Similar Problems, Divergent Responses: A Comparative Analysis of Drug Consumption Room Policies in the UK and Germany

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Drug Consumption Rooms (DCRs) have been defined as supervised healthcare facilities that enable the consumption of pre-obtained drugs under safer and hygienic conditions (Hedrich et al. 2010). The first official DCR was opened in Berne, Switzerland in June 1986 and by the mid-1990s DCRs were in operation in Hamburg, Frankfurt, Germany and Rotterdam in the Netherlands. The spread of these facilities was quite rapid so that by the mid 2000s there were 12 DCRs across seven Swiss cities, 25 rooms in 14 German cities and 22 in 12 Dutch cities (Hedrich, 2004). DCRs have also been implemented in Spain, Australia, Canada, Luxembourg, Norway and Denmark. At the time of writing there are advanced plans for the introduction of pilot projects in France. However, there are no DCRs operating in the UK and no Government-supported plans for the introduction of DCRs in the UK. The aim of this paper is to explore why DCRs are implemented in some countries and not in others: and in particular to focus on the question of why DCRs have been introduced in many of Germany's federal states but not in any of the countries that make up the UK.

As such, it is an exploratory article, drawing on the available evidence to suggest possible explanations. It is hoped that this will lead to more detailed primary research in the future.

Much of the research and the literature on DCRs has focused on effectiveness, including cost-effectiveness (e.g. Hedrich et al., 2010; Andresen and Boyd, 2010). There has been considerably less analysis of why DCRs have been set up at particular points in time, in particular cities and countries around the world. From an evidence-based, public health perspective, such decisions would be made through a coming together of evidence of need and evidence of effectiveness: if a service

promises a cost-effective impact on a demonstrated need it should be implemented. However, this linear, 'top-down' model of a government carefully assessing evidence and formulating policy, which is then implemented by local agencies has been eschewed by social policy theorists in favour of theories of *governance,* which emphasise complexity and the role of a variety of actors in policy formulation, and implementation (e.g. Hudson and Lowe, 2004). Moreover, given the disproportionate and distorted media interest in drugs and drug users (Reinarman, 1997), the space for calm, evidence-based, top-down drug policy is, we would argue, considerably less than in many other areas of social policy. Finally, DCRs lie at the more radical end of the already much-contested field of drug policy: in order to introduce a DCR, a state that has made the possession of controlled substances an offence must then provide a space for drug users to use these controlled substances.

The initial aim of this paper is to focus on how policy and practice decisions have been made in two countries that, while appearing to have similar problems with regard to injecting drug use, have taken markedly different paths in their responses to these problems, and clearly divergent paths with respect to DCRs in particular. Ultimately, we aim to explore what the influential factors may have been in these divergent responses.

Similar problems?

Germany has a higher population (82 million) than the UK (62 million). Comparing drug user populations is much more problematic: 'problem drug users' (as defined by the EMCDDA) are a hidden population and a range of estimation techniques can be used to estimate their number. A function of the European Monitoring Centre for Drugs and Drug Addiction is to promote the adoption and publication of a range of comparable indicators of drug use, drug addiction and drug-related problems across the European Union. Drawing on their work, the estimate of the number of problem drug users in Germany in 2000 was 3.1 per 1,000 population aged between 15 and 64, compared to 6.7 per 1,000 in the UK (EMCDDA, 2003). Comparative figures for people who inject drugs were 2.3 for Germany and 4.2 for the UK. Similar problems exist for estimating the number of drug-related deaths, with different definitions adopted across the EU. However, the EMCDDA has attempted to apply standard definitions and according to one such definition ('Selection B'), the number of deaths

in 2001 stood at 1,239 for Germany and 1,827 in the UK (EMCDDA, 2005). While the difficulties inherent in such comparisons should be emphasised, it would appear from a cursory examination that the scale of the problems potentially addressed by DCRs is similar in the two countries and that the available evidence suggests that there is a larger population of people who inject drugs (PWID) in the UK and higher numbers of drug-related deaths.

Statistics at national level may mask local areas of need. DCRs are generally recommended as a local response to particular needs, rather than a universal service (Independent Working Group on DCRs, 2006) and all have been located in cities, with high concentrations of injecting users and drug-related problems. Both countries have a high proportion of the population living in urban areas compared with the rest of the world, with 73 per cent of the German population in towns of 2,000 or more and 80 per cent of the UK population in such areas (Population Reference Bureau, 2012). Both countries contain cities with areas associated with active drug markets and higher numbers of PWID. In the UK Glasgow and London have been shown to have higher estimates of problem drug users (Information Services Division, 2011; Hay *et al.*, 2006). In Germany it is Hamburg, Frankfurt, and Berlin.

In summary, available data suggest similar situations in the two countries, with substantial numbers of PWID and drug-related deaths, and concentrations of users in some urban areas. The available national statistics suggest that the problems associated with injecting drug use are worse in the UK than in Germany. The paper now turns to focus on the 'stories' of the development - or non-development – of DCR services in the two countries.

The German story

In Germany, the introduction of consumption rooms has been closely connected with the provision of sterile injecting equipment. Prior to the implementation of DCRs in Germany, staff working in low-threshold facilities were in a difficult situation: on the one hand providing sterile injecting equipment in order to increase safer use and on the other sending drug users back onto the street to use their drugs. Accordingly, it was quite obvious that there was a need to offer the opportunity for safer

consumption within drug services. Before the first drug consumption room had been officially permitted in 1994 in the German city of Hamburg, a number of drug services had already tolerated the use of pre-obtained drugs in their facilities since the mid 1980s. The toleration of the use of illicit drugs was illegal for the drug services themselves, and this resulted in a precarious legal situation. As in most other countries of the world, the narcotic law does not allow the possession and use of illicit drugs, and this practice could therefore have constituted a criminal offence. However, it took about a decade for the operation of drug consumption rooms to be approved by law. With the 3rd amendment to the German narcotic law, which came into force on 1 April 2000, the operation of drug consumption rooms was allowed under defined legal regulations. In this respect a legal framework for operating drug consumption rooms was created, allowing all German federal states to introduce this service. A newly introduced paragraph in the national narcotic law (§10a BtmG) defines the permission to operate DCRs as follows:

> Anyone who wants to operate a facility that provides drug addicts with the opportunity or allows them to consume narcotics, that have been brought with them and have not been prescribed by a physician, on its premises requires the permission of the highest responsible state agency.

In order to get this permission, services had to adhere to 10 minimum standards which ensure safety and control when using narcotics in drug consumption rooms. These standards include regulations governing the provision of equipment, emergency care, referral to other health services, measures for the prevention of criminal offences, cooperation with local public order authorities, a precise definition of the target group that is allowed to enter the DCR, presence of trained and qualified staff, and monitoring and documentation of the work.

Why were DCRs introduced in Germany?

There are a number of discrete reasons leading to the introduction of the legal framework to operate DCRs. First of all there was the need to respond to the spread of infectious diseases (HIV/AIDS and hepatitis) among the drug-injecting population.

Second, there was an urgent need to find a solution to the open drug scenes (e.g. in Frankfurt and Hamburg) which led to numerous complaints in affected neighbourhoods. Third, the high rates of drug-related deaths demanded further harm reduction measures. Increasing concern about the spread of blood-borne viruses and drug-related deaths led to a policy and practice paradigm shift away from a solely abstinence-oriented approach towards 'acceptance' or harm-reduction approaches. This shift is reflected in the response of drug service providers, who were willing for a considerable period of time to tolerate injecting drug use on their premises, despite the legal risk.

However, perhaps the most important influence was the appearance of open drug scenes in a number of German cities. In the late 1980s through to the early 1990s, drug problems were highly visible in a number of German cities, leading to public order responses. However, it became clear over this period that large, open drug scenes could not be managed simply through law enforcement. In Frankfurt, the police chased the drug users from one end to the other of a park for many months (the public called it 'junkie-jogging'), without any impact on the drug scene. Faced with such clear failures, public health responses were vociferously demanded and, crucially, supported by the police.

The momentum to implement DCRs therefore appeared to come primarily from the dynamics of open drug scenes: their visibility and their counterproductive effects on the economy of a city. Open drug scenes tended to be located around central train stations or in the middle of shopping areas, parks etc. and shop-owners near these drug scenes demanded responses from politicians. The owner of mainline stations in Germany, Deutsche Bahn, had their own very rigid approach, consisting of pushing the drug users out of their premises into public spaces. Local politicians in cities like Hanover and Frankfurt viewed open drug scenes as tarnishing the image of their cities and feared that they would have a negative impact on tourism and business. Police support for DCRs was forthcoming because they viewed them as holding the potential to end this widespread drug-related public nuisance by taking drug users out of public spaces. There was therefore a powerful coalition of support for DCRs, each 'partner' driven by rather different motivations: politicians, fearful for the image

of their cities and associated economic impact; the police, who had run out of ideas on how to control public order problems surrounding open drug scenes; and treatment agencies, driven by the desire to prevent the spread of infectious diseases and overdose deaths.

The German mass media reported quite positively about the implementation of DCRs. This is remarkable, because many other drug services have been heavily criticised in the media. DCRs have been perceived as a professional response towards damaging behaviour. The fact that the police supported these services, made them more ‘acceptable’.

This was the first wave of implementation, once a few rooms had been opened, the arguments from professionals and the positive evaluation results from the projects that had already implemented, led to the implementation of DCRs in other cities, where the visibility of open drug scenes was not so strong. In Germany, there are now 27 drug consumption rooms operating in 16 cities, in six German states (Berlin, Hamburg, Hesse, Lower Saxony, North Rhine-Westphalia and Saarland). While Hamburg operates five and Frankfurt am Main four drug consumption rooms, many other cities have to manage with fewer facilities and also with considerably restricted opening hours. As such, two mobile consumption rooms each are operated in Berlin and Cologne. All of the other cities only run one drug consumption room.

A major challenge that remains is the expansion of DCR provision in Germany. For instance, in Germany the service providers and some (opposition) political parties (in Bavaria have repeatedly demanded the introduction of DCRs but the state government has continued to reject the idea over many years. The positive results of DCRs, from the perspective of local authorities and DCR operators, should encourage the further development of DCRs. The ultimate goal is to adopt appropriate regulations which allow the operation of DCRs in many countries of the world, in order to ensure that people who use drugs have access to effective harm reduction.

In terms of effectiveness, DCRs need to adapt their services to the local consumption patterns, including inhaling and smoking. Further, DCRs need to

provide access to target groups younger 21 who might have developed a risky consumption of new drugs (such as legal highs).

The UK story

In 2002 the Home Affairs Select Committee (HASC)[1] recommended 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.

It made this recommendation on the basis of 'bringing heroin use above ground, so that those who wish to be helped can be, and those who do not wish to be helped can at least indulge their habit at a minimum risk to their own health ant that of the public' (HASC, 2002, Vol 1, para 184).

However, the UK Home Office (home affairs department) evidence to the HASC had already made clear the Government's opposition to DCRs on a number of grounds (Home Affairs Committee, 2002):

- '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.'

[1] The Home Affairs Select Committee is a cross-party group of politicians charged with examining aspects of Home Affairs policy

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.' On this basis, the Government rejected the Home Affairs Select Committee's recommendation to set up pilot injecting rooms.

It is notable that all of these objections would apply elsewhere in Europe, other than the suggestion that there might not be the same level of public or political tolerance as that found in Switzerland.[2] Presumably the fear here was that higher level of local community media and political resistance to the idea would prevent the implementation of pilot DCRs.

A rather different set of explanations was provided by the then-Home Secretary, David Blunkett in an interview with *Druglink* magazine:

> 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)

A new theme here is the emphasis on the need to avoid undermining policy on prescribing. This refers to the Home Office's plans to trial heroin prescription, which were eventually realised in the RIOTT trial (Strang *et al.*, 2010). The UK Government of the time clearly did not want any confusion over 'shooting galleries' to undermine these sensitive developments. The use of the term 'shooting galleries' is also interesting. This is a phrase that has dogged discussion of DCRs in the UK and has been used in inaccurate and misleading ways by the media, politicians and other commentators. The idea that DCRs might be used as 'a type of attraction' is confusing. Clearly DCRs aim to attract injectors.

[2] Why Switzerland was selected in this way is not immediately clear: DCRs were also operating in a number of other countries including Germany and the Netherlands.

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 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.

The grounds for rejecting DCRs therefore changed appreciably over the period 2002 to 2005. There were new concerns expressed about the legal situation and the need to distinguish DCRs from supervised heroin prescription. The legal situation had not changed over this period but the Home Office was trying to take forward its policy on heroin prescription. By contrast, concerns about the evidence base had subsided, although lingering doubts were expressed about evidence of the impact of DCRs on local communities. By this point, the evidence base on DCRs had grown appreciably. In particular, an extensive and authoritative review of the evidence had been carried out for the European Monitoring Centre for Drugs and Drug Addiction (Hedrich, 2004). A number of important publications had also begun to emerge from the well-conducted evaluations of the new facilities in Sydney and Vancouver. Concerns about media responses had also fallen off the agenda.

Reflecting the growing evidence base and a perceived need to revisit the issue of DCRs in more detail, the Joseph Rowntree Foundation – a charity funding social research and development in the UK – supported the setting up of an Independent Working Group on Drug Consumption Rooms (IWG, 2006). The IWG was set up to review the evidence-base on the effectiveness of DCRs, the evidence of needs in the UK that might be addressed by DCRs, and the obstacles (legal, practical, social, political) that lay in the way of piloting the idea. The IWG was intentionally set up as a group of individuals whose views could not be readily dismissed by the Government or the media. It included senior police officers, renowned professors, a barrister and a consultant specialising in addiction. It was chaired by Dame Ruth Runciman, a widely-respected figure in the drug field, closely associated with the implementation of needle and syringe exchange projects in the 1980s. The IWG's report was published in 2006 and there was widespread coverage of the central recommendation that DCR pilots should be set up and evaluated in the UK. The national debate about the idea that followed the report represented the highest profile that the idea has attained in the UK. Articles were included in all of the national and many of the local newspapers and the story was covered on television and radio news bulletins.

While much had been done to pave the way for a positive response from the Government, including meetings with senior civil servants in Government Departments and ministers in Scotland and Wales, the Home Office rejected the idea. By contrast, the response of the then-opposition leader, David Cameron was more supportive:

I certainly wouldn't rule them out because anything that helps us get users off the streets and in touch with agencies that provide treatment is worth looking at.'

Reasons for the Government's negative response are likely to include the considerable problems faced by the Labour Government at the time of the report's release. As Hunt and Lloyd (2008)have pointed out, the Government was 'reeling from one high-profile crisis to the next…not an ideal time for endorsing new initiatives that are likely to produce more controversy' (p.99). While meetings in Westminster before the report's release suggested that a window of opportunity may have been opening, by the time of the report's release this window had slammed shut.

Since the IWG report, there have been a number of local developments, with individual cities recognising the need for a DCR service and, in some cases quite advanced plans being developed, including a potential site and source of funding. However, such plans have so far floundered, often due to local police pressure (in some cases reflecting Home Office pressure on them). Plans have also developed in Scotland and Wales. At the time of writing, a recommendation has been made for the setting up of a DCR in Brighton, following an independent review of drug strategy for the area (Independent Drugs Commission for Brighton and Hove, 2013). This is a particularly interesting development, given the involvement of the leader of the Green Party in setting up the strategic review and some support from the local police chief.

Conclusions: explanations for diverging pathways

So, given broadly similar problems at national level in Germany and the UK, why have there been such diverging pathways in terms of the utilisation of DCRs as a response to such problems? With regard to the British experience with DCRs, a

particular feature has been the consideration of the idea at *central* UK government level – first through the HASC and then in responding to the IWG. From a national perspective, it is easy to see why DCRs are not a hugely attractive prospect for any government in power. The rather candid response to the HASC from the Government of the time showed how fears around likely media reactions to the concept made it a potential vote-loser: the media might accuse them of opening "drug dens". While the stated premises for rejection may have varied in the years that followed, it seems highly likely that the underlying problem has been (and continues to be) the perceived unpopularity and the political consequences. By comparison, the German experience has been one of *local* developments that have eventually gained support through federal law. Many of the debates about DCRs have played out at the local level, rather than in the national media and federal government. This is not to say that there have not been local developments in cities around the UK, where particular problems and needs have been identified and a DCR has been considered as a response to these needs. However, hitherto, these developments have come to nothing. This may reflect the limited local powers and autonomy in the UK, compared to the situation in Germany. British police chiefs may have had more interference from central government than their German counterparts, although this situation may be changing, with the arrival of local Police and Crime Commissioners (PCCs) in England, who have considerable influence over local policing strategy. The degree to which the Government is prepared to take a ‘hands-off’ approach to the question of DCRs (or indeed may be forced to take a hands-off approach) seems likely to be tested in the forthcoming months as the arguments and media outrage play out once again in Brighton.

Another highly significant difference between these two accounts is the presence of large open drug scenes in Germany, which appear to have had no counterpart in the UK. Germany, and a number of other countries such as Switzerland, have experienced the colonisation of parts of their cities by drug users. These gatherings have been associated with serious health and public order problems and have played a pivotal role in persuading communities that something has had to be done to move users into services such as DCRs. Why such drug scenes have not developed in the UK is not immediately clear: it could reflect different approaches to

policing or legislation concerning police powers. It might also reflect the British climate.

Associated with the issue of open drug scenes is the response of the police. The police are crucial to the successful operation of a DCR (e.g. IWG, 2006): for example, in refraining from arresting DCR service users on the way to the facility and in working in partnership with DCR staff to ensure public order is maintained in the area immediately surrounding a DCR. The police response to the idea of DCRs in Germany has been broadly positive: in contrast to the response of many police chiefs in the UK. This may reflect differences in the level of autonomy (as discussed above) or differences in philosophy or approach. It may also be that the initial support of German police forces was *in extremis* – i.e. the overriding priority of controlling open drug scenes forced them to accept DCRs as a potentially effective if unpalatable solution.

A further interesting difference concerns direct action. The Non-Government Organisations running the German projects initially took the risk of allowing drug users to inject on their premises, despite the lack of legal safeguards. By contrast, this does not appear to have happened in any systematic way in the UK. At least in part, this may reflect a widespread misunderstanding on the legal situation in the UK: in particular the extent to which the manager of a DCR can be prosecuted for allowing drug consumption to take place on the premises.

The way that DCRs have been debated in the media appears to have been very different between the two countries. In the UK, whenever the issue has been discussed, much of the reporting has been negative. In particular, the term ‘shooting galleries’ has been used, with all the stigma that that term conveys. At the time of writing, the local *Brighton Argus* has just emblazoned its front page with the headline ‘OUTRAGE OVER SHOOTING GALLERIES’.

However, there is also the role of chance or serendipity. The UK appeared to come very close to a DCR trial in 2006 but at the critical stage, the winds of political fortune changed and a once-confident Government was in turmoil. Drug policy is rarely the central priority of any European government and drug policy decisions often reflect wider political goals and sometimes the fears and ambitions of individual politicians.

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