The War is Lost: A Proposal for Drug Consumption Rooms in the UK

This paper argues that Drug Consumption Rooms ('DCRs', also called 'Safer Injecting Facilities') should be introduced as the solution to current problems with drug consumption and regulation in the UK.

DCRs are facilities which enable people to "use controlled substances (purchased elsewhere) in a hygienic and medically-supervised setting"[1]. While these facilities are widespread – with over seventy in Europe[2] - the UK government has consistently opposed DCRs on legal, ethical and policy grounds, most recently in 2016[3].

This proposal begins by outlining the flaws in the current system, such as the inflexibility of the Misuse of Drugs Act 1971 ('MDA'), that have led to a 60.9% increase in drug-related deaths since 2010, with 2018, 2019 and 2020 all setting new records for the total number of drug-related deaths[4].

A DCR Bill laid before Parliament in 2018[5] will act as the framework for proposed legal amendments and, combined with a detailed DCR 'model' and broader positive evidence relating to DCRs, will be the benchmark against which criticisms of DCRs are assessed.

[1] Advisory Council Misuse of Drugs ('ACMD'), *Reducing Opioid-Related Deaths in the UK* (2016), p.36.
[2] European Monitoring Centre for Drugs and Drug Addiction, *DCRs: an overview of provision and evidence* (2021). p.2.
[3] Government detailed rejection of ACMD (2016) DCR recommendation, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699825/Letter_from_Victoria_Atkins_MP_to_OBJ.pdf
[4] Office for National Statistics ('ONS'), *Deaths related to drug poisoning in England and Wales: 2020 registrations*. (2021), p.2. See also the 2018 Registrations Report, published 2019.
[5] The Bill failed to proceed through Parliament in time, so was dropped. It is available here: https://services.parliament.uk/Bills/2017-19/superviseddrugconsumptionfacilities.html.

The Current Flaws:

Causation

The ONS identified three principal causes for current levels of drug-related deaths[6]: an ageing cohort of drug users; new trends in the use, purity and availability of drugs; and users neglecting opiate substitute therapy ('OST'). The statistics from 2020 are consistent with the year-on-year trend, even with the pandemic.

I argue that these causes have been fomented by failures to adapt regulation, to pursue effective treatment, and to neuter drug supply. These failures have left the UK with poor, recovery-oriented practice which increases risks to users[7]: practices focussed on harm-reduction are required.

Legislation

Central to the architecture which makes this recovery-oriented practice inevitable is the MDA, which criminalises the production, distribution and supply of controlled drugs. The greatest hurdles to DCRs come from ss.5, 8, 9 and 9A of the MDA, which create the following offences:

- s.5: possessing a controlled drug, subject to circumstantial defences.
- s.8: as the occupier of a premises, knowingly permitting or suffering the actual or attempted production or supply of controlled drugs.
- s.9: frequenting a place used for smoking opium, or to possess 'utensils' for such.

[6] ONS (2021), *Drug Poisoning Deaths: 2020 Registrations,* p.10.
[7] Public Health England ('PHE'), *Understanding and preventing drug-related deaths*. (2016), p.15.

- s.9A: supplying or offering to supply any article for the administration [s.9A(1)] or preparation [s.9A(3)] of a controlled drug, believing that there will be unlawful administration.

There have been some positive legislative changes. The Misuse of Drugs (Amendment) (No.2) Regulations 2003 disapply s.9A(1) and (3) MDA in respect of practitioners, pharmacists and persons engaged in lawful drug services, allowing them to provide certain articles for drug consumption to users. These articles include hypodermic syringes (s.9A(2)) and aluminium foil (2014 Regulations) but omit other utensils crucial to drug administration (including tourniquets[8]), thereby limiting the degree of any assistance.

The limited nature of these changes is largely due to the 'war on drugs', the government's commitment to tough policing and criminalisation of controlled substances through the MDA and other measures. This war has failed to reduce drug use[9], and this ineffectiveness has led to increasing uncertainty concerning "de-facto criminalisation" in some regions[10]. This proposal will replace nebulous police discretion with concrete legal change.

These changes are insufficient to cure the inflexibility of the broader regime, not least because the measures they permit are ineffective and incoherent.

Practice

The clearest impact of these legislative changes are Needle and Syringe Programmes ('NSPs'). Provided by pharmacies, NSPs are intended to reduce drug-related

[8] Forston (2006), *Setting up a DCR: Legal Issues. Paper F for IWG*, p.36.
[9] Home Office, *(2019), Drugs Misuse: Findings from the 2018/19 Crime Survey for England and Wales*, p.2.
[10] https://www.telegraph.co.uk/politics/2021/09/22/scots-caught-class-drugs-could-escape-just-warning-legal-shake/

morbidity (principally blood-borne viruses) by providing users with sterile injecting equipment[11]. NSPs also advertise wider support services to users, and provide the supposed 'wonder-drug' for opiate overdoses, Naxolene.

Drug-related litter bins are increasing in number. Although many users welcome them, there are "inconsistent collection procedures"[12], and user concerns remain over increased policing in their vicinity, insufficient advertising and incorrect placement[13].

A third strand to current practice is Opioid Substitution Therapy ('OST'). This involves prescribing replacements such as methadone for illicit opioids, and providing support to improve lifestyles[14]. Over 57% of OST patients continue illicit drug use alongside, with repeated interruptions to OST largely caused by inflexible treatment programmes[15].

Current practices are incoherent, government going so far as to provide equipment and facilitate injection but not safe, supervised locations for users. Crucially, these practices do nothing to prevent user "risk behaviour" such as needle-sharing and groin injections, thus increasing the risk of complications[16]: stronger measures which change user behaviour are needed.

Policy

The Government Drug Strategies outline government thinking and aspirations regarding drug regulation.

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[11] NICE, *Needle and Syringe Programmes*. Public Health Guideline (2014). p.7.
[12] Parkin et al (2011), *Injecting drug-users' views of drug-related litter bins in public*. Health & Place 17, p.1220(a).
[13] Ibid, p.1222.
[14] https://www.gov.uk/government/publications/opioid-substitution-treatment-guide-for-keyworkers/part-1-introducing-opioid-substitution-treatment-ost
[15] Alam et al (2014), *Interruption of medication-assisted treatment for opioid dependence: insights from the UK*. Drugs and Alcohol Today, Vol. 14 No. 3, pp. 114-125
[16] PHE, *HIV Survey*, p.14.

The most recent Strategy was published in 2017[17]. Analysing the 2010 Strategy, Parkin criticised its focus on "recovery" (a euphemism for user economic productivity) rather than harm reduction[18], which explained the absence of UK DCRs[19].

"Colliding intervention" was a further problem: the lack of a formal national policy resulted in local authorities implementing "spontaneous versions of the Strategy… lack[ing] effective harm reduction"[20]. The one attempt at a national policy to combat drug-related litter came in 2005[21], but was soon "disregarded [locally]"[22] as a mere "template", rather than a concrete framework[23].

These criticisms remain relevant: despite its new fourfold approach towards demand, supply, recovery and global action regarding controlled drugs, the "overarching aim" of the 2017 Strategy is still focussed on recovery and reducing drug-use, with "no real prospect" of reducing associated harms given the failure to introduce "new measures"[24].

There is a disconnect between one of the purposes of the Strategy ("to ensure an effective, universal approach to drug use"[25]) and its contents, characterised by an expectation that "local partners identify risks and take appropriate action"[26]. This is justified as deference to local knowledge[27], but neglects the issues of "colliding

[17]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF
[18] Parkin (2016), *Colliding intervention in the spatial management of street-based injecting and drug-related litter within settings of public convenience (UK)*. Space and Polity, 20:1, p.76.
[19] Ibid, p.90.
[20] Ibid, p.76.
[21]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/221089/pb10970-drugrelatedlitter.pdf
[22] *Colliding Intervention*, p.89.
[23] Ibid, p.79.
[24] Winstock et al (2017), *A New Drug Strategy for the UK*. BMJ, p.1.
[25]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF, p.1(a).
[26] Ibid, p.12(b).
[27] Ibid.

intervention". I outline below how local knowledge can be filtered through a standard framework to improve certainty and harm-reduction[28].

Failed Combination

The ineffectiveness of this inconsistent regulation, practice and strategy in reducing harm is demonstrated by the statistics.

In 2018, accidental poisoning caused 80% of male, and 67% of female, drug-related deaths[29], despite "65% of users carrying Naxolene"[30]. In 2020, almost half of all drug-related deaths involved opiates[31], partly a result of an increase in the availability and purity of heroin[32].

The number of users reporting an overdose has increased year-on-year since 2016[33], and Hepatitis C infections in drug users have increased by 10% since 2008[34]. This bleak picture exists despite very high use of NSPs[35]; supervised facilities with on-hand support are desperately needed, evinced by findings that OST is most effective when supervised by trained staff[36].

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[28] In 'Community Engagement' on page 11 of this proposal.
[29] ONS (2019), *Deaths related to drug poisoning in England and Wales: 2018 registrations.,* p.4.
[30] PHE (2019), *Unlinked Anonymous Monitoring (UAM) Survey of HIV and viral hepatitis among PWID.* p.3.
[31] ONS (2021), *Drug Poisoning: 2020 Registrations*, p.7
[32] PHE, *Understanding drug-related deaths*, p.7.
[33] Home Office (2019), *Drugs Misuse Findings,* p.12.
[34] PHE (2019), *HIV Survey*, p.3.
[35] Ibid, p.15: in one survey, 91% of participants had used NSPs at least once.
[36] Alam et al (2014), *Interruption of medication-assisted treatment,* pp. 114-125.

The Solution:

Positive Evidence

DCRs are a proven means of reducing drug-related harm[37]. DCRs reduce unsafe injecting practices, with a "69% reduction in syringe-sharing"[38], and a reduction in the "rushed injections" associated with police presence and the cause of most overdoses[39]. This improvement in user behaviour is key to the reductions of drug-related deaths[40] and blood-borne infections[41] achieved by DCRs. Change behaviour will also mitigate the (unavoidable) absence of DCR protection outside opening hours: users are aware of the methods and need for safer injecting.

DCRs also reduce drug-related pressure on health services[42]; a Sydney DCR achieved a "68% decrease in the average monthly number of ambulances… in the vicinity" during its operating hours[43]. This feeds into the wider economic benefit of DCRs to society, with prevented HIV/ Hepatitis C infections bringing a net profit of CAN$14.6million after running costs[44].

Communities also benefit from the reduction in drug-related litter: Barcelona's DCR achieved a "fourfold reduction" in the number of syringes collected on the streets

[37] Kennedy et al (2017), *Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review*. 161-183.
[38] Milloy et al (2009), *Emerging Role of SIFs in HIV Prevention*, Addiction, 104, 620–621, p.620.
[39] Stoltz et al (2007), *Changes in injecting practices associated with the use of a medically supervised safer injection facility*. Journal of Public Health: Vol.29, No.1, p.37(a).
[40] Kappel et al (2016), *A qualitative study of how Danish drug consumption rooms influence health and well-being among people who use drugs*. Harm Reduction Journal, 13:20, p.1(b).
[41] Ibid
[42] Stoltz, *Changes in Injecting Practices*, p.38(a).
[43] Salmon et al (2009), *The impact of a supervised injecting facility on ambulance callouts in Sydney, Australia*. Addiction, 105, 676–683
[44] Lloyd et al (2010), *Commentary on Pinkerton (2010):DCRs—time to accept their worth*. Addiction, 105, p.1437.

between 2004 and 2012[45]. In conjunction with drug-related litter bins, DCRs can improve community spaces.

Construction

Typically, DCRs contain rows of booths, with a medical team on-hand to provide equipment, advice and medical treatment. The provision of other services, such as links to rehabilitation and advice centres, is also common[46], reducing usage and promoting recovery alongside harm-reduction.

This 'typical' model requires several additions to maximise coherence and efficiency.

Legal Amendments:

Some proponents of DCRs have questioned the need for legislative change, positing that (as in Frankfurt) "accords" between police and local authorities not to take action against DCR users and staff are sufficient[47]. Aside from the risk of "colliding intervention", this proposal would create significant rule of law issues: the potential for considerable regional variation would likely lead to uncertainty, reflecting current concerns surrounding 'forced' de-facto criminalisation[48].

Thus, DCRs must be established in legislation. ss.3(3)-(5) of the DCR Bill provide exemptions from prosecution under ss.5, 8 and 9 MDA for employees licensed to provide DCR facilities and users authorised by those employees to use controlled substances in the DCR.

[45] EMCDDA, *Provision and Evidence*, p.5(b).
[46] Ibid, p.4.
[47] Joseph Rowntree Foundation (2006), *The Report of the Independent Working Group ('IWG') on Drug Consumption Rooms*. pp.79-80.
[48] n.10

Under this framework, it remains an offence to supply/ offer to supply a controlled drug[49]. Given that supply includes "distribution"[50], DCR users sharing drugs would risk arrest, particularly as payment or reward is unnecessary under the MDA[51]. As such, DCRs would have a zero-tolerance approach to drug dealing or sharing. This institutes DCRs without undermining appropriate criminalisation.

s.2(3)(a) Bill must be amended to require a doctor on-site during DCR operating hours: while 98% of emergencies within DCRs can be dealt with by staff alone, this reduced to just 30% when no doctor was present[52]. In time, as DCR staff become more experienced, this requirement could be relaxed, for instance having doctors 'on-call'. Such relaxations would be assessed for each DCR according to its clinical record.

Amendments for DCR Staff

The DCR Bill must extend the MDA Regulations to include 'licensed employees' of DCRs, and a wider range of permitted articles according to user needs (with scope to extend this list, short of drug supply) to ensure effective assistance.

Furthermore, caselaw under s.23 Offences Against the Person Act 1861 ('OAPA') must be placed on a statutory footing. S.23 criminalises the administration of 'noxious substances' – which include heroin[53] - which endangers life/ inflicts grievous bodily harm. Voluntary injection by the user breaks the chain of causation[54], departing from the earlier position which caught even those *assisting* administration[55].

[49] s.4(1) MDA
[50] s.37(1) MDA
[51] https://www.cps.gov.uk/legal-guidance/drug-offences
[52] *IWG*, p.49.
[53] *R v Cato* [1976] WLR 110.
[54] *R v Kennedy (No.2)* [2007] UKHL 38.
[55] *R v Rogers* [2003] 1 WLR 1374

This position is plainly crucial for DCR staff. Although settled law in England and Wales, the Scottish case of *MacAngus v HM Advocate* notes various authorities holding that voluntary injection will not necessarily break the causal chain[56].

To bring certainty across the UK, s.3A Bill would entrench the law's current position, such that criminal liability is limited to direct administration by another with the requisite *mens rea*. S.24 OAPA, which catches administration done with intent to injure, would quite properly remain a criminal offence.

Negligence

Relatedly, the standard of medical negligence would remain unchanged. A practitioner will not be negligent for acts/omissions done in accordance with the practice accepted by a responsible body of medical practitioners, so long as that acceptance is not unreasonable or irresponsible[57]. The push to implement DCRs should not undermine existing protective standards.

Substances Covered

The main thrust of harm-reduction should be aimed at opiates. DCRs must also respond to emerging threats, principally cocaine (for which deaths reached their highest ever level in 2020, five times higher than in 2010[58]), and fentanyl (as well as a spike in fentanyl-related deaths, 80% of users who ingested fentanyl in 2010 did so unknowingly)[59].

[56] [2009] HJCAC 8 at [32]-[34]
[57] *Bolam v Friern Hospital* [1957] 1WLR582; *Bolitho v City and Hackney HA* [1996]4AllER771.
[58] ONS (2021), *Drug Poisoning: 2020 Registrations*, p.8.
[59] Bijral et al (2019), *Prevalence of Recent Fentanyl Use Among Treated Users of Illicit Opioids in England.* Clinical Toxicology. 57:5, pp.369-371.

This last point suggests a need for drug testing, alongside the standard consumption booths. To ensure that this does not hinder uptake, DCR testing should be limited initially to areas where there are particular problems with contamination (especially from fentanyl, such as the Humber region[60]), with analysis at the discretion of the user. Detection of an unexpected toxin often results in users discarding the controlled substance[61], reducing associated harms.

Community Engagement

Much opposition to DCRs stems from misconceptions: regarding NSPs, NICE stated that "local communities need information about [an NSP's] aims and its effectiveness" for these facilities to be accepted[62]. To this end, s.2(2)(b) of the Bill could be amended, requiring that applications for a DCR "must provide information about the suitability of the premises, including evidence of positive engagement" with the general public and local authorities. Suitability of the premises would encompass their location – under s.2(3), operational considerations (reliant on local knowledge) would be balanced against community interests, to ensure that DCRs are not located next to sensitive sites like schools.

Positive engagement could be achieved through advertised public meetings and online campaigns which would highlight the inaccuracy of common concerns, showing particularly that DCRs do not increase crime[63] or drug use[64]. Attaching DCRs to existing hospitals or HIV treatment centres – as done in Canada[65] – could achieve this

[60] Ibid, p.369(a).
[61] https://idpc.net/blog/2017/01/recreational-mdma-testing-a-european-perspective
[62] NICE, *NSPs*, p.26.
[63] Donnelly and Snowball (2006), *Recent trends in property and drug-related crime in Kings Cross*. Contemporary Issues in Crime and Justice, No.105, p.3(c)
[64] Kerr et al (2006), *Impact of a Medically Supervised Injection Facility on Community Drug Use*. BMJ, Vol. 332, No. 7535 , p.221(b).
[65] *Report of the INCB for 2016*. United Nations (New York, 2017), p.60(a).

balance, as many drug users would be visiting the area already. This would also enhance 'signposting' in DCRs.

Signposting

Working in conjunction with emerging practices, such as OST, will improve harm-reduction. Putting users in contact with other services like housing support is also crucial: in 2018, "47% of injecting drug users were homeless"[66]. DCRs are proven to increase uptake of addiction services[67].

A Clear Choice

It is against this model that the various criticisms of DCRs must be assessed.

International Context

The International Narcotics Control Board ('INCB') was highly critical of DCRs in previous decades[68]. However, its stance has now changed, with a recent positive assessment of DCRs in France and Germany[69] providing significant support for their introduction.

Notwithstanding, there are criteria which DCRs must meet to be acceptable to the INCB, including that "their ultimate objective is to reduce the adverse consequences of drug abuse… without condoning or increasing [it]… within a framework that offers treatment and rehabilitation services… [without constituting] a substitute for demand reduction programmes"[70].

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[66] PHE, *HIV Survey*, p.3.
[67] DeBeck et al (2011), *Injection Drug Use Cessation and North America's First SIF*. D&AD 113, p.174.
[68] IWG, p.70.
[69] *Report of the INCB for 2018*. United Nations (Vienna, 2019), pp.29-30.
[70] INCB 2018 Statement on DCRs, available at: https://www.incb.org/documents/News/Alerts/Alert_on_Convention_Implementation_Feb_2018.pdf

The proposed DCR model meets these criteria: signposting to other services will be a key function of DCRs, while evidence from DCRs in Australia illustrates that they do not lead to an increase in drug use[71], while Canada has seen improved addiction treatment uptake and long-term cessation of drug use[72]. These findings were reiterated in 2017 in a systematic review of DCR-related literature, which also emphasised that DCRs have a positive effect on drug-related crime[73].

A further issue for the INCB centres on the need for users to acquire drugs outside the DCR[74]. Although not developed further, this criticism is likely founded in fears of increased crime and drug use, and the condoning of such. As we have seen, the first two concerns are demonstrably incorrect; the third is reflected in domestic criticisms and requires deeper analysis.

The Domestic Front:

In its rejection of DCRs, the UK government emphasised potential enforcement difficulties, with "low-level dealing" inside facilities and "users [travelling] from wide distances" placing burdens on police forces in DCR areas[75].

DCRs' zero-tolerance approach to dealing will reduce this risk; furthermore, the government's evidence to corroborate this fear is limited to a single DCR in Switzerland, providing little support for a broader trend.

A more compelling argument would have focussed on increased nuisance near DCRs (such as the evidence of increased 'move-ons' around the Sydney DCR in its initial

[71] Kerr, *Community Drug Use,* p.221(b).
[72] n.67
[73] Kennedy (2017), *Public Health and Public Order*
[74] https://www.incb.org/documents/News/Alerts/Alert_on_Convention_Implementation_Feb_2018.pdf
[75] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699825/Letter_from_Victoria_Atkins_MP_to_OBJ.pdf,

years, stabilising thereafter)[76]. Experience in Germany has shown that this problem is "related to the quality of co-operation between police and drug services… [with] agreement about the need for DCRs" avoiding the most significant issues, such as drug markets moving closer to DCRs in order to avoid police[77]. Community engagement – and the legality of DCRs – will ensure that police do not simply confiscate drugs or issue cautions, and instead direct users to DCRs.

The second concern about attracting distant users is demonstrably incorrect: the overwhelming majority of DCR users live locally[78], greater distance between place of drug purchase and place of residence being associated with public injecting[79]. This makes any 'swarming' effect overwhelming one police force unlikely, and reaffirms the importance of locating DCRs appropriately under the statutory framework.

The government rejection also cited a more principled concern that DCRs "condoned" wider drug use and criminality, undermining the necessary "tough" regulation of the MDA[80].

Plainly, a rebuttal needs to go beyond repeating contrary evidence - a change in outlook is needed. The war on drugs is futile unless enlightened harm-reduction measures are pursued. This is a view increasingly held by many in authority, including seven Police and Crime Commissioners in a 2019 letter to the Home Secretary[81].

[76] *Trends in Drug-related Crime*, pp.3-5.
[77] Ibid
[78] *IWG*, p.37
[79] Hunt et al (2007), *Public Injecting and Willingness to Use a DCR*. International Journal of Drug Policy 18, p.64(a).
[80]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699825/Letter_from_Victoria_Atkins_MP_to_OBJ.pdf
[81] https://www.theguardian.com/society/2019/jul/22/uk-home-secretary-urged-to-introduce-drug-rooms-to-save-lives

The final government concern about "ethical dilemmas for medical professionals"[82] can be challenged: although doctors would be facilitating the use of harmful substances, it is more ethical to ensure that users consume drugs in a setting that will minimise harm to users (and wider society). s.3A of the Bill removes concerns surrounding criminal liability: acts of assistance – short of direct administration – are legal and to be encouraged.

Although much of the literature citing these benefits is quite out-dated, more recent assessment illustrates that DCRs continue to provide these benefits[83]. Additionally, the focus on the Vancouver and Sydney DCRs in DCR literature does not undermine the 'weight' of the evidence; positives to European DCRs have been detailed, and there is no reason why UK DCRs cannot achieve the same benefits for drug-related problems if this project is accepted.

Conclusion

This proposal has demonstrated that current regulation, practice and policy has exacerbated existing problems and failed to adapt to emerging threats. The proven benefits of DCRs warrant their implementation.

This implementation requires legal amendment. With adaptations to an existing legislative framework, DCRs can be legalised while preserving principled aspects of the law, and achieving greater legal certainty through concrete change.

The evidence of DCRs' benefits to both users and wider society, combined with operative safeguards, illustrate government concerns to be unfounded. A sea-change

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

[83] Potier et al (2014), *Supervised injection services: What has been demonstrated? A systematic literature review*. Drug and Alcohol Dependence, Vol.145 (December, 2014), pp.48-68. See also Kennedy et al (2017), cited throughout this proposal.

in attitudes both internationally with the INCB, and domestically amongst police figures, illustrates a new appreciation of DCRs.

The current war benefits neither society nor drug users; legally, morally and practically we can – and must – change this fight to achieve effective harm-reduction.

Word Count: 2996.