant agencies and a strong potential for interagency working. The support of the local police will be crucial to the success of any pilot project.

- Local communities and stakeholders should be closely involved in the development of pilot projects.

- These pilots must be carefully evaluated and the calculation of the cost of this piloting exercise should include resources for an extensive evaluation, which would include local community and user surveys and an assessment of cost-effectiveness.

- Although legislative change would be the safer option for piloting DCRs in the UK, there are arguments for delaying any such change until the pilots have been evaluated and their effectiveness assessed. Amending or introducing legislation would prove a wasted effort if the pilots were then shown to be ineffective. Furthermore, the implementation and operation of pilot projects may provide valuable insights into the particular type of legal protection that might be required.

- However, it is clear that there would be some dangers in setting up DCRs under the current law. These dangers would be minimised by the imposition of a set of clear rules governing the behaviour of users and staff. To this end, it is recommended that a set of minimum standards is developed which forms part of the clinical governance for pilot DCRs and is subject to regular audit.

The IWG is keen to see a public debate take place on its recommendations and on the issue of DCRs more generally. It is hoped that the use of misleading terms like ‘shooting galleries’ and ‘drug dens’ can be avoided in this debate. DCRs represent a serious policy option, with clear public health and public order objectives, that has been implemented in eight countries around the world. It would also be an initiative in line with the UK’s record of being in the forefront of developments in the field of harm reduction. The IWG regards the idea as deserving proper consideration and informed debate.

Conclusion

DCRs certainly cannot provide the answer to all the ills associated with problem drug use. Furthermore, they seem only to offer a palliative when everyone would prefer to see a cure. However, while the IWG holds the view that no drug intervention should ever give up on the possibility of treatment and, ultimately, abstinence, there are a large number of problem users in this country who are, for whatever reason, currently unable or unwilling to control or reduce their use. The IWG considers DCRs to be a rational and overdue extension to the harm reduction policy that has produced substantial individual and public benefits in the UK. They 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.

Notes

Chapter 1

1 The term ‘drug consumption room’ is used to describe an official, protected space for the hygienic consumption of pre-obtained drugs in a non-judgemental environment, under the supervision of trained staff (adapted from Hedrich, 2004).

2 Chapter X, Decree-Law 183/2001, http://www.drogas.pt/media/legislacao/english/dl183_01.pdf.

3 Personal communication, João Goulão, Chairman, Institute on Drugs and Drug Addiction, Lisbon, Portugal.

Chapter 2

1 The EMCDDA is a decentralised agency of the European Union, its central role being to provide the EU and its member states with objective, reliable and comparable information on drugs and drug addiction.

2 Evaluation of the Government’s success in this respect will not be possible until later in 2006, when figures on deaths in 2004 become available.

3 The six supporting IWG papers are published on the JRF website at http://www.jrf.org.uk/bookshop/details.asp?pubid=749

Chapter 3

1 This differentiation is not without complications, in that all private harms are likely to have public consequences. For example, overdoses will cost society money in terms of emergency services, hospital treatment etc. However, the division is useful in separating those harms that have a

predominant impact in one sphere from those that have a *predominant* impact in the other.

2 Defined by EMCDDA as 'injecting drug use or long duration or regular use of opiates, cocaine and/or amphetamines' (http://www.emcdda.eu.int/?nnodeid=1372).

3 The prevalence estimates for Scotland and Northern Ireland were obtained using the capture–recapture method whilst the estimates for England were produced on the basis of combining capture–recapture estimates for certain areas (Brighton, Greater Manchester, Liverpool, and parts of London) with additional multivariate indicator estimation work in other parts of England (Hickman *et al.*, 2004a, 2004b).

4 One third of a sample of 398 drug users attending needle and syringe exchange projects surveyed in a study carried out for the IWG were living in hostel accommodation (see boxed information on this study later in this section and Hunt *et al.*, forthcoming).

5 Assuming there are around 93,000 injecting drugs users in England (Frisher *et al.*, 2006) and, if at least 20 per cent of injecting drug users are in contact with NSPs (Hickman *et al.*, 2004b), this suggests somewhere in the region of 18,600 injecting drug users in contact with NSPs. Assuming that they are similar to the sample surveyed in the IWG research, we would expect 42 per cent of this sample to have injected in public *at least once* in any given week: a total of 7,812. On a monthly basis, this would be approximately 31,000 injections per month. Moreover, a substantial number of injectors are injecting in public many times a week and there are also, inevitably, people injecting in public places who do not use NSP programmes. The IWG is therefore confident in concluding that, in England alone, tens of thousands of injecting episodes per month occur in public places.

Chapter 4

1 Naloxone is an opioid antagonist which blocks the opioid receptors in the brain and thereby blocks the effect of heroin and other opioids.

2 The rate of overdose intervention in the Vancouver Insite project was 1.3 per 1,000 injections, falling within this range.

Chapter 5

1 *Political Declaration: Guiding Principles of Drug Demand Reduction and Measures to Enhance International Cooperation to Counter the World Drug Problem*, Special Session of the General Assembly Devoted to Countering the World Drug Problem Together, 8–10 June 1998.

2 Schedule IV drugs include cannabis and heroin.

3 Swiss Institute of Comparative Law, *Use of Narcotic Drugs in Public Injection Rooms under Public International Law*, AVIS 99-121c, 7 January 2000.

4 Where smoking and injecting facilities coexist, we have been struck by the vigorous efforts that project workers make to deter transitions from smoking to injecting.

5 Switzerland has only signed the first two of the three Conventions.

6 The NTA guidance on the prescription of injectable heroin states that eligible clients should have a 'protracted history (>3 years) of heroin dependence', have failed to respond to at least six months of oral maintenance treatment and be willing to comply with supervision and monitoring arrangements (NTA, 2003).

Chapter 6

1 There is very little information on the Luxembourg project that had only very recently been set up at the time of writing.

2 However, there may be a danger that a low rate of overdose incident will lead to a lack of preparedness on the part of staff – and may therefore make overdose incidents more dangerous in such circumstances.

3 This is reportedly the most common situation, although the IWG was frustrated by the dearth of official information.

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Appendix: Terms of reference

Aims

1 To take an objective and evidence-based approach to the following question, drawing on both the national and international literature: 'Is there the potential for DCRs to have a significant impact on the private and/or public harms associated with drug use in the UK?'

2 Should the IWG decide that there is such potential:
- to consider the pros and cons of different models
- to identify the legal, political and practical obstacles to implementation and seek solutions
- to make recommendations for the development and evaluation of appropriate demonstration projects.

3 To publish an accessible report summarising the evidence, the arguments and the recommendations.

Membership

Members have been identified and approached on account of their personal expertise in a relevant field and have joined the group in an individual capacity, rather than as representatives of their organisations.

Timescale

The timescale will need to be flexible. If, after considering evidence relating to the first aim, the Working Group decides that there is no need for drug consumption rooms in the UK, then the Working Group would end at this point and a report would be published. This would mean a short timescale. Should the Working Group decide that there does appear to be a need, a much longer timescale would be required to consider evidence relating to the second aim. In this case, it is envisaged that the process would

take around 18 months, with a view to publishing the report at the end of 2005. This would mean producing an agreed final report by the end of September 2005.

Number of meetings

The intention is to hold meetings every three months. Should the Working Group go on to consider the second aim, this could mean around eight meetings over the 18-month period (including a meeting after the report was agreed to discuss dissemination/ publicity). However, we will need to be flexible – and there may need to be more or less meetings at particular points in time.

Organisation of meetings

Papers will be circulated a week before the meeting, to allow members to come prepared for discussion. While written papers will form the main business of meetings, it is also expected that experts will be invited to talk to the Working Group on particular issues. Minutes of each meeting will be taken, written up and circulated.

Role of the Joseph Rowntree Foundation

The Foundation is supporting the Working Group financially and one of the Working Group members works for the Foundation. However, the views expressed in the report will be those of the Working Group as a whole and will therefore be largely independent of the Foundation (in the same way that views expressed in JRF-funded research reports are the views of the researchers, rather than the Foundation). However, it is expected that the report will be published by the Foundation and a press release produced by the Foundation, in association with the Working Group.