

Independent Working Group on Drug Consumption Rooms

Paper D

The social impact of public injecting

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Summary

Background and aims

Public drug use and related activities such as drug dealing and disposal of needle and syringes and other drug related litter (DRL) in public places are associated with real and perceived community concerns regarding decreased public amenity, personal safety and crime. Strategies which address the community concerns around these problems by aiming to deter or displace these activities include targeted policing of drug dealers and users and fortification of the built environment. Strategies which aim to reduce the impact of DRL in the community include dedicated drugs litter clean-up teams and provision of public sharps disposal units.

In continental Europe, Australia and Canada, drug consumption rooms (DCRs) have been implemented to improve public amenity near large urban drug markets. A DCR is a dedicated space at legally sanctioned premises where pre-obtained drugs can be used hygienically, and drug paraphernalia appropriately disposed of in the context of low threshold health and social welfare provision. DCRs appear to have contributed to reductions in public drug use and discarded needles and syringes (Hedrich, 2004; Kimber *et al.*, 2003) and calls have been made for their establishment in the UK. However, there is a gap in the understanding of the potential role of DCRs in the UK setting, regarding the nature, extent, frequency and perceived social impacts of public drug use. The Joseph Rowntree Foundation Drug and Alcohol Research Committee funded The Institute for Applied Social and Health Research at The University of Paisley to address this gap in understanding.

This report addresses the study's aims to:

- examine where public drug use occurs and what community members consider as evidence of public injecting or class A drug use;
- describe and map the nature, extent, frequency and perceived impact of public injecting and other use of class A drugs – especially the smoking of heroin and/or crack cocaine in four sites in the UK;

- report the results of 100 key informant interviews and observations plus supplementary existing local information gathered by rapid assessment techniques;
- assess the social impact of drug use in specific locations;
- compare findings from across four study areas and discuss differences with reference to local variations which might have given rise to them.

Methodology

Research team experience of observing and recording drug injecting was used to scope local areas to be studied and produce street maps of areas where public drug use occurs. Using Rapid Assessment techniques (Stimson *et al.*, 2001) pre-existing local data and available reports were gathered as additional indicators of public drug use. These include all data on drug paraphernalia gathered by cleansing teams, needle exchange data, local authority community safety audits and policy reports, an ENCAMS drugs litter study and commentary in local community media. The amount and richness of existing information varied between study sites.

Research team members contacted potential participants whose day to day life at home or at work was likely to expose them to public drug use or its aftermath. Thereafter, a snowball sampling technique was used to contact and recruit further participants. A total of 100 people took part in the study; 25 from each of the four cities: Glasgow, Edinburgh, Bristol and London.

Participants were interviewed about their observations of public drug use and its aftermath. They were specifically asked about their engagement with drug users or any actions they had taken, for example to clear away DRL. They were asked to comment on the impact of public drug use and to express their ideas for solutions to the problems they associated with public drug use. Interviews were semi-structured and data recorded in structured notes. Sixty-one participants also took researchers on 'walk-about tours' of their local areas. During these tours, participants indicated where they had seen drug consumption or other evidence of public drug use and pointed out 'signs' that were present on the day.

Results

Awareness and nature of public injecting and drug use

Participants identified public drug use sites and made connections between drug use and sex work, homelessness, and theft. The stereotypical drug user was described as an unhealthily, dirty, discredited or moderately threatening character. Participants demonstrated awareness of the behaviours and items that might constitute signs of drug use. They also considered items and behaviour such as condoms, human waste and fighting as emblematic of drug use. It is likely that awareness of public drug use is lower among the general population than among the study sample, which was purposively drawn to include people who were aware of public drug use.

Extent and frequency of public injecting and drug use

Drug use was reported in open areas (e.g. alleyways, car parks and derelict open spaces); neglected property (e.g. squatted and seldom used parts of buildings); and publicly accessible residential or commercial property (e.g. specific houses, cafes, toilets, gardens and stairwells).

Public drug use was said to occur at all times of the day and night, although summer months, weekends and evenings were associated with raised levels of activity.

Participants gave reasons for drug use taking place in certain locations rather than others. Recognising drug users' desire for privacy, shelter and adjacent drug markets, participants did not describe public drug use as indiscriminate. Some spoke knowledgeably and with compassion, describing the circumstances of homeless and chaotic public drug users as desperate and fearful.

Observed activities and events associated with public drug use included:

- dealing and buying drugs (50 participants);
- drug users loitering (48 participants);
- injecting (37 participants);
- sex workers operating on streets (19 participants);
- thefts/begging (16 participants);
- smoking crack (15 participants – 14 in South London);

- shouting/swearing/fighting/aggression (14 participants);
- overdose/collapse (9 participants);
- smoking heroin (3 participants – all Glasgow);
- snorting cocaine (2 participants – both Edinburgh).

The following signs of public drug use were pointed out or described:

- used needles and syringes – once to daily (78 participants);
- used foil (29 participants – 14 in South London);
- other injecting paraphernalia (26 participants);
- drug bags/wraps (16 participants – 14 in South London);
- makeshift pipes (11 participants – 8 in South London);
- crack house/drug consumption address (10 participants);
- needle disposal bins (5 participants – all in South London);
- crack house/drug consumption address now closed (4 participants – all in South London);
- derelict site used for drug consumption (3 participants – all in South London);
- bag of crack (1 participant – Bristol).

Social impact of public injecting and drug use

Participants reported being annoyed by DRL, publicly visible drug use, drug use close to their own homes or that children could observe. They reacted with anger, intimidation, disgust and fear. These reactions were especially common when drug users appeared in groups. Further, participants *routinely* found living or working in drug using and dealing areas: offensive; worrying; harassing; disturbing; depressing; exhausting; uncomfortable; threatening or violating. Some reported negative impacts on property values, business success or the general standing of an area. Participants expressed concern for 'other people', especially customers or tourists who might be put off coming to an area. Children were identified as especially vulnerable to the effects of public drug use.

Participants referred to the broader illicit drug use milieu in their area (e.g. drug dealing, street-based sex work, begging, homelessness, sex litter, other anti-social behaviour and drug related crime) significantly eroding or constraining their quality of life. Some reported having taken action to banish drug users from their neighbourhood. Others expressed tolerance, explaining that they had become accustomed to the activities or that they

appreciated drug users' efforts to be discreet given their poor circumstances. Public impact and attitudes and reactions towards drug use cannot therefore be predicted merely from the presence of public drug use.

Participants were aware of two types of environmental planning responses to public drug use: displacement and fortification. While some reported a reduction in public drug use at particular sites, others predicted new patterns of drug use in neighbouring areas. Some also complained about loss of amenities such as toilets, gardens, clubs and car parks.

Participant actions

Participants who were fearful, wanted to avoid trouble or being called on as witnesses, avoided drug users or signs of drug use. Others reported clearing up drug paraphernalia and human waste and intervening to save overdosing or unconscious drug users. Some did this as part of their jobs, while others did so voluntarily. Some voluntarily monitored and recorded evidence of public drug use in their neighbourhood, took legal action against users, appealed directly to them to move away or made reports to police, housing or cleansing teams. Some reported strengthening environmental defences to prevent drug users accessing their property. Although participants were keen to prevent public drug use close to their own homes, they were aware of displacement effects of targeted policing and crack house/squat closures.

Participants employed in the public sector reported having been trained and equipped to pick up and dispose of drug use paraphernalia safely. Some had also been trained in first aid, health and safety, drug awareness and handling public complaints about drug use. On the other hand, participants employed by private businesses generally lacked training and safety equipment. Needle-stick injuries were reported by participants who worked as police officers, cleaners, and bar staff. Most injuries were described as 'accidents' but deliberately concealed needles posed additional risks.

Proposed solutions

When asked to propose solutions to the problems of public drug use, some participants discussed these in the context of wider social problems. Often sympathetic to drug users, these participants called for improved and expanded drug treatment

provision, housing, education, support for prisoners, their families, alleviation of poverty and reconsideration of drug legislation.

Other participants called for more policing and reinforcement of physical environments to prevent drug use. Extreme suggestions included various methods of killing drug users. Physical assaults were alluded to and strategies involving weapons were described as personal defence against drug users.

Forty-two participants suggested ways of getting drug use out of public spaces. Participants said:

- ‘Give drug users a supervised place where they can inject.’ (Glasgow worker);
- ‘We should have consumption rooms here.’ (Edinburgh worker);
- ‘[We] need designated spaces where people can go to get it off the street and away from view. There is no point giving them clean needles if they then have to go and find the first secluded public space and use.’ (South London worker).

Other participants who knew about DCRs objected to them on the grounds that:

- they might encourage drug use;
- they might not be used by all drug users;
- they did not want DCRs in their local area.

Factors influencing the impact of public drug use

Participants at the South London and Bristol sites reported more negative social impacts of public drug use than participants at the other sites. The South London and Bristol sites both have a higher prevalence of crack cocaine use than Glasgow and Edinburgh. The South London and Bristol sites are also more strongly characterised by intense competition between residential and drug market needs for urban space.

Participants’ favoured solutions were not directly related to their perceptions of the general social impact of public drug use in their area. Rejecting solutions such as those emphasising fortification or designing-out drug use were not popular in South London where many changes to the built environment had already been made. It

appears that experience of interacting with drug users may be an equally important factor for influencing the type of solution that participants would favour.

Data from other sources

Study results were consistent with published reports and data from other local sources regarding: the type and location of DRL; the occurrence of drug related crime; the adverse impacts of public drug use; and proposals for addressing public drug use and DRL. Routine surveillance of DRL is inconsistent and partial, so the study's findings could not usefully be compared with those data. We recommend improvements in routine surveillance so that in future they might be used to indicate the extent of public drug use.

Conclusions

This study was undertaken in areas where public drug use is known to occur and involved participants who were likely to be aware of it. This sample expressed some sympathy towards public drug *users* and some understanding of why drug use occurs in public. Nevertheless, every participant reported at least one negative response to DRL or drug use in public view or close to their own homes. They were intimidated by groups of drug users and were routinely offended, worried and fatigued by living or working in areas where public drug use occurs. Their ideas for solutions to the problems of public drug use ranged across the spectrum from severe penalties and violence to ending poverty and legalising drugs. A significant minority (42%) signalled awareness of DCRs as a potential solution to the problems of public drug use.

Chapter 1 Introduction

Background

Problematic use of class A drugs such as heroin and crack cocaine can be associated with public nuisance and anti-social behaviour. This might include: drug dealing; loitering with intent to purchase drugs; public drug use and intoxication; disposal of needle and syringes and other drug related litter (DRL) in public places; sex work; rough sleeping; begging; operation of shooting galleries and crack houses as well as acquisitive crime (and in the case of crack cocaine, violent crime) (Broadhead *et al.*, 1999; Wood *et al.*, 2001; Baumer, 1994; Geter, 1994; Weeks *et al.*, 1998; Ouellet *et al.*, 1991; Klee and Morris, 1995).

Public nuisance and anti-social behaviour associated with problematic use of class A drugs are often concentrated in areas close to illicit drug and sexmarkets. Injecting and other class A drug use in public and semi-public places (e.g. alleyways, parks, public toilets, car parks, stairwells, derelict sites, shooting galleries and crackhouses) largely occurs in the context of expedience. Drug users often wish to consume drugs as quickly as possible after purchase, due to cravings or withdrawal symptoms, as well as fear of apprehension by police or intimidation by other drug users, having no alternative place to use due to homelessness, their drug use not being tolerated in their own home or too great a distance to return to their own home (Klee and Morris, 1995). The urgent and unhygienic nature of injecting in public and semi-public places is also associated with increased risk of HIV and HCV transmission, abscess and overdose (Klee and Morris, 1995; Maher *et al.*, 1998; Bluthenthal *et al.*, 1999; Aitken *et al.*, 2002; Broadhead *et al.*, 2002; Vlahov *et al.*, 1992; Murphy *et al.*, 2001).

Drug related nuisance and anti-social behaviour are associated with real and perceived local community concerns regarding crime, decreased public amenity and personal safety (e.g. needle-stick injuries) (Strike *et al.*, 2004). For example, although environmental needlestick injuries are rare and the actual risk of HCV or HIV transmission is very small, the perceived risk is associated with significant community concern and negative attitudes towards injecting drug users (IDUs) (Thompson *et al.*, 2003). Moreover, although DRL comprises less than 1% of total litter in England (Johnson, 2004), a repeated survey of local authorities in England

in 1988, 2001 and 2004 showed that discarded needles are found in nine out of ten local authorities and the number of needles found increased each year (ENCAMS, 2005).

There is a range of local authority responses to drug related nuisance (DRN). Dedicated drugs litter clean-up teams, public telephone hotlines and the provision of needle exchange services and public sharps disposal aim to reduce the impact of DRL in the community (ENCAMS, 2005). In addition, strategies which aim to deter drug related nuisance include street-level policing targeting drug dealers and drug users, use of anti-social behaviour orders (ASBOs), installation of 'blue lights' in public toilets to make drug injecting more difficult, increased security and/or environmental changes to public and residential spaces (e.g. CCTV, fences, gates and lighting, removal of seating and shrubbery).

Deterrent strategies are not without their shortcomings. Intensive street policing is associated with temporary displacement of drug dealers and drug users, but also increases users' blood-borne virus (BBV) risk taking and compromises injecting hygiene and practice of safer injecting techniques (Klee and Morris, 1995; Maher *et al.*, 1998; Bluthenthal *et al.*, 1999; Maher and Dixon, 1999; Aitken *et al.*, 2002; Broadhead *et al.*, 2002; Wood *et al.*, 2003). Similarly, blue lights, rather than deter users, may actually lead to more risky injecting practices as well as making those environments more hazardous for employees and the public (Flemen, 2003). Finally, a risk of extensive security and environmental design measures to prevent crime or anti-social behaviour is the promotion of a fortress mentality, reduction in aesthetic standards as well as displacement of these activities to less secure areas (Geason and Wilson, 1988; 1989).

Another strategy to improve public amenity (and reduce harms to users) near large urban drug markets has been the establishment of drug consumption rooms (DCRs). This strategy has already been implemented in continental Europe, Australia and Canada. DCRs are dedicated spaces which are legally sanctioned premises where pre-obtained drugs can be used hygienically, and DRL appropriately disposed of in the context of low threshold health and social welfare provision (Dolan *et al.*, 2000). DCRs are well utilised by public injectors, have contributed to reductions in public drug use during their hours of operation and to reductions in discarded needles and syringes (Hedrich, 2004; Kimber *et al.*, 2003; Wood *et*

al., 2004). Moreover, local community support of DCRs relies on anticipated and perceived improvements in public amenity (Thein *et al.*, forthcoming).

Calls have been made for the establishment of DCRs in the UK but there is a gap in understanding the potential role of DCRs in the UK setting as regards the nature, extent, frequency and perceived social impacts of public drug use. The Joseph Rowntree Foundation Drug and Alcohol Research Committee funded The Institute for Applied Social and Health Research at The University of Paisley to address this gap in understanding.

Aims

The study aims were to:

- describe and map the nature, extent, frequency and perceived impact of public injecting and other use of class A drugs – especially the smoking of heroin and/or crack cocaine in four sites in the UK;
- report the results of 100 key informant interviews and observations plus supplementary existing local information gathered by rapid assessment techniques;
- examine where public drug use occurs and what community members consider as evidence of public injecting or class A drug use;
- assess the social impact of drug use in specific locations; and
- compare findings from across four study areas and discuss differences with reference to local variations which might have given rise to them.

This report is divided into four chapters. Chapter 2 describes how the study was undertaken. Chapter 3 provides the findings of the study. Chapter 4 discusses the results and draws conclusions.

Chapter 2 Methodology

Selection and description of study areas

The study areas in Glasgow, Edinburgh, Bristol and South London were selected for this study because the research team had recent experience of observing and recording public injecting and smoking in some of these locations (Taylor *et al.*, 2004; Rhodes *et al.*, 2005). Through their experience of observing and videoing public injecting, the research fieldworkers in these studies had learned the locations where public drug use took place and become familiar with local people. Some of these people used drugs in public, others provided services for drug users and street populations. Those who lived or worked nearby also became familiar to fieldworkers simply because they often met in the neighbourhood. This local familiarity provided good social access for participant recruitment and the knowledge to select study areas known for public drug use.

The study areas also provide examples of different drug scenes and local community settings: Glasgow, the largest city in Scotland (population 600,000) is estimated to have 11,235 problem drug users (population prevalence ~3.3%) (Hay *et al.*, 2005). Among people attending substance misuse services and reporting illicit drug use, heroin is the most commonly used drug, with 70% of Glasgow service users using heroin in 2003–4. In contrast, only 1.4% of this group reported crack use in 2003–4. (Drug Misuse Statistics Scotland, 2004). The main open drug markets are located near the city centre in a transition zone where low cost accommodation, light industry and warehouses meet redevelopment and an improved public park. These areas are also known for street-based sex work (Expert Group on Prostitution, 2004).

Edinburgh, the capital of Scotland (population 448,850) is estimated to have 5,667 problem drug users (population prevalence ~2.1%) (Hay *et al.*, 2005). Among people attending substance misuse services and reporting illicit drug use, heroin is the most commonly used drug, with 65% of Edinburgh service users using heroin. Of this group, 4.4% reported crack use in 2003–4 (Drug Misuse Statistics Scotland, 2004). The main open drug markets in Edinburgh are located in the city's central gardens, graveyards and traditional narrow passageways. The street-based

sex work market in Edinburgh is small and does not overlap with the drug markets or study areas (Expert Group on Prostitution, 2004).

Bristol is the financial and cultural centre of the south-west of England (population 400,000) and is estimated to have approximately 8,000 problem drug users (population prevalence ~2.0%) (Government Office South West Drugs Team, 2005). Among people attending substance misuse services and reporting illicit drug use, heroin is the main drug of misuse (80%) and crack cocaine is the main drug for one in ten (10%) (National Treatment Agency, 2005). The main street drug and sex markets are located in multicultural inner city areas where there is also a concentration of services for drug users and the homeless.

The South London study site is located in the Borough of Lambeth (population 260,000). One-quarter of Lambeth residents live in this strategic and multicultural hub. The boroughs of Lambeth, Southwark and Lewisham are estimated to have 12,500 problem drug users (population prevalence ~3.1%) (Hickman *et al.*, 1999). The drug market operates in and around the train and underground stations and the neighbouring market stalls and shops. There is a street-based sex market on streets just beyond the town centre. The combined use of heroin and crack is prevalent in the area (GLADA, 2003; Cragg Ross Dawson, 2003). This is reflected in the one-quarter (25%) of drug users entering treatment in Lambeth having crack cocaine as their main drug of misuse and under half (45%) heroin (National Treatment Agency, 2005).

Ethical approval and local Drug Action Team concerns

Approval for the conduct of the study was obtained from The University of Paisley's Research Ethics Advisory Group. Information about the study was provided to participants in written and verbal formats and written consent to participate was obtained in all cases (Appendix 2). Although it had been approved by the ethics advisory group, the first version of the participant information sheet met resistance from local Drug Action Teams in the Edinburgh and South London study locations. These DATs pointed out that local communities might interpret the research as a signal that DCRs were being planned for their area. They predicted that this would threaten fragile community support for existing harm reduction services and result in resistance to both

the study and any future plans for DCRs in these areas. They requested that our researchers not approach public sector employees or residents until this was resolved. Although DAT involvement or approval for the study were not required, their endorsement was sought as best fieldwork practice. A second version of the information sheet was therefore produced to address these concerns (Appendix 3). The following text was inserted into the revised participant information sheet:

Please note your local area was chosen for research purposes as an example of a UK setting where there are a number of drug users. This does not mean a DCR is planned for your area. If your local authorities were to consider DCRs in the future, this would be a separate process requiring community consultation.

While this simple clarification enhanced fieldwork practice, the cautionary advice offered by DATs indicates their perception of the delicacy of public reaction to DCRs and harm reduction services generally. These DATs predict that the introduction of DCRs would require careful local consultation, be politically sensitive and likely to meet some resistance, as has been observed in other settings (van Beek, 2004; Schneider and Stoever, 2001; Stoever, 2002).

Initial scoping and pre-existing data

The research team have experience of observing and recording drug injecting in sites chosen for the study. This experience was used to scope the local areas to be studied and produce street maps of areas where public drug use occurs. Rapid Assessment techniques (Stimson *et al.*, 2001) were used to gather pre-existing local data and available reports as additional indicators of public drug use. These include data on drug paraphernalia gathered by cleansing teams, needle exchange data, local authority community safety audits and policy reports, ENCAMS drug related litter studies, a Joseph Rowntree Foundation commissioned study of impact of drug dealing and dealers (Bristol only) and commentary in local newspapers, newsletters and web forums.

Sampling and recruitment

The research team included local experts with knowledge of public drug use areas. These team members contacted potential participants whose day to day life at home or at work was likely to expose them to public drug use or its aftermath. These potential participants were given information about the study, invited to take part and introduced to a researcher. Thereafter, a snowball sampling technique was used to contact and recruit further participants. A fieldwork protocol was devised and used to ensure good practice and common standards across the four fieldwork sites (Appendix 4).

Data were gathered from local residents, business proprietors, service providers and others whose work is likely to bring them into contact with public drug use or signs that this has taken place. Research fieldworkers did not approach area residents directly to invite them to take part in the study. Residents were only recruited to the study if they were already familiar with the local area experts and in discussion with them, and agreed to be introduced to our research fieldworkers who were conducting the interviews. Those who were working in the study areas were approached by researchers if it appeared that their job might entail working with drug users or the aftermath of public drug use. These procedures were recommended by The University of Paisley's Research Ethics Advisory Group.

Initial DAT concerns about the sensitivity of the study introduced delays to recruiting participants in Edinburgh and South London. There was no room in the project timetable to allow for fieldwork delays so until DAT concerns had been addressed, fieldworkers in these areas had to concentrate on recruiting participants who were not employed by local authorities and were not residents. The study sites also differed with regard to use of the built environment. Some sites were busy markets and transport hubs. Others were quiet locations used for either leisure or light industry. Some sites were principally residential. Others were dominated by commercial and business premises. As a direct consequence of this, the profiles of people available to participate in the study varied between sites. Since any differences in results between areas may simply be a result of the different compositions of the sub-samples, caution should therefore be exercised when comparing areas.

A total of 100 people took part in the study: 25 from each of the four study areas. The Glasgow sample comprised 21 participants who worked in the mapped areas and 4 residents. In Edinburgh 18 workers and 7 residents took part. In Bristol, 9 workers and 16 residents. In South London, 17 workers and 8 residents. Table 1 shows the variety of occupations of working participants.

Table 1.

Occupations of participants working in study areas	Number of participants
Glasgow	
Council worker/park keeper	5
Car park worker	5
Shop/restaurant/warehouse worker	4
Toilet attendant	3
Council cleaner/Cleansing dept	3
Tour guide	1
Edinburgh	
Shop/ pub/restaurant worker/proprietor	12
Tour guide	2
Toilet attendant	2
Car park worker	1
Police	1
Bristol	
Shop/garage worker	4
Youth/community work	2
Park keeper	1
Church worker	1
Rapid clean-up team	1
South London	
Community Safety/Street Population/homeless	4
Housing Estate services	4
Shop/restaurant/pharmacy worker	3
Police	3
Anti-social behaviour coordinator, Housing	2
Drugs and Sex Litter Rapid Response	1

Data gathering

Participants were interviewed about their observations of public drug use and its aftermath. They were specifically asked about their engagement with drug users or any actions they had taken, for example to clear away discarded paraphernalia. They were asked to comment on the impact of public drug use and to express their ideas for solutions to the problems they perceived. Interviews were semi-structured and data recorded in structured notes (Appendix 5). Interviews took place in locations suggested by participants. These included participants' homes, workplaces and cafes. Sixty-one participants also took researchers on 'walk-about tours' of their local areas. During these tours, participants indicated where they had seen drug consumption or other evidence of public drug use and pointed out 'signs' that were present on the day. On average, participants spent 35 minutes contributing to the interview and walkabout tour. Where it was safe and appropriate, photographs were taken. These are used to illustrate findings.

Analysis

Interview and walk-about data were analysed to address the aims of the study, i.e. participants' awareness of public drug use; the nature and location of its signs; their extent and frequency; the impact of public drug use; factors influencing social impact; and proposed solutions. Numeric data from individual participants were summed to give findings for each research site. Qualitative data were coded according to themes on experience of interacting with public drug users, attitudes towards them, perceived impact of public drug use and proposed solutions. Coded themes were explored to discover relationships between these data at the participant and community levels. Additional data from pre-existing sources were also analysed to examine the similarities or differences in the findings from these sources and those of the study participants. How the various data were analysed is shown below.

Awareness and nature of public injecting and drug use

Participant awareness of public drug use was first tested in open questions; they were asked to describe activities or any other evidence of public drug use that they had seen. During walk-about tours, participants directed the routes to be taken and were asked to point out anything they thought indicated drug use. In

supplementary questions, participants were asked whether they knew what drugs were being used in the situations they had described. Responses to these questions were assessed for their range, accuracy and reasonableness of interpretation.

Quantitative data on participants' observations of activities and events and the range of items pointed out or described as 'signs of drug use' were grouped to indicate the nature of identified public drug use. In addition to their own experiences, participants were asked about local information, other news and complaints made by others.

Extent and frequency of public injecting and drug use

Data on the number, timing and frequency of each type of observation and sign give indications of the extent and frequency of public drug use. The number of participants reporting each activity and sign is also given.

Participants' statements about the locations and timing of drug use are summarised in lists. The described and pointed-out activities, events and 'signs' are shown on maps for each area. These show the extent of overlapping experiences among participants. The walk-about routes taken, locations identified as sites of public drug use and associated signs and activities allow data to be clustered and interpreted as drug consumption areas. Maps are presented in abstract formats.

Social impact of public injecting and drug use

To discover whether participants understood or sympathised with public drug users, they were asked why drug use might take place where it does, what problems they perceived and whether they could propose solutions. Their professional experiences, experiences as residents, reactions, opinions and proposed solutions were recorded as qualitative data. These are grouped into themes for the report and illustrative quotes are given.

Factors influencing the impact of public drug use: participant level

Maps of observed and pointed-out signs were analysed to suggest reasons for local concentrations of those signs. These were compared to interview data on informants' opinions and reactions to public drug use and smoking in these areas. These higher level

analyses were conducted to learn more about relationships between the evidence and impact of public drug use in specific locations.

Because participants were exposed to such a variety of influences and so many sources of information it is not possible in a small study like this one to draw conclusions about how participants may have formed opinions, why they might have reacted in different ways or why they might perceive different problems or propose different solutions to public drug use. Analyses comparing participants' interactions with drug users with their opinions and reactions therefore aimed only to explore whether relationships may exist.

Factors influencing the impact of problematic drug use: community level

The main items signifying the presence of drug users are: drug users loitering, dealing and buying; overdose events; prostitution; rough sleeping; thefts; and noisy behaviour.

The main items signifying drug consumption are: witnessed injecting; smoking; sniffing or snorting; discarded injecting equipment; and other discarded paraphernalia.

The main environmental signs of drug use are: changes to the environment to deter drug use; disposal bins for injecting equipment; human waste or blood; and graffiti.

This combined area analysis looked at relationships between each of these signs of public drug use and both negative reactions to it and the types of solution proposed by participants.

Data from other sources

Using the Rapid Assessment approach (Stimson *et al.*, 2001) pre-existing local data and data from the current interviews are triangulated. The extent of similarity or difference between these 'local expert', 'local government', 'local media' and 'local participants' demonstrate how public drug use is seen and understood and the aspects of it that have an impact across the range of local stakeholders. The quantity and richness of existing information varied between study areas.

Limitations

The study has some limitations. First, it purposively recruited participants who were likely to be aware of public drug use because of their jobs or where they lived. The wider public is therefore not represented in this study. Second, although participants were asked open questions about potential solutions to public drug use, the introductory information sheet introduced the concept of DCRs. This may well have biased them towards discussion of DCRs.

Chapter 3 Results

Respondents were asked to describe the nature, extent, frequency and social impact of public drug use in the area in which they either resided or worked. This chapter looks firstly at the overall responses to these questions and then examines any differences in responses according to location and respondents' attitudes.

Awareness and nature of public injecting and drug use

Data on the nature of public drug use were taken from:

- participants' observations of activities and events;
- the range of items pointed out or described as 'signs of drug use'.

Activities, events and signs

Participants reported many and varied signs which indicated the nature of public drug use. Between them, they identified dealing, buying and loitering in connection with drug markets. They recognised collapsed and unconscious people as having overdosed and had observed the injecting, snorting, sniffing and smoking of illicit drugs. They were able to point out existing and recently closed sites where drugs were consumed and purchased and described some of these as 'crack houses'. Other sites of known public drug use included specific houses, cafes, toilets, alleys, street sites, open spaces, wasteland, derelict buildings and vehicles. They also suspected that people were using drugs when they spent a long time in toilet cubicles or hid in bushes. Participants made connections between drug use and sex work, homelessness, and theft (e.g. robbery, burglary and shoplifting). Discarded needles and syringes, spoons, swabs, citric packs, needle covers, paraphernalia packaging, prescription ampoules, foil, drug bags, wraps and cut-down drinks cans were all recognised as signs of drug use. One participant told how children had found a bag of crack.

Thirty participants associated drug use with one or more of the following activities/signs: used condoms; condom packaging; human excrement; urine; blood; vomit; phlegm; graffiti; bullets; fighting; shouting; begging; violent crime; and rough sleeping. Although many of these items might be unrelated to drug use, for

participants they were, nonetheless, emblematic of drug use. In one case, a toilet attendant interpreted an incident of self-induced vomiting as an attempt to retrieve bags of drugs from the stomach. On the whole, however, participant reports and interpretations of observed behaviour were plausibly connected with public drug use and few appeared to over-interpret signs. For example, general litter such as lighters and bottles that may have been used to consume drugs were not by themselves reported as evidence of drug use and one participant was cautious about interpreting a series of meetings in a phone box as evidence of dealing, even when he witnessed the police intervening to stop it.

People were identified as drug users if they appeared 'stoned', 'out of it' or if they had a certain 'junky look'. Grey or yellow skin, skinny build and dirty and unhealthy appearances were the stereotype descriptors. They were referred to as 'smack heads', 'crack heads', 'dodgy people' and 'junkies'. Shoplifters, homeless people, hostel dwellers, beggars, sex workers, pimps, Goths and *Big Issue* sellers were also suspected of being drug users. The stereotypical drug user was thus pictured as a discredited or moderately threatening character. For a few participants, the scope of suspicion extended to 'young people', 'pregnant women', 'people with backpacks', 'people with dogs' 'people with expensive cars' and 'people from out of town'. More moderate descriptions suggested that drug users were likely to be male and aged from their teens to their early thirties. In Bristol and the South London study site, participants also spoke knowledgeably and with compassion describing the desperate circumstances of homeless, chaotic and fearful public drug users.

It's a tribal situation like Mad Max, this is a group of people who are out of synch with the rest of society. (South London worker)

Awareness of public injecting and drug use among others in the study sites

In addition to their own experiences of witnessing public drug use, participants were asked to report other news or local information that they were aware of. They reported colleagues, neighbours, family and friends having experiences similar to their own regarding DRL and observed drug use. In addition to regular discoveries of discarded paraphernalia, several large bundles of DRL were reported when an unused part of a building was

accessed or building work begun. News circulated about overdose and drug related deaths and about crack houses and places used to shelter for sleep or to use drugs. Some suggested there was frequent discussion about the impact of drug use and drug markets on local areas. For these participants, street-based commercial sex and gang fights were threatening and reports of theft were widespread. Specific needle-stick injuries were reported and risks to children highlighted. Other participants noted that drug use was 'not news' and therefore unworthy of discussion; that it was so obvious that 'anyone who opens their eyes will see it going on'.

While discussing their own abilities, and those of others in their area, to recognise signs of public drug use, some respondents commented that the wider public could be unaware of public drug use.

Not all of the community see injecting. Most of the impact is on people in local authority housing. Most [of them] are intimidated and it ruins their quality of life. Some are very angry about it. (South London worker)

The area is not what people think it is. They see the nice tourist parts but are unaware what really goes on. (Edinburgh resident)

A lot of people won't realise it occurs here because it's beside the Royal Mile. (Edinburgh worker)

In Glasgow, for example, three participants asserted that public drug use remained hidden because they alone ventured into certain areas to clear up its aftermath. These comments are likely to be valid. The study does not represent the wider public. In the opinion of researchers and fieldworkers, public drug use is less obvious in the Glasgow and Edinburgh study areas than in the Bristol and South London study areas.

Recognition of drugs used

Participants were asked what drugs they thought were being used in the contexts they described. The collected data indicate a range of drug use knowledge among participants. Eleven of the 25 Glasgow participants, eleven of the 25 Edinburgh participants, four

of the 25 Bristol participants and ten of the 25 South London participants did not know what drugs might be being used. Others associated heroin with injecting, crack with makeshift pipes, methadone with prescriptions and cannabis with hand-rolled joints. Bristol participants were most likely to be confident that they knew what drugs were being used, with 21 of these 25 participants reporting heroin, crack or cocaine use.

Extent and frequency of public injecting and drug use

When asked about the extent of public drug use, participants described or pointed out three broad categories of locations where drug use occurred. Open areas included alleyways, car parks, cars, derelict or rubble/rubbish strewn open spaces and train stations. A second category of neglected property included disused and seldom used parts of buildings, building sites, crack houses and squatted buildings. A third category of publicly accessible places held as residential or commercial property included specific houses, cafes, pubs, toilets, gardens, bushes, backyards, doorsteps, stairwells, bin shelters and garages. Locations of drug use signs are shown on maps for the four study areas on pages 90 to 97.

Walk-about tours and participant interviews revealed that public drug use occurs at all times of the day and night. Some local variations were observed so that school children could be seen smoking cannabis on weekday evenings at one location in Glasgow whilst the weekends at the South London study site were said to attract a recreational drug market. Summer months, weekends and evenings were associated with more general outdoor activity, including drug dealing and drug use.

For each activity, event and sign reported, data were gathered on their quantity, frequency and timing. Tables 2 and 3 summarise the observations that are most obviously credible as evidence of public drug use. Appendix 6 provides fuller tables showing *all* reported 'signs', including data on when seen, number of mapped sightings and number of reporting participants. Appendix 6 also provides maps with annotated sightings to show the variety of signs or activities that participants pointed out or described at specific locations.

Table 2. Credible observed activities and events

Activity/event	Site reported	Number of people typically seen	Frequency of typical observations seen
Drug users loitering	Glasgow	5	Twice weekly – daily
	Edinburgh	5	Daily
	Bristol	3–5	Daily
	South London	1–10	Weekly – daily
Dealing and buying	Glasgow	2–8	Twice weekly
	Edinburgh	2	Twice weekly
	Bristol	1–5	Daily
	South London	1–10	Once – daily
Injecting	Glasgow	1	Monthly
	Edinburgh	1	Once
	Bristol	1	Monthly
	South London	1–6	Once – weekly
Overdose/collapse	Glasgow	1	Once
	Edinburgh	1 (10 in police reports)	Monthly
	Bristol	1	Once
	South London	1	Once
Smoking (crack assumed)	South London	1–10	Once – daily
	Bristol	3	Daily
Smoking (heroin assumed)	Glasgow	1–2	Once – monthly
Snorting (cocaine assumed)	Edinburgh	1	Once
Smoking (cannabis assumed)	Glasgow	15–20	Daily
Sniffing (glue assumed)	Edinburgh	1	Weekly

Table 3. Credible pointed out and described signs

Signs pointed out or described	Site reported	Number of items typically seen at one time	Frequency of typical observation
Used needles and syringes (frequent)	Glasgow	1–10	Twice weekly – daily
	Edinburgh	1–10	Daily
	Bristol	3	Daily
	South London	1–20	Every few days – daily
Used needles and syringes (less frequent)	Glasgow	2–5	Weekly or less
	Edinburgh	1–5	Weekly
	South London	1–15	Weekly
Used needles and syringes (single finds)	Edinburgh	60	Once
	Bristol	1000s	Once
Foil (and lighters/ matches)	Glasgow	1–2	Once – twice weekly
	Edinburgh	1–5	Once – daily
	Bristol	1	Daily
	South London	1– many	Monthly – daily
Drug bags/wraps	Glasgow	2	Weekly
	South London	1– many	Weekly – daily
Other IDU paraphernalia	Glasgow	1–10	Once – daily
	Edinburgh	1–6	Once – daily
	Bristol	1	Monthly
	South London	1–20	Weekly – daily
Pipes/cut down drinks cans	Glasgow	1	Weekly
	Edinburgh	1	Monthly
	Bristol	2	Daily
	South London	1–2	Weekly- daily
Environmental changes to deter use	South London	3+ sites	Permanent last 1–2 years

Public needle disposal bins	South London	many sites	Permanent last 1–2 years
Human excrement/urine/vomit/blood/phlegm	Glasgow	1	Weekly
	Edinburgh	1	Monthly – twice weekly
	Bristol	1	Weekly
	South London	1–3	Weekly – daily
Bag of crack	Bristol	1	Once
Graffiti	Bristol	1	Daily

Participants’ explanations for why drug use occurred in their area

On the whole, participants seemed to have measured ideas as to why public drug use took place in certain locations rather than others. Some participants said that drug markets flourished because of a lack of police action. Others noted that the markets were traditional in certain areas and linked to street sex work. Complex networks were described in which property and drug businesses were combined with social connections and controlled by higher level suppliers.

Participants noted that drug users looked for privacy and shelter from the weather and that being near to open drug markets made sense. Hostels, services for drug users and public toilets were identified as facilities that would draw drug users to an area. One participant described hostels as ‘the street under a roof’. Displacement effects of policing neighbouring areas and crack house/squat closures were also identified as reasons for people to be living – and using drugs – on the streets and in residential estates. One participant offered a list of reasons, saying:

Drug users are seeking quieter spots due to CCTV and closure of squats and securing of derelict sites, and are being pushed out of view due to policing strategies – Asbos, gentrification. It doesn’t really take care of the problem, just passes it on to someone else. (South London resident)

Other participants noted that an area reputation for drug use could become a self-fulfilling prophecy.

There is an attitude, a sense that one could get away with quite a lot in [area] and it has always had the 'drugs link' reputation' and people just tend to gravitate toward the drugs market.
(South London worker)

Social impact of public injecting and drug use

Participants described the impact that public drug use had on themselves and their community. They also described their awareness of environmental changes, their own actions to compensate and protect them from public drug use and their solutions to deal with public drug use in the longer term.

Some participants expressed sympathy for drug users who were using outdoors and appreciated their efforts to keep away from residential areas. However, many others condemned or resented them, associated drug dealing and use with specific racial groups, homelessness, theft or sex work and blamed them for blighting an area's reputation and their own quality of life.

Negative reactions

Negative drug user stereotypes are reflected in participants' accounts of the impact of public drug use on local areas. Annoyance, discomfort and avoidance of certain areas were all reported. Residents expressed resentment of drug users and services when they knew that their own neighbourhood was labelled and avoided in this way. Describing the stigma effect of public drug use on her neighbourhood, one Bristol participant noted:

If I apply for a job, I have to give a different address or they don't send an application form.
(Bristol resident)

Four broad categories of negative reactions were found and are described below.

Routine exposure

Twenty participants said they *routinely* found living or working in drug using and dealing areas: offensive; worrying; harassing; disturbing; depressing; exhausting; uncomfortable; threatening or

violating. Some expressed frustration and complained that they had little option but to suffer or tolerate the public drug use that took place close to their homes and businesses. Eight Bristol participants reported drug users 'constantly coming and going' past their homes. One Edinburgh participant said, 'quite frankly, the whole thing pisses me off! Would you want to live with junkies on your door step?'. Some participants picked out their observations of drug use and sex work as their most distressing experiences. In Bristol and South London, participants also complained about drug paraphernalia litter. The following quotes are illustrative.

It's a sense of loss of control over your own living environment, feelings of being imprisoned, helplessness, and despair. There only needs to be one or two crack houses on an estate and the whole place can spiral downwards and generally bring down the tone of the estate. (South London worker)

You become habituated to living in a constant state of red alert, high adrenalin levels. Fight or flight. I am always watching all the dark shadowy places, ready for a confrontational, aggressive encounter. Having to be ready to react to a dealer, user or beggar, it is not easy. People feel vulnerable and at risk and harassed. It increases the general stress of life. Some people get to the point where they can't deal with it. I really notice it when people come to visit from outside the area. They are just not used to it. (South London resident)

It gets to the point where the street is full of rubbish and amenity is generally decreased and all these things go together. Then you lose tolerance, and think enough is enough and get a zero tolerance attitude to the whole thing. (South London worker)

The begging, the dealing, the using it just wears you down. You don't want to see the ugliness of it all. If I didn't have a business here I would

have moved a few years ago. It's the grind of constantly being faced by people using drugs and the attitudes that go with it. When I was young it was exciting but now it just wears me down. (South London worker)

Single encounters and fear of 'drug using others'

Immediate responses or responses to single encounters with drug users included anger, intimidation, disgust and fear. These responses were often linked to encounters with groups of drug users. In total, 32 participants expressed feelings of this kind.

Sometimes I worry they will break in while I'm out or follow me in. I've been forced to take alternative routes out the building because the way has been blocked by intimidating groups of drug users, especially crack users as they are prone to being violent and unpredictable. I was once attacked by a women on the street who banged my head into a metal pole. (South London resident)

The first quote below comes from a participant who disassociates himself from drug users as a class of people. This contrasts with the second quote from a participant who does not reject drug users *per se*, but complains about the aggressive behaviour of some drug users.

I have lost count with the number of meetings I've had with the police and nothing has changed. Why should my livelihood suffer for the sake of junkies? (Edinburgh worker)

It's not the sight of people using that is the problem, I feel sorry for them. The aggressive behaviour is the problem and being confronted on a daily basis with the fear that you might be mugged or have your flat broken into. (South London resident)

It is the first participant's conceptualisation of drug users and drug problems that is typically reflected in the remaining two categories of negative reactions.

Impacts on property and other people

Twenty-nine participants reported the impact of public drug use in terms of its effect on property values, business success or the general standing of an area. Participants often expressed this as their concern for others. Their comments referred to a generalised conception of 'other people', especially potential customers or tourists, who might be put off coming to an area. Children were identified as especially vulnerable to the potential harmful effects of exposure to public drug use and DRL. Some children were said to be prohibited from playing outdoors and parents were said to be fearful for their safety around discarded needles or to resent having to teach them about drug related risks.

Other people are scared of attack with blood filled needles. (Glasgow worker)

The whole city is sick of it being taken over by junkies and beggars. (Edinburgh worker)

I worry about the effect it will have on the future when my small child is old enough to play outside. (Bristol resident)

NIMBY

'Not in my back yard' is the sentiment expressed in this final category of negative reactions to public drug use. Participants who were tolerant of drug use in some situations nevertheless identified specific problems as: DRL, publicly visible drug use, drug use close to their own homes or that children could observe. Twenty-seven participants expressed 'not in my back yard' sentiments regarding the location of either public drug use or the location of services for drug users. The first two quotes are examples of the 'anywhere but here' style of complaint.

Don't mind with junkies if it is not visible and they pick up their needles, it's their chosen lifestyle just as long as it doesn't impinge on mine. (South London worker)

It aggravates me. I feel violated by people coming into my front yard. They can do whatever they want but not in my or others' front garden. (South London resident)

These next quotes are from participants who want to prevent local drug services attracting more users to their neighbourhoods.

Tenants should have got notice that [drug treatment service] was opening up. Don't mind what they do but we should have been told. (Edinburgh resident)

I disagree with the amount of agencies in the area. Not fair to have all agencies concentrated here. (Bristol resident)

This participant's quote expresses a more liberal variation on the NIMBY position.

If you want the 'vibrancy' of the area/community you can't just exclude one element of it. I would just prefer to have less of it thrust in our faces. (South London resident)

Environmental responses

Participants were aware of two types of environmental planning responses to public drug use: displacement and fortification. Some reported that environmental regeneration, landscaping or CCTV installations had deterred public drug use at particular sites. These participants also signalled awareness of displacement effects and predicted new patterns of drug use in neighbouring areas.

Other participants pointed out ways in which their neighbourhood had been reinforced with gates and fencing; amenities had been closed; and changes made to the environment to increase opportunities for surveillance – all as measures to deter drug consumption. Some of these participants complained about loss of amenities such as toilets, gardens, clubs and car parks. Nevertheless, further security was often called for as a solution to public drug use.

Had to erect cages around our flats to keep the drug users and sex workers out and associated litter out, but still get stuff in our gardens. (recruited as South London worker, also resident in area)

All of the designing out – putting up bars and cutting down trees and shrubbery is making [area] a very claustrophobic place to live. Also some users used to huddle together behind four trees, and the council cut one tree down, and then another two, so that there were five users huddled behind one tree – depressing. (South London resident)

Shopkeepers and restaurant workers reported disruption to business because of drug users loitering near their premises. Their solutions lay in employing specialist security staff or permitting drug users to gather instead at the rear of their premises, 'where the customers do not see them'. Two participants working with homeless people in South London explained that it was better not to disrupt injecting in established locations and one member of the rapid response DRL team reported being asked by drug users to wait till they were finished injecting so that he could collect their used equipment. In the same area however, two participants reported pursuing anti-social behaviour orders and evictions against drug using residents and police participants reported a duty to 'move them on'. Limited tolerance was thus mixed in the same spot with efforts to banish drug users. Public impact and attitudes and reactions towards drug use cannot therefore be predicted merely from the presence of public drug use. Participants commented that public reactions were likely to be influenced by cultural familiarity with drug use. Recent settlers in an area and those with aspirations to gentrify an area were picked out by participants as least likely to tolerate sharing an environment with public drug users.

Most people who have lived in the area for a long time are used to it but people who have moved here recently have difficulty adjusting. (South London resident)

People moving to the area because of the relatively low house prices and vibrant, diverse neighbourhood tend to get a bit of a shock when first having to deal with the day to day impact of public drug use. (South London resident)

Some people have left [area] because of the drug issue in the past few years, some of my parents' friends who were left-wing radical people who moved here in the 70s, just found it got too much and they were too old to deal with it on a day to day basis. (South London resident)

Participants' actions

Participants were asked about their residential and professional experiences and roles regarding public drug use. Two specific ways in which they intervened to reduce the impact of public drug use on themselves and others in their area were reported. These included potentially harm reducing interventions and clean-up operations and direct interventions with drug users. Some respondents spoke about taking avoiding action. Those whose work brought them into contact with public drug use discussed how prepared they were to tackle public drug use and its aftermath.

Harm reducing interventions and clear up

In Glasgow:

- Five participants reported phoning an ambulance on discovering an unconscious or overdosing drug user and/or intervening to revive him or her.
- Nine participants reported picking up and safely disposing of discarded needles and syringes as part of their jobs.
- Five participants reported picking up foil; one had picked up spoons; one had cleaned blood from toilet walls; and one had cleaned up human excrement from a staircase.

Equivalent figures for Edinburgh are:

- four interventions with respect to overdose;
- eleven picked up and disposed of needles and syringes, five as part of their jobs;

- five picked up foil; three had picked up paraphernalia packaging; one had cleaned blood from toilet walls and floors.

Equivalent figures for South London are:

- One participant called an ambulance having observed an overdose event.
- In their professional roles as police officer and rapid response drug litter team members, two participants had been called to attend a body in fatal overdose cases.
- Another participant called an ambulance when someone fell several floors from a neighbour's flat window in an attempt to escape a police raid of a crack house.
- Five participants reported picking up and safely disposing of discarded needles and syringes, two as part of their jobs.
- Five participants reported picking up foil; six had picked up other paraphernalia; four had picked up condoms; three had cleaned blood from walls or floors; and four had cleaned up human excrement.

In Bristol,

- seven picked up and disposed of needles and syringes or moved them out of the way. Two did this as part of their jobs.

During walk-about tours and interviews, Bristol participants paid relatively little attention to discarded paraphernalia associated with drug use.

Interventions with drug users

Participants took a variety of actions to move drug users away. Five Glasgow participants had spoken directly to drug users, asking them to leave a given place or not to inject. Residents there informed the study about consultations, a petition and community meetings that had been organised to protest about both public drug use and proposals about the location of drug user services. Phoning the police or city council to report public drug use or DRL was a common response, although participants also complained about slow or inadequate police attention. All nine of the Glasgow participants taking direct action or requesting help noted, however, that they did so only in particular circumstances: when drug users had been abusive, were injecting or showed

signs of overdose. On the other hand, three of the four residents in the Glasgow sample reported never having intervened, reasoning that others were paid to do so.

In Edinburgh, 12 participants spoke directly to drug users to move them on. Eleven phoned the police to report injecting, abusive or loitering drug users but again slow police responses were commented on. One resident noted that local 'trouble' had increased since a treatment agency was opened nearby. Meanwhile, others had paid for gates to be installed specifically to prevent drug users accessing their gardens. Three participants reported discarded needles and syringes to the council and one reported this to his landlord. As with Glasgow, the Edinburgh participants only intervened directly in particular circumstances rather than in response to all signs of drug use.

In Bristol, seven participants had confronted drug users to move them on. Many Bristol participants seemed to be actively involved in monitoring and campaigning on drugs issues. Counting and recording evidence of drug use or dealing appeared as something of a local hobby. They kept journals, made films, took photographs and joined action groups. Three participants explained that they filmed and photographed drug users and sex workers as security measures and to provide evidence to the police. Four participants called the Rapid Response Unit to report drug paraphernalia litter and two described joining a 'clean sweep' community tidy-up scheme. Two participants who reported evidence to the police complained that their response was inadequate or too slow. Another said that the police were monitoring a local house where a drug related arms cache was suspected.

In South London, eight participants reported moving drug users on, asking them to stop using or to leave. Three had phoned the police when they witnessed injecting, abusive or distressed drug users. Four had contacted cleansing teams to report discarded needles and syringes. One had phoned a friend to alert her to drug use in her garden. Another had written to the council about the need for a space where users could go. There appeared to be a good deal of liaison between residents and service providers in South London. Three residents described their roles with local resident associations as being focused on drug use issues. One reported the formation of a housing estate 'vigilante' group in

response to the frequency and severity of drug use and property crimes. Their reported activities included photographic documentation of drug users and related litter and proactive neighbourhood watch.

Avoidance

While some participants were prepared to intervene to prevent or respond to drug use and litter in their area, perhaps agreeing with the participant who said that, 'negotiation is the best policy', 13 others avoided all contact with drug users or signs of drug use. Fear of the unknown and avoidance of 'trouble' featured in their explanations. One said that when witnessing public drug use, it was 'best to leave these things alone. You don't know what will happen.' One Edinburgh and four Bristol participants who had witnessed dealing or drug consumption said that they did not react because they were afraid of the consequences of being called to court as a witness. In South London, six participants stated they were used to public drug use in the area, were desensitised to it but nevertheless were also mindful to 'look the other way' or avoid specific places.

Policing

Some respondents complained about ineffective policing, in particular that the police did not respond in time to catch people who were using drugs in public. On the other hand, many participants said they thought the police did a good job, focused on the right priorities and kept the main thoroughfares safe by restricting drug use to less public spaces.

Professional training

Participants employed as police officers, by car parks or by city councils, in cleansing teams, parks, and public toilets reported having been trained to safely pick up and dispose of drug use paraphernalia. Litter pinchers, gloves, sharps bins, and incident log books were provided and used. In Edinburgh, police and toilet attendants reported being vaccinated against hepatitis B. A few participants had also received training in first aid, health and safety issues, drug awareness and dealing with the public. This last item was considered important by some participants because the public regularly reported DRL or complained to them about public drug use. This is discussed further below.

Other participants whose work brought them into contact with drug users and drug use paraphernalia had quite different experiences. Participants employed in shops, restaurants, pubs, warehouses, privately owned car parks and tourist businesses reported having no training and no safety equipment. One Edinburgh barmaid noted that a pub cellar had become a no-go area for staff because of discarded needles and syringes. In Bristol, individuals working in anti-social behaviour and community safety teams also lacked safety training. Three participants described requesting sharps boxes and either obtaining NHS supplies of these on the black market or being denied them because of their cost to private business.

Needle-stick injuries – personal or among their colleagues – were reported by participants who worked as police officers, cleaners, and bar staff. Most injuries were described as ‘accidents’ but risks were also linked to police searches of clothing and malicious ‘booby traps’ of hidden needles in bins and concealed places.

It's dangerous for cleaners. You can't see needles in the grass. Users put needles around the inner rim of bin bags, so have to be really careful emptying bins. Some cleaners have quit because they can't cope with the conditions: dealing with needles, faeces, urine, blood, abuse from frustrated residents, and feeling threatened by drug users. (South London worker)

Professional participants also reported that in their roles they received complaints from the public that were related to public drug use. In Glasgow, five participants had received complaints about DRL and three had received complaints about drug use. These participants were shop assistants, car park attendants, park keepers, council workers and cleansing team members. In Edinburgh, only a police officer participant had received complaints about drug consumption. Meanwhile, a toilet attendant and two tour guides had received general complaints about drug users hanging about. In Bristol, only one participant, a garage assistant, reported receiving general complaints from the public. This is not to suggest that Bristol participants did not complain about the impacts of public drug use in their area, merely that other participants did not receive complaints from the public in their line

of work. These data show that complaints are received by people in a wide range of occupational roles. Many of them will not have been trained for this and are unlikely to have the skills or coping mechanisms to deal with public complaint.

The South London sample indicates the considerable quantity of professional time focused on public drug use. Three South London police officers participated and reported that up to 80% of their role was concerned with public drug dealing and use issues. These ranged from referring drug users to services and pursuing them for ASBO offences to attending overdoses. All three independently reported receiving six types of complaints from the public with regard to drug use: dealing; public drug use or sex; DRL; intimidation; break-ins; and rough sleepers. Eleven other participants worked with street populations, homeless people or had roles in housing or criminal justice initiatives. Eight of this group said they too responded to resident concerns and complaints about drug use. In turn, they reported to police, council, housing and clean-up teams and estimated spending 30% to 100% of their professional role focused on drug issues.

Proposed solutions

Participants commented on potential solutions to the drug problems they perceived in their local areas. Altogether, 39 participants thought that physical environments needed to be fortified or more policing was required to prevent/discourage drug use in certain areas. More extreme suggestions included various methods of killing drug users. Two participants alluded to serious physical assaults that had been made on drug users 'to sort them out'. One reported intervening to prevent a girl being beaten up, while others reported keeping weapons to hand to defend themselves.

Some participants believed there was no solution, that drug use was inevitable or that the problems lay in social reaction towards drug users. Others identified 'drug problems' as indicators of broader social problems including unemployment, poor education and reduced social cohesion. Twelve participants argued that drugs should be legalised or reclassified. Improved and expanded drug treatment provision, education, and support for prisoners, their families and the alleviation of poverty were all called for. A lack of housing and suitable temporary accommodation were recognised as problems for public drug users. Sympathy for drug

users was often linked to participants' perceptions that they were not personally immune to drug problems. As one commented:

Even those [residents] that have suffered due to drug use are still understanding. What if their kid got involved? (South London worker)

Forty-two participants suggested displacing public drug use to indoor alternatives.

Glasgow participants said:

- 'Give drug users a supervised place where they can inject.' (worker);
- 'If they are giving out needles they should provide a place for them to inject as well.' (worker);
- 'Supervised centres.' (worker);
- 'Drop-in centres but not in the midst of residential places where kids are around.' (resident); and
- 'An area with nurses and doctors where they can inject safely.' (worker).

Edinburgh participants said:

- 'If they've got somewhere to do it, it wouldn't bother me as long as they don't do it on my stairs.' (resident);
- 'We should have consumption rooms here.' (worker);
- 'Keep it out of public sight.' (worker);
- 'You'd struggle to find the right area because of people living and working there. But it would take it off the street. It's finding the right area.' (worker).

South London participants said:

- 'Provide a place where users could go and not be harassed by police.' (resident);
- 'An environment for them to use which is safe for them and us.' (resident);
- '[Something that] removes the evidence from the street.' (worker);

- ‘It would be a terrifically good idea to have clean rooms and more resources into re-hab. Anything to take it off the street would be a help.’ (resident);
- ‘Drug consumption rooms would provide not just a place to inject but somewhere to drop into, to break the ‘shoplift, score, fix’ routine. A place indoors to pause. They are barred from all the restaurants and cafes. As well as have access to primary health care.’ (worker);
- ‘Need designated spaces where people can go to get off the street and away from view. There is no point giving them clean needles if they then have to go and find the first secluded public space and use.’ (worker);
- ‘Drug consumption rooms could have a role if it were a setting where people were challenged, encouraged, assertively engaged and linked to get housing, health care and drug treatment.’ (worker);
- ‘Drug consumption rooms sounds like a good idea, but I wonder whether addicts would use them. They might feel exposed or paranoid because drug use is still illegal and fear of the police or be worried that they would run into someone who they owed money.’ (worker);
- ‘It is analogous to street drinking issue and wet areas. We need to recognise the needs of individuals and circumstances, that is designating places where they could go and where the problem is contained. Not in the centre of town, not in a residential area, not at the front of a school – would need to be well designed and resourced.’ (worker);
- ‘Providing a space for users to go might assist with the needles and intoxication on the street and it would be much better for people with kids. But it would not solve the problem that people who use are desperate for money and can be very aggressive.’ (resident)

South London participants also raised doubts about DCRs. One said that they would not solve the problem for homeless users because, ‘these people do not want to be normalised or have tabs kept on them’. Another said he thought DCRs had a role, ‘but realising it here would be very difficult’.

One Bristol participant said: ‘legalise shooting galleries’. Others knew about DCRs but expressed reservations about them. First, they objected to them on the grounds that they might encourage

drug use. Second, they thought that they might not be used: especially by local Jamaican drug users or others who were unknown to services. Third, they did not want DCRs in their local area. As one resident explained, 'there are too many agencies in [area] already'. Picking up this theme, three Bristol participants suggested alternative locations at the sites of newly emerging local drug markets or away from residential areas.

Factors influencing the impact of public drug use

Signs of public drug use were pointed out and described in a variety of places in each of the study areas. The maps in Appendix 6 illustrate this. Participants gave overlapping information so that some specific sites appeared to be quite well known for public drug use and related activities. It also seems that certain specific sites have become known for public drug use and related activities through word of mouth. An area's reputation for public drug use could thus be reinforced and spread beyond those who have encountered it directly. Other specific sites and signs were known only to those who lived or worked in their immediate vicinity.

Participants were asked to identify these signs of public drug use. However, the study's central concern is with the *social impact* of public drug use. There is no reason to assume that social impact or preferred solutions to perceived problems should be related merely to experience of its 'signs'. At the end of interviews, participants were therefore asked:

- what impact public drug use had had on themselves, those close to them and their neighbourhood; and
- what they thought could be done to address problems they had identified.

Data collected in response to these questions were explored to discover whether perceptions of social impact or proposals for solutions might be related to participant attitudes or experience of relating to drug users.

First, responses were examined at the individual respondent level. Second, a cross site comparison attended to community level differences in what respondents drew attention to as evidence of public drug use.

Individual respondent level

Participants' experience of interacting with public drug users may be shaped by their professional roles and experiences as residents living in areas where public drug use occurs. Participants were asked about these roles and about their activities in relation to public drug users. No relationship was found between participants' interactions with drug users and their assessment of the general impact of public drug use in their area.

Neither was any relationship found between participants' assessments of the general impact of public drug use and the type of solution they were most likely to favour. That is, participants who reported strong negative impacts of public drug use were almost equally likely to propose solutions that were tolerant of drug users as they were to propose rejecting/displacing drug users.

Nevertheless, participants who interacted with drug users were more likely to propose solutions that focused on finding suitable places for drug use rather than on deterring local drug use. For example those interacting with users (e.g. offering assistance in overdose scenarios or clearing up discarded injecting paraphernalia) were more likely to propose some kind of tolerance area or service for drug users.

Comparison across study sites

To allow comparison between study sites, Table 4 shows the number of participants in each study area who described or pointed out: evidence of drug users; drug consumption; and environmental change.

Table 4. By area: participants (of whom residents) pointing out and describing signs and activities as evidence of drug users, drug consumption and environmental effects

	Glasgow	Edinburgh	Bristol	South London
Drug users	14 (4)	18 (5)	23 (13)	22 (8)
Drug consumption	22 (4)	25 (7)	17 (8)	19 (8)
Environment	1	2 (1)	2 (2)	13 (8)

Table 4 shows broadly similar numbers of participants reporting presence of drug users and evidence of public drug consumption in each of the four study areas. However, with regard to reported

environmental effects, South London differs from the other study areas. Thirteen South London participants reported environmental effects. In contrast only two participants from Bristol, two from Edinburgh and one from Glasgow commented on environmental effects.

Next, with regard the impact of public drug use, we noted which participants made tolerant or positive comments versus those making rejecting or negative comments.

Table 5. Summary of impact data by study area: participants (of whom residents)

	Glasgow	Edinburgh	Bristol	South London
Acceptable/ tolerable	4	2	0	1
Both tolerable and negative	7	4 (2)	0	1 (1)
Negative	8 (2)	13 (3)	13 (11)	22 (7)
No comment	6 (2)	6 (2)	12 (4)	1

Table 5 shows that there is a prevailing sense of public drug use having negative impacts, especially in South London and Bristol. In Bristol no participant expressed a willingness to tolerate the impact of public drug use, while 15 felt negatively about it. Similarly, in South London only one participant expressed tolerance of the impact of public drug use while another expressed both some tolerance and some hostility. In Glasgow and Edinburgh, the spread of opinion is slightly wider. Eleven of the 19 Glasgow participants who commented expressed some tolerance. Six of the 19 Edinburgh participants who commented expressed some tolerance. These area differences may arise from differences in the extent to which drug using and housing areas share space. The Glasgow and Edinburgh study areas are in city centres where residences are interspersed with commercial and public buildings and are not easily accessed from the street. In Bristol and South London, the study areas have a greater concentration of residences, many of which are accessed directly from public streets. The following quote from a South London participant speaks of the frustration of choosing between the pleasures and risks of maintaining her garden that drug users were accessing to inject or smoke drugs.

I am thinking unless the situation improves, I am going to have to cut down the front hedge. I don't want to, but am thinking I will have to.
(South London resident)

Support for these tentative conclusions is suggested by a final analysis. This compares the popularity of different types of solution to public drug use across the four study areas. These results are summarised in Table 6.

Table 6. Summary of proposed solutions by study area: participants (of whom residents)

	Glasgow	Edinburgh	Bristol	South London
Tolerant	8 (1)	5 (3)	4 (4)	11 (7)
Both tolerant and rejecting	2	1	1 (1)	9
Rejecting	8 (1)	7 (2)	12 (8)	0
No comment	7 (2)	12 (2)	8 (2)	5 (1)

Both Glasgow and Edinburgh have roughly equal numbers of participants proposing solutions that tolerate drug users and services and proposing solutions that seek to reject users and services. In Bristol, where public drug use occurs close to housing but where relatively little has been done to reinforce the environment against drug user access, participants' proposed solutions emphasise displacing or rejecting drug users and building defences to keep them away. Bristol participants said:

Clear undergrowth so injectors can't hide.
(Bristol resident)

[We need] better street lighting. (Bristol resident)

[We need to] have a special area for junkies and prostitutes like in Amsterdam. Not in a residential area and not in [this area]. (Bristol resident)

In the South London study site, public drug use also takes place close to housing but there is a strong perception there that much has already been done to reinforce the public environment to design-out crime and discourage drug use (see Table 4). Here, 11

participants expressed a preference for solutions that tolerated drug users in the community, none sought only rejecting solutions and nine suggested a combination of tolerant and rejecting solutions. The following quote is from a South London participant.

People are largely homeless and in [this area] with no where else to go. This is becoming more apparent with the closure of squats and crackhouses and empty buildings being secured quickly which forces people out onto the street and residential areas. Having nowhere to go makes people more creative, desperate and risky. It is becoming more difficult to survive as a homeless IDU in the inner London area. (South London worker)

Data from other sources

Data on aspects of public drug use were gathered from a variety of local sources and compared with participants' responses.

Awareness, nature and extent of public injecting and drug use

Consistent with fieldwork reports across the four study sites, a DRL survey (ENCAMS 2005) found that community residents at DRL hotspots in south western England identified DRL as used needles and syringes, foils, spoons, ampoules, cans/bottles with holes, cellophane, condoms, urine, vomit, faeces and discarded clothes/mattresses. Moreover, DRL was observed both on the street separately or with other litter in alleys, crevices, car parks, wasteland, toilets, front and back gardens, and parks and play grounds (ENCAMS, 2005).

Several existing sources of information on the nature and extent of public drug use are consistent with findings from interview data which suggest that public drug use and DRL are visible in public places, particularly those close to drug markets. One indicator of public drug use is the volume of DRL collected in the community. In Glasgow a total of 14,337 needles/syringes (average/month = 1,195) were collected between April 2004 and March 2005 (Glasgow City Council Environmental Services, personal communication, June 2005). Moreover, the three wards where the fieldwork was undertaken had the highest counts of discarded

needle/syringes during that period. In Edinburgh, a total of 362 needles and syringes were collected between January 2004 and June 2005 (average/month = 30) (Edinburgh City Council Culture and Leisure Department, personal communication, June 2005). In Lambeth (borough of the South London study site) an average of 93kg of drugs and sex litter, an estimated 1,860 needles/syringes per month were collected between July 2004 and March 2005 (Lambeth Drugs and Sex Litter Rapid Response Unit, personal communication, June 2005). In the Bristol study area approximately 1,680 needles and syringes were collected between November 2004 and June 2005 (average/month = 280) (Waste Services, Bristol City Council, personal communication, July 2005).

Another indicator of the potential for DRL in the community is the number of needles/syringes distributed and returned to Needle Syringe Programmes (NSPs). This is a less rigorous indicator however as there are several alternatives for non-public disposal (e.g. community pharmacy, public sharps bins, domestic and general waste bins). For example, in Glasgow an estimated 267,473 (37%) of 733,747 needles and syringes distributed between December 2003/04, were not returned to NSPs for disposal (National Treatment Agency, 2005). In contrast in Edinburgh an estimated 355,563 (77%) of 464,249 needles/syringes distributed in 2004/05 were not returned to NSPs for disposal (Edinburgh Drug Action Team, 2005). In a survey of English local authorities, reported needle exchange return rates ranged between 72% and 84% for pharmacy based and fixed site NSPs (ENCAMS, 2005).

The figures for DRL collection are worthy of comment. The Edinburgh figures do not include counts of needles and syringes collected from cemeteries, commonly used for injecting in that city. Lambeth collections are weighed rather than counted, while Bristol differentiates *proactive* (i.e. identified by the clean-up team) and *reactive* (i.e. identified by a member of the public). Eighty-seven percent of collected DRL in Bristol was collected proactively. These problems were not overcome by the most recent ENCAMS survey of DRL collections. This postal survey of English local authorities produced only a 41% response rate (ENCAMS, 2005). Standardisation of these methods of recording counts of DRL could provide opportunities for routine surveillance and indicate impact of interventions to reduce DRL.

Police statistics on drug related arrests are also an indicator of the level of drug related activity in an area. For example, in Glasgow in a 10-month period police reported 630 drug offences from one hostel. In Bristol between April and July 2004, 24 drug related police operations were undertaken and 64 arrests made relating to class A drugs. In that time an estimated 1,490 street deals of crack, 11,750 street deals of cocaine, and 59,330 street deals of heroin were seized (Safer Bristol Partnership Crime and Drugs Audit (SBPCDA), 2004). Further, approximately 40% of police activity in Bristol in 2003 related to anti-social behaviour (including drug dealing and use, begging, sex work, intimidation and harassment, and litter) and the study area ranked fourth in Bristol for anti-social behaviour offences (SBPCDA, 2004: 55). In Lambeth (South London) during 2003-2004, 76% of offences defined as drug related (possession, trafficking/supply, and prostitution) were for possession (London Borough of Lambeth Community Safety Audit (LCSA), 2004). Consistent with the fieldwork reports, most of the drug related crimes in the South London study site were in close proximity to the site's town centre. The police statistics here may serve as indicators of public drug use and are consistent with other indicators of public drug use in those areas. However, these statistics will also be affected by police activity in the areas.

The operation of crack houses or shooting galleries was identified in both the Bristol and South London study sites. This was also reflected in existing information. Twelve crack houses were closed in Bristol between February and July 2004 (SBPCDA, 2004), and in the South London area in 2003-2004 79 Council properties were closed due to identified drug activity (LCSA, 2004).

The visibility of drug dealing and concern about drug related crime highlighted in the fieldwork is further documented in local media sources. In Glasgow, hostels are viewed as 'lucrative' places to sell drugs (Page, 2004). The South London study site has been portrayed as a 24-hour drug 'supermarket' with rampant, blatant crack dealing, with 'crazy crackheads' and 'smack heads in stairwells', and as a place that 'nice' people don't come to for fear of being mugged or assaulted (Whittell, 2002; Thompson, 2002; Key, 2003).

Social impact

The interview data highlighted that public drug use, DRL and other drug related activities had a significant social impact and were associated with mostly negative feelings among affected local residents. This adverse social impact is also documented in several existing sources. According to ENCAMS, in the Bristol area covered by the current study, people were 'fed up' with: the area attracting 'undesirables' and felt that there were too many services in the area for drug users such as hostels and drug programmes; drug dealers and users who were associated with crime, violence, guns and intimidation; blatant sex work and pimping; dirty run-down streets, including derelict buildings and litter. In addition DRL was perceived to be part of a wider problem of drug use, general litter and sex work (ENCAMS, 2004). Further, a recent Joseph Rowntree Foundation study examining the impact of drug dealing and dealers also showed that residents were concerned about the negative reputation that the drug market gave their area, and the violence associated with it, including fear of reprisals (May *et al.*, 2005).

Public intervention

Interview data show that people intervened to tidy up and dispose of DRL as part of their jobs but also as directly affected residents/concerned citizens. The ENCAMS study (2005) focuses on how local authorities receive residents' *reports of* DRL but does not monitor voluntary clearing up by residents or DRL that is not passed to local authorities. This suggests that where residents are clearing up DRL this may not be recognised or recorded. However, local councils in the study areas have established strategic responses to drug related problems. The Bristol Neighbourhood Renewal Strategy for 2001-2006 (Bristol Partnership, 2004) explicitly aims to reduce drug related crime and fear of crime and nuisance and litter. The Lambeth Community Safety Strategy explicitly aims to reduce drugs crime, environmental nuisance and anti-social behaviour. Within the last two years, all four study areas have established rapid response clean-up teams to collect DRL. Public sharps bins are also installed in South London and are under consideration in Bristol. In Bristol the rapid response team aims to achieve a 50% reduction in DRL in known hotspot areas (SBPCDA, 2004).

Moreover, consistent with the interview data, ENCAM survey residents' attitudes included feeling: unsafe to go out at night due

to fear of muggings and verbal abuse; angry at drug dealers and users but also at authorities for turning a blind eye or not doing enough to address the problem; worried about the future of their children; and frustrated at having to deal with impact of others' drug use on their lives (ENCAMS, 2004). Attitudes towards DRL were that it was disgusting, selfish, filthy, dangerous, and despicable, with feelings of hatred towards those responsible. Respondents were especially concerned about children and DRL, both the risk of accidental needle-stick injuries/BBV infection, and growing up in an environment where DRL is the norm. Businesses feared that DRL may drive customers away/result in a loss of income (ENCAMS, 2004).

Concerns about safety and quality of life in relation to drug dealing, drug use, and DRL and other anti-social behaviour were also documented in other resident surveys. In the Bristol Fear of Crime Survey (Safer Bristol Partnership, 2004) 35% of respondents reported that drugs/dealers/or users are a problem in their neighbourhood, and 69% mention litter as a concern (although not specified as drugs litter). Further, 51% of residents in the Bristol study area were fairly to very worried about being threatened, insulted or harassed by strangers in public (SBPCDA, 2004). In Bristol, contributing factors to women feeling unsafe on the streets, as pedestrians and at home included beggars and drug users on streets, poor lighting and lack of police (SBPCDA, 2004).

In Lambeth (South London), 60% of residents surveyed reported that drug dealing/drug use were fairly or very serious problems in their area. Thirty percent had been offered drugs in the past 12 months; 42% reported drug dealers made them feel unsafe; 38% reported drug users made them feel unsafe; 17% reported they had been a victim of anti-social behaviour; 45% reported that verbal abuse and harassment was a problem in their area; and 47% reported that begging was a concern (LCSA, 2004). Most people surveyed felt unsafe in the South London study site, the most frequently given reasons were gangs and the reputation of the area, but 98% felt safe in their homes during the day and 90% felt safe at night. Drugs and alcohol were consistently perceived as underlying causes of both crime committed and community fear of crime (LCSA, 2004).

Concerns about drug use and DRL, community safety and anti-social behaviour are also documented at local community

meetings and in the media. Glasgow and Edinburgh residents have voiced concerns around public drug use and discarded needles (Govanhill Community Development Trust 2004; Southside Community Council 2005) and feeling 'intimidated' and 'harassed' in areas that are supposed to be 'high-quality public spaces' (Ferguson, 2005). Media headlines report crack house closures in Bristol (Allen, 2005) and warn of the risk to children of being injured by discarded needles/syringes and other DRL in Scotland (Edinburgh Evening News, 2002a, 2002b; McDermott, 2003; McGregor, 2002; Mooney, 2003; Paisley, 2002). Community newsletters from the Bristol study area illustrate high levels of community concern about public drug use and DRL with pictures of a disused building (located close to a children's nursery) littered with used drug paraphernalia and blood (St Paul's Unlimited, 2005a). In their reports on local community resistance to the relocation and expansion of drug services, they claim these campaigns have resulted in these developments being blocked by the council (St Paul's Unlimited, 2005b). Local web forums based in Bristol and South London also discuss concerns around drug use, dealing and violence.

Several participants in the interviews noted however that the extent of drug related problems had been reduced to some degree with recent local council initiatives targeting the problem as part of broader regeneration. These testimonies reflect Glasgow's regeneration of the city centre and east end, which includes high profile commercial developments and prestige residential facilities combined with intensive policing and new CCTV cameras. These changes have been associated with a decrease in drug dealers and prostitution (BBC News, 2003; Evening Times, 2004). Findings from the Lambeth Community Safety Audit also suggest that council and police anti-nuisance initiatives have contributed to improvements in amenity, quality of life, and improved community confidence (LCSA, 2004).

Glasgow City Council has introduced a policy to close larger homeless hostels in favour of smaller scale accommodation. Part of the rationale for this was the problems of managing drug dealing, drug use, drug overdose and violent and other anti-social behaviour on and near these premises (Glasgow Street Homelessness Review, 2000) This is consistent with police data presented earlier and interview data associating public drug use and drug dealing problems with large hostels in Glasgow. In

Edinburgh, the City Council has been reported to have plans to ban begging (Ferguson, 2005; Harvie, 2005). In Bristol and South London other aspects of the strategic responses include anti-nuisance teams, use of anti-social behaviour orders, environmental and security improvements to estates, and neighbourhood warden schemes.

Proposals for addressing public drug use

Proposals for addressing public drug use and DRL documented in existing sources were similar to those generated in the interviews. Suggestions from the ENCAMS study include more proactive police presence in stopping dealing and using and protecting the public (e.g. zero tolerance policing, CCTV, and securing places where users and dealers congregate) as well as providing assistance for users (treatment, rehabilitation, employment opportunities). Similarly it was recognised that DCRs might get users off the street and provide links to assistance, but they were also perceived as being too liberal and likely to attract more drug users to the area (ENCAMS, 2004).

Chapter 4 Discussion and conclusion

This report confirms the occurrence and density of drug related activities and nuisance found in previous studies recording public drug use in Glasgow, Bristol and South London (Taylor *et al.*, 2004; Rhodes *et al.*, 2005). The current study also included Edinburgh sites, which local experts had identified as areas where public drug use occurs. As with participants at the other sites, those resident and working in Edinburgh were aware of this local public drug use. This suggests that where local experts are aware of public drug use, evidence of it is also likely to have come to the attention of those local residents and workers whose immediate environment is affected. This does not suggest however, that the general public are aware of public drug use. On the whole, public drug use occurred at quiet, hidden sites which, as Klee and Morris (1995) report, drug users seek for privacy and shelter when they do not have other options.

As with research from Canada and Australia (Strike *et al.*, 2004; Thein *et al.*, in press) public drug use, dealing, DRL and other anti-social behaviour were associated with significant levels of community concern. The social impact of exposure to public drug use and litter included feelings of reduced safety, public amenity, and quality of life. Participants were aware of local strategies to address public drug use and litter and many had reported public drug use, cleared up litter or intervened directly with drug users. Participants were also critically aware of the displacement potential of some strategies and reflected on the loss of amenity to the general public caused when their neighbourhood was fortified against public drug users.

Interview data and data from other sources suggest that the social impact of public drug use in the areas studied is greatest in the South London and Bristol sites. Lack of separation in the use of urban space (Lofland, 1998; Raudenbush and Sampson, 1999) may be crucially important for the social impact of public drug use. At the Bristol and South London sites, public drug use and residential areas share space closely. In contrast, at the Glasgow and Edinburgh sites public drug use is mainly concentrated in neglected semi-public areas and relatively few residences can be accessed directly from streets where public drug use occurs.

The South London and Bristol sites are also characterised by a higher prevalence of crack cocaine use than the Glasgow and Edinburgh sites. Associations between crack use and violence (McClelland, 2005; Baumer, 1994; McBride and Swartz, 1990) may contribute to the stronger negative social impacts found at the Bristol and South London sites.

Participant perceptions of the general social impact of public drug use in their area were not directly related to the type of solution they favoured. It appears that experience of interacting with drug users may be an equally important factor for influencing the type of solution that participants would favour. While 27 participants wanted only to reject, displace or even execute public drug users, 43 participants favoured at least some tolerance. Strategies emphasising changes to the built environment have been implemented in South London; yet here, no participant suggested simply rejecting drug users and strategies emphasising managed tolerance were favoured overall. In all study sites, at least some participants identified drug consumption room type facilities as having a potential role in removing drug use from public view and linking drug users with relevant treatment and health and social welfare services.

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Appendices

Appendix 1. Photographs

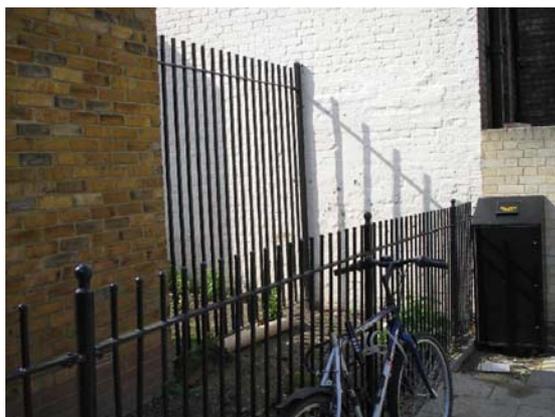
Participants were aware of public drug use but the general public may be less aware because it usually occurs in neglected areas, hidden from general view.



Evidence of public drug use was found in a variety of locations at each of the study sites.



Environmental impacts of public drug use include fortification and facilities for disposal of drug use paraphernalia.



Negative social impact where public drug use and residential areas share space.



Appendix 2. Consent form

South London/Edinburgh/Glasgow

Participant Identification Number:

CONSENT FORM

Title of project: Social Impact of Public Injecting

Name of researcher: Prof Avril Taylor

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to take part in the above study.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix 3. Information sheet

SOCIAL IMPACT OF PUBLIC INJECTING STUDY

Information sheet

You are invited to take part in a research study exploring the social impact of public injecting and other drug use in your local area. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the background and purpose of the study?

Public drug use, discarded needles and other signs of drug use are often associated with local community concern about amenity and personal safety. In some countries, health services where people can go to use class A drugs (such as heroin), have contributed to reduced public drug use and discarded needles. These health services are known as drug consumption rooms (DCRs). Calls have been made for setting up DCRs in the UK but at this time little is known about the nature, extent, frequency and community perceptions of public drug use in the UK. This study aims to describe the social impact of public injecting and use of drugs in four areas (Bristol, South London, Glasgow, and Edinburgh). The study will take approximately three months and the study findings will be used in evaluating whether there is a role for DCRs in UK settings. Please note your local area was chosen for research purposes as an example of a UK setting where there are a number of drug users. This does not mean a DCR is planned for your area. If your local authorities were to consider DCRs in the future, this would be a separate process requiring community consultation.

Who is organising and funding the research?

This study is being undertaken by researchers from the Institute for Applied Social and Health Research at the University of Paisley and is funded by the Joseph Rowntree Foundation; a UK-based social policy research and development charity (www.jrf.org.uk). This study was reviewed and approved by the University of Paisley Research Ethics Advisory Group.

Why have I been chosen?

You were selected as a possible participant in this study because in day to day life at home or at work you come into contact with public drug use or its aftermath such as drugs litter.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

A researcher will make a time to interview you. The interview will last for approximately 20 minutes and you will be asked about your awareness, experiences, and opinions of the impact of public drug use in your local area. If you come into contact with public drug use as part of your job you will also be asked about how you have been trained to deal with it. After the interview, if you are willing and available, the researcher will also ask you to take them on a brief 'walk-about' tour based on your typical day to day activities to point out and describe aspects of public drug use and/or its aftermath with which you come into contact.

Are there any possible risks in taking part?

There are no foreseeable risks in taking part in this study. However when consenting to participate in the walk-about tour, the University of Paisley cannot be held liable for any injury that might occur during that time.

Will my taking part in this study be kept confidential?

All information you give is kept confidential and will be reported in an anonymous way.

What will happen to the results of the research study?

A report on the findings of this study will be provided to the Joseph Rowntree Foundation and given to local Drug Action Teams and other relevant service providers. The findings from this study may also be published in academic journals. You will not be personally identified in any report or publication.

Contact for further information

If you have any questions about this study please ask the researcher who gave you this form. If you would like any further information about this study please contact the Project Manager – Dr Linda Cusick, by phone: 0141 848 3449 or by email: linda.cusick@paisley.ac.uk

Appendix 4. Fieldwork protocol

Mapping protocol

Scoping and initial access

Start date: March 2005

Mapping areas of public drug use – Alex, Peter and Greg

- Using A–Z map of each city, select areas where public class A drug use occurs.
- Enlarge each area so that four square grids fit onto an A4 sheet of paper.
- Annotate specific points within this boundary where public drug use occurs with a cross with a brief explanation of what and where it is, e.g. 'pathway behind Marks and Spencers', 'bush beside park bench'.

Contact potential key informants – Alex, Peter and Greg

- Identify potential key informants who may come across public drug use in their day-to-day lives.
- Twenty-five key informants are needed for each area. Key informants should come from at least four of the following categories: residents, local police, local cleansing and contractor staff from local council, other local employees whose work is likely to bring them into contact with public drug use, social housing workers, local business proprietors, pharmacists and tourist information employees.
- Explain the study to each potential informant and invite him or her to take part. Explain that we would like to conduct an interview and, if possible, a 'walk-about' tour of the area in which they believe the public drug use occurs. Give key informants information sheet explaining study. Ask them if they have any questions relating to the study.
- If participant agrees to take part, take contact details (telephone number) and if their job brings them into contact with public drug use, the hours in which they work. Make arrangements for a meeting or advise them that Jo or Jeanne will contact them later. Fieldwork will take place in April and early May so advise informant that interview and 'walk-about' will occur within this period.

Rapid assessment data gathering

Start date: Ongoing throughout March and April

– Jeanne, Jo and April

Using pre-existing data, collect information about public drug use. This can include local authority cleansing team reports on drug paraphernalia litter, local newspaper reports about public drug use and/or paraphernalia litter and relevant local authority reports or action plans.

Fieldwork protocol for:

Semi-structured interviews and 'walk-about' tours

Start date: April 2005

Jeanne, Jo and April

- Recontact key informants from list by Alex, Greg or Peter and explain the study. You might refer to the statement on first page of data recording sheet.
- Phone or go to workplace/address of participant and arrange convenient time in which an interview and 'walk-about' can take place.
- Before you set off for the day's fieldwork, let a colleague know where you are going and when to expect you back.
- Meet key informant at agreed time and place. **DO NOT MEET OR CONDUCT INTERVIEWS ALONE IN A PRIVATE INDOOR SPACE (E.G. PARTICIPANT'S HOME).**
- Before conducting interview and/or 'walk-about' make sure participant has read information sheet and has the opportunity to ask any questions.
- If participant wants to take part in study ask them to sign the consent form. Reassure them that they do not need to use their usual signature or their own name.

Semi-structured interviews and 'walk-about' tours

- In semi-structured interview and 'walk-about' tour lasting around 20 minutes you will ask key informants about their awareness and experiences of public drug use within their area. Use the Data Recording Sheet to guide this.
- Before starting the 'walk-about', ask participant open questions about work/residence and fill in details on the data recording sheet on page one and data on Tables 1 and 2.
- Key informants can then take researchers on a 'walk-about' tour of local area in which they believe drug use occurs publicly. If they do not want to do this then the rest of the data can be gathered by continuing the interview discussion using open questions, e.g. 'tell me about...'.
 - Draw route taken with a highlighter pen on blank map.
- During 'walk-about', use numbers and letters to annotate on map the signs that the participant describes which are not currently visible, e.g. park bench where drug dealing occurs and those pointed-out signs which are visible, e.g. discarded needles and syringes. Record details on Tables 3 and 4.
- Continue with Tables 5–7, noting words on Data Recording Sheet that the participant uses to describe 'nature', 'extent', 'when' and 'frequency'.
- Take photos appropriately of unidentifiable locations that are pointed out as drug use scenes (whether this is currently visible evidence or not). Photos must not include people or landmarks, which may identify location or any company name, e.g. 'Burger King'. Photos must not be taken where offence might be taken or where there is possible risk. Be discreet!
- Once 'walk-about' is completed, ask Closing Questions 8, 9 and 10 and record information in Data Recording Sheet.
- Once both interview and 'walk-about' tour have been completed, mark participant off on participant list with appropriate participant number and fill in their key informant status. If participant only completes interview, mark 'Interview Only' on table.

Snowball sampling

- Walk key informant back to initial setting-off point and ask to be introduced to another participant. Residents should not be cold-called by interviewers.
- When you are back home/at the office, phone your colleague to tell them you are safe. If you do not make this call at the expected time your colleague should phone the local police and Linda Cusick, giving details.

Appendix 5. Data recording sheet

Joseph Rowntree Foundation – The Social Impact of Public Injecting

Participant No: _____

Key Informant Category: _____

Location: _____ Local District: _____

Contributed Interview: y / n

Contributed 'walk-about' tour: y / n

Time Taken: _____

Researcher:

Introducing the study, you might say something like this:

'I am conducting a study on behalf of the Joseph Rowntree Foundation and the University of Paisley. I am going to ask you about the public use of drugs within this area. We are interested in illicit drug use that happens outdoors or in other places that the public might see. This may include injecting or smoking drugs. We are especially interested in heroin and crack use but it is not always easy to know what people are using so we want you to tell us anything you think might be this kind of drug use.'

Eligibility

How long has participant worked in the area?

How long has participant lived in the area?

PROFESSIONAL/RESIDENT EXPERIENCE

1. Professional – does their work bring them into contact with public drug use?
What do they deal with?

<u>Professional Experience</u>	<u>Extent</u> (How much?)	<u>Frequency</u> (How often?)

Other info on professional role:

- Have you received any advice or training?
- If you were to train a new member of staff to do their job, what kind of additional advice or training would you give to them?
- Do other people come to you with complaints about drug use?

2. Resident

<u>Resident Experience</u>	<u>Extent</u> (How much?)	<u>Frequency</u> (How often?)

Other info on resident role:

NATURE, EXTENT and FREQUENCY

Signs

3. Described signs – signs, which are not currently visible, e.g. park bench where drug dealing occurs, corner where groups of people hang about.

<u>Map Ref</u>	<u>Described Signs</u>	<u>Extent</u> (How much?)	<u>When</u> (Day/night/ weekend)	<u>Frequency</u> (How often?)
1				
2				
3				
4				
5				

Other info on described signs:

- Do you know what types of drugs might be used in the circumstances described?

4. Pointed-out signs – signs that are currently visible, e.g. two discarded needles/syringes, urine, and graffiti.

<u>Map Ref</u>	<u>Pointed-Out Signs</u>	<u>Extent</u> (How much?)	<u>When</u> (Day/night/ weekend)	<u>Frequency</u> (How often?)
A				
B				
C				
D				
E				

Other info on pointed-out signs:

- Do you know what types of drugs might be used from the signs pointed out?

5. Individuals – different examples of sighting of ‘drug users’.

<u>Individuals</u> (people)	<u>Extent</u> (How much?)	<u>When</u> (Day/night/ weekend)	<u>Frequency</u> (How often?)

Other info on individuals:

6. Observed activities – e.g. groups of people hanging around specific area, drug dealing, witnessing actual drug use (injecting, smoking).

<u>Observed Activity</u>	<u>Extent</u> (How much?)	<u>When</u> (Day/night/ weekend)	<u>Frequency</u> (How often?)

Other info on observed activities:

- Do you know what types of drugs they are using?

7. Participant's actions – level of engagement the individual has with public drug use, e.g. Have they witnessed an overdose? Do they tidy up drug paraphernalia? Do they move people on? Have they called police/council?

<u>Experiences</u>	<u>Extent</u> (How much?)	<u>When</u> (<u>Day/night/</u> <u>weekend</u>)	<u>Frequency</u> (How often?)

Other info on participant's experiences:

- Why do you think drug use occurs here?

PERCEIVED IMPACT

Closing Questions

Impact – current thoughts on situation.

8. What impact has all of this had on you/your family/friends/neighbourhood?

e.g. we might expect participants to say things like: ‘I don’t go near this area now’, ‘The value of property has dropped in this area!’ Also include emotions felt by participant, e.g. fear, anger, hostility. DO NOT PROMPT PARTICIPANTS.

Other News – hearsay evidence, gossip.

9. As well as your own observations, have you heard about the problem in your area from any other sources (e.g. people or newspapers)?

UNPROMPTED

But expect examples to include 'I read in the newspaper that a syringe was found in this street', 'My neighbour told me she saw somebody injecting in the close last week'.

Ideas on Solutions

- 10A. What do you think can be done to solve this problem? UNPROMPTED
- 10B. Are there some drug use places that you don't really mind about as much? Where are these? Why is this?

Appendix 6. Data, tables and maps¹

¹ n/s = needles and/or syringes
du = drug users

Full data version Table 2. Observed activities and events (as summarized in Table 2, page 24 of this paper)

Activity/event	Site reported	Number of people typically seen	When seen	Frequency of typical observations	Number of mapped sightings	Number of reporting participants
Drug users loitering	Glasgow	5	All	Twice weekly – daily	9	9
	Edinburgh	5	All	Daily	15	12
	Bristol	3–5	All	Daily	2	10
	South London	1–10	Day/w'end eve	Weekly – daily	0	17
Dealing and buying	Glasgow	2–8	All	Twice weekly	4	7
	Edinburgh	2	Day	Twice weekly	0	5
	Bristol	1–5	All	Daily	12	25
	South London	1–10	All/crack in eve	Once – daily	22	13
Injecting	Glasgow	1	Day	Monthly	1	5
	Edinburgh	1	All	Once	3	5
	Bristol	1	All	Monthly	4	10
	South London	1–6	All/w'end	Once – weekly	0	17
Overdose/collapse	Glasgow	1	All	Once	1	5
	Edinburgh	1 (10 in police reports)	All	Monthly	0	4
	Bristol	1	Day	Once	0	1
	South London	1	Day	Once	0	2
Prostitutes working in area	Glasgow	2–5	All	Daily	2	3
	Edinburgh	6	Night	Daily	1	1
	Bristol	6	All	Daily	4	4
	South London	1+	All	Weekly	0	11
Smoking (crack assumed)	South London	1–10	All/esp. evening	Once – daily	0	14
	Bristol	3	All	Daily	1	1
Smoking (heroin assumed)	Glasgow	1–2	Day	Once – monthly	0	3

Table 2 (cont'd)

Activity/event	Site reported	Number of people typically seen	When seen	Frequency of typical observations	Number of mapped sightings	Number of reporting participants
Snorting (cocaine/heroin assumed)	Edinburgh	1	Evening	Once	0	2
Smoking (cannabis assumed)	Glasgow	15–20	Evenings and weekends	Daily	0	1
Sniffing (glue assumed)	Edinburgh	1	Day	Weekly	0	1
Thefts and begging	Glasgow	1–2	Day	Once	0	1
	Edinburgh	1–2	Day	Weekly	4	1
	Bristol	1–3	All	Daily	3	5
	South London	1–3	Day	Weekly – daily	0	9
Shouting/ swearing/ noise/ aggressive/ threatening	Edinburgh	2–6	Day	Once/daily	0	2
	Bristol	1–2	All	Daily	1	4
	South London	1–6	All	Once – weekly	2	8
Long time in toilet cubicle	Glasgow	1	Day	Daily	1	2
Police removing n/s from user	Edinburgh	1	Day	Once	0	1
Vomiting to bring up drug bags	Glasgow	1	Day	Once	0	1
Syringe selling	South London	1–2	Eve	Few times	0	1
Rough sleeping/ bedding	Glasgow	6	Nights	Daily	1	1
	Edinburgh	2	Day	Monthly	1	1
	South London	n/s	All	Daily	19	6
Police violence	Bristol	1	All	Weekly	0	1
Post-IDU profuse bleeding	South London	1–2	Day	Few times	0	1

Full data version Table 3. Pointed-out and described signs (as summarized in Table 3, page 25 of this paper)

Signs pointed out or described	Site reported	Number of items typically seen at one time	When seen	Frequency of typical observation	Number of mapped sightings	Number of reporting p'pants
Used needles and syringes (frequent)	Glasgow	1–10	All	Twice weekly – daily	20	14
	Edinburgh	1–10	All	Daily	24	14
	Bristol	3	Day	Daily	8	11
	South London	1–20	All	Every few days – daily	22	13
Used needles and syringes (less frequent)	Glasgow	2–5	All	Weekly or less often	Shared locations with above	11
	Edinburgh	1–5	All	Weekly		9
	South London	1–15	Day	Weekly		6
Used needles and syringes (single big finds)	Edinburgh	60	Day	Once	0	1
	Bristol	1000s	Day	Once	0	1
Foil (and lighters/ matches)	Glasgow	1–2	All	Once – twice weekly	3	5
	Edinburgh	1–5	All	Once – daily	7	7
	Bristol	1	All	Daily	1	3
	South London	1–many	All	Monthly – daily	12	14
Drug bags/ wraps	Glasgow	2	All	Weekly	2	2
	South London	1–many	All	Weekly – daily	30	14
Other IDU paraphernalia	Glasgow	1–10	All	Once – daily	5	4
	Edinburgh	1–6	All	Once – daily	12	6
	Bristol	1	All	Monthly	1	3
	South London	1–20	All	Weekly – daily	33	13
Pipes/cut-down drinks cans	Glasgow	1	All	Weekly	0	1
	Edinburgh	1	Day/w'end	Monthly	1	1
	Bristol	2	All	Daily	1	1
	South London	1–2	All	Weekly – daily	9	8
Rough sleeper bedding, homeless IDU site	Glasgow	1	Nights	Daily	1	1
	South London	1–6 sites	All	Weekly – daily	16	6

Table 3 (cont'd)

Signs pointed out or described	Site reported	Number of items typically seen at one time	When seen	Frequency of typical observation	Number of mapped sightings	Number of reporting p'pants
Phone booth crack site	South London	1 booth	Day	Weekly – daily	2	6
Address drugs used	Bristol	1–3	All	Daily	3	4
	South London	2 flats	All	Weekly – daily	3	6
Condoms and condom packs	Glasgow	1–5	All	Weekly – daily	7	5
	Bristol	5	All	Daily	0	2
	South London	2–5	All	Weekly – daily	7	9
Environmental changes to deter use	South London	3+ sites	NA	Permenant last 1–2 years	9	10
Public needle disposal bins	South London	Many sites	NA	Permenant last 1–2 years	6	5
Human excrement/ urine/vomit/ blood/pleghm	Glasgow	1	Days /w'end	Weekly	1	1
	Edinburgh	1	Day	Monthly – twice weekly	2	2
	Bristol	1	All	Weekly	1	1
	South London	1–3	All	Weekly – daily	27	15
New n/s	Edinburgh	3	Day	Daily	0	1
Bullets	Bristol	2–3	Day	Twice	0	1
Bag of crack	Bristol	1	Day	Once	0	1
Graffiti	Bristol	1	All	Daily	1	1
Expensive cars	Bristol	1	All	Daily	1	1

Notes on Tables 2 and 3

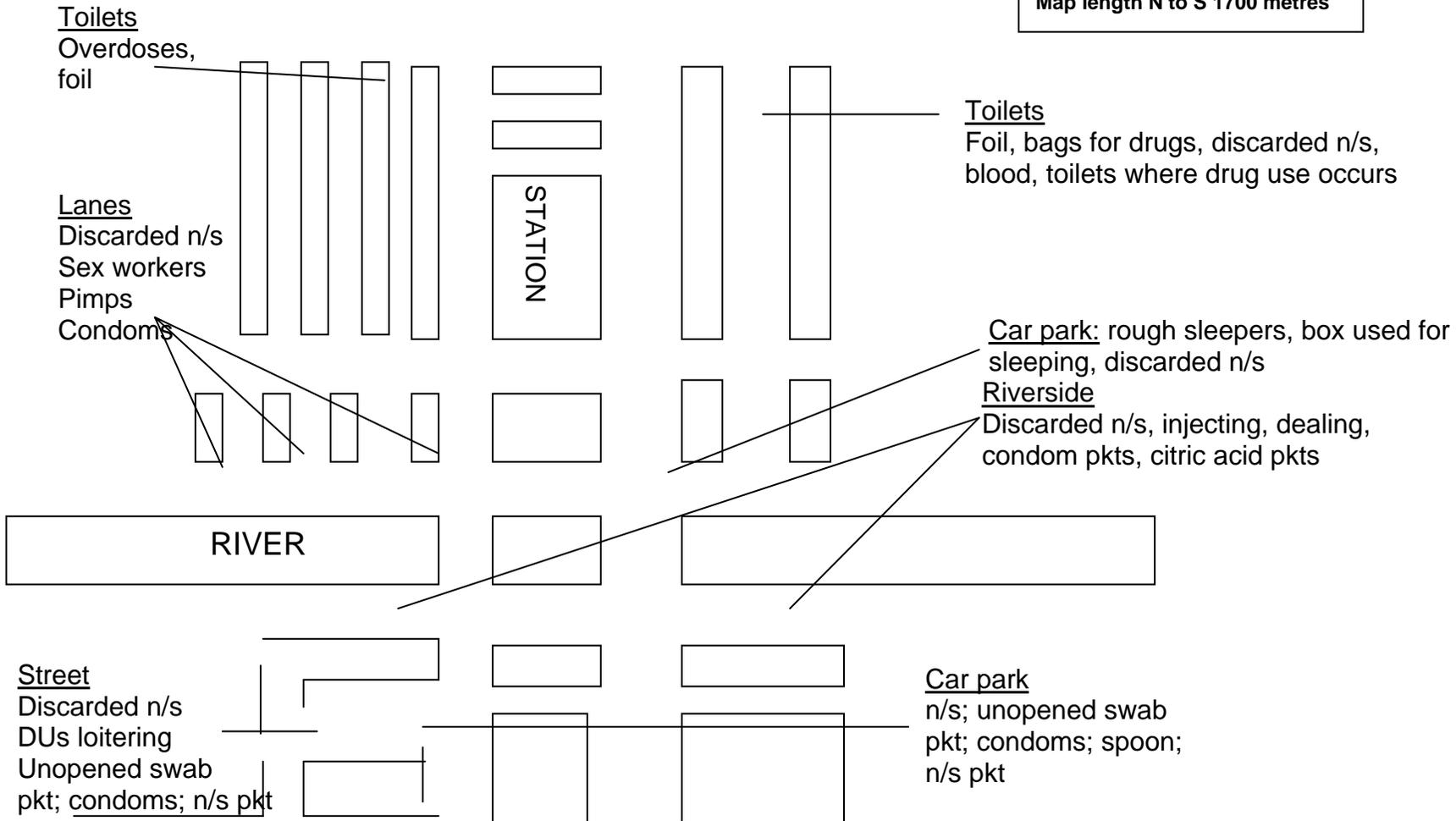
- The “when seen” columns: although participants reported seeing many of the signs only during the ‘day’ this does not mean that the activity leading to them is restricted to daytime. Participants were often aware that drug use occurred at all times of the day and night.
- The “frequency of typical observations” columns: participants often reported seeing activities and signs at ‘all’ times. Where they commented that their observations were more frequent in the evenings and at weekends, this is noted in the tables.

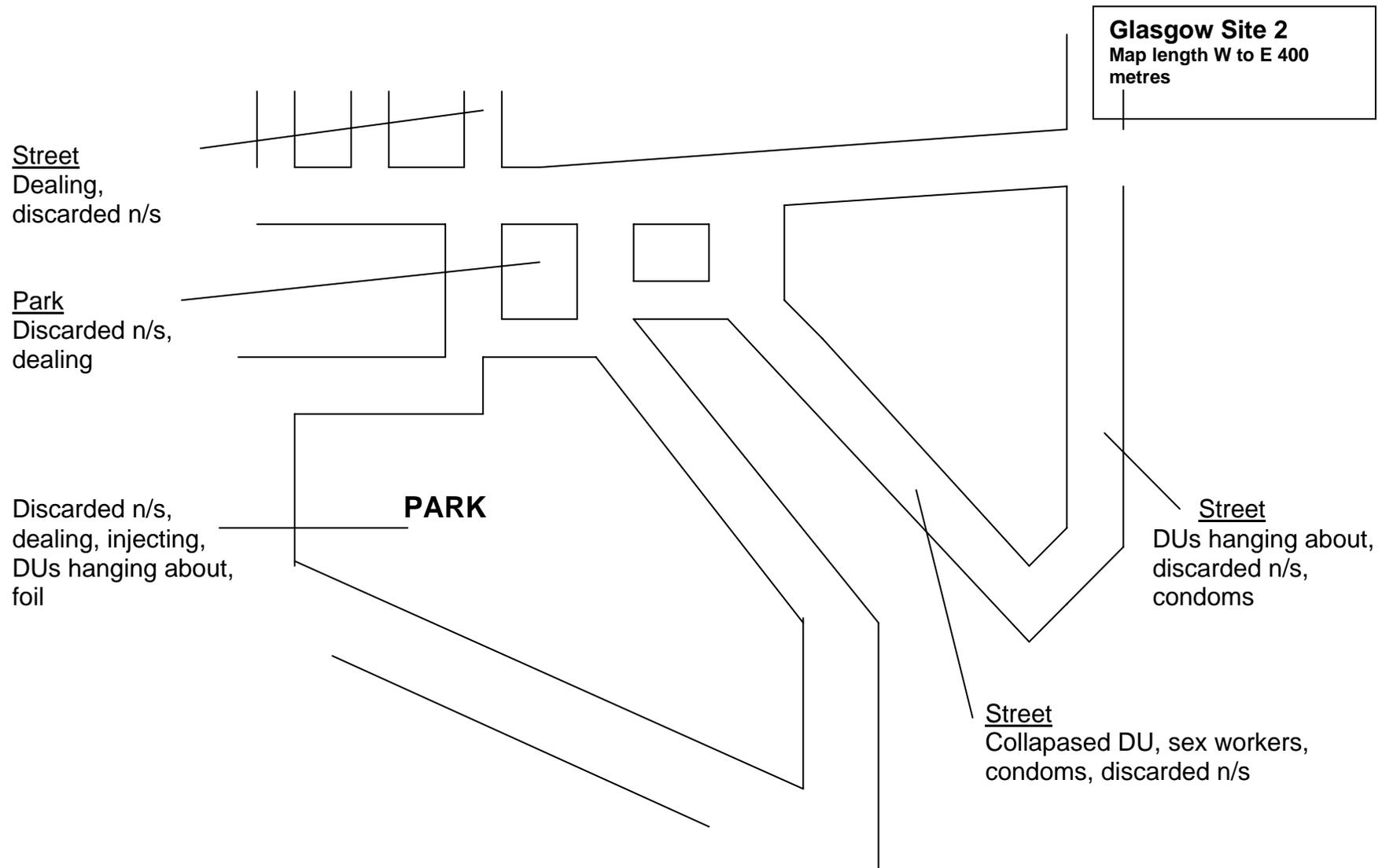
In table rows, numbers of sightings and participants differ because:

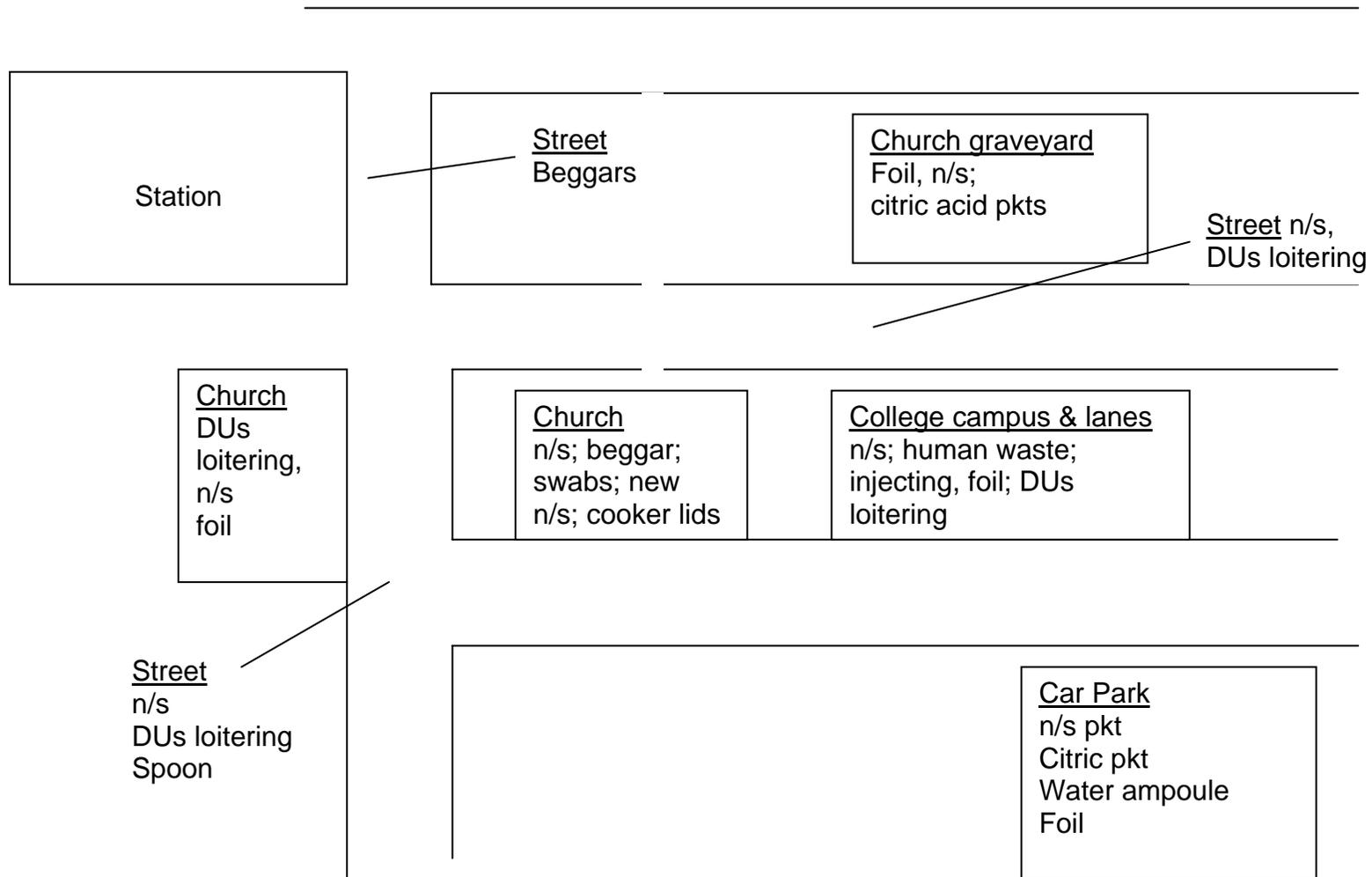
- some participants pointed out more than one location for a given sign.
- some participants described signs without giving a specific location. This was often the case for those who did not participate in walk-about.
- reported activities overlap with pointed-out signs. For example, a participant might describe rough sleeping as a regular occurrence in a general area such as a park but also point out bedding as evidence of this.
- Some annotated mapped signs and activities correspond to two entries in the tables. For example, the tables cluster other IDU paraphernalia but a participant might point out a sterile wipe and a discarded cooker at the same location.
- There were many reports of used needles and syringes as evidence of public drug use but a wide range in the number of items seen and the frequency of these observations. Rather than collapse all this data together, Table 3 provides three rows on 'used needles and syringes'. The first of these shows data for relatively frequent finds as reported by participants finding needles and syringes at least twice weekly. The second shows data for less frequent finds, those occurring weekly or less often. The third shows data for single finds of large numbers of needles and syringes. These occurred when areas were opened up following a period of general public disuse.

On the maps that follow, the annotated sightings show the variety of signs or activities that participants pointed out or described at a specific location.

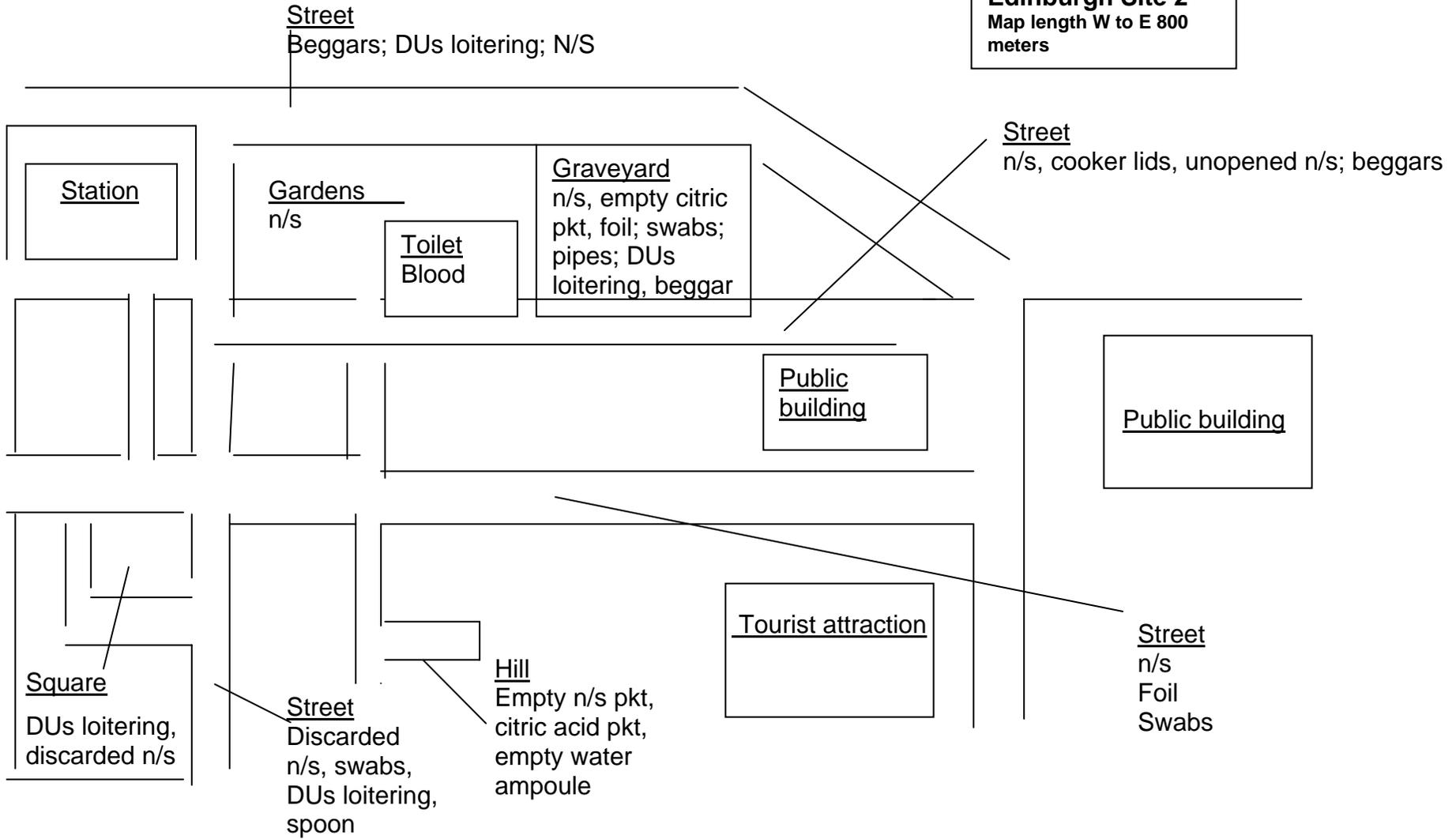
Glasgow Site 1
Map length N to S 1700 metres







Edinburgh Site 2
Map length W to E 800
meters



Bristol Site 1
Map length W to E 500 metres

Street
Vomit
Dealing
Begging
Basements
used for
injecting

Street
Fights
Dealing
Begging
Expensive
cars
Discarded
n/s

Street
Sex workers,
Discarded n/s

Street
Discarded n/s
Shoplifting
Dealing
DUs loitering
Sex workers
Drugs
paraphernalia
Crack smoking

The social impact of p...

Street
Discarded n/s
Dealing
Crack tins
Grafitti

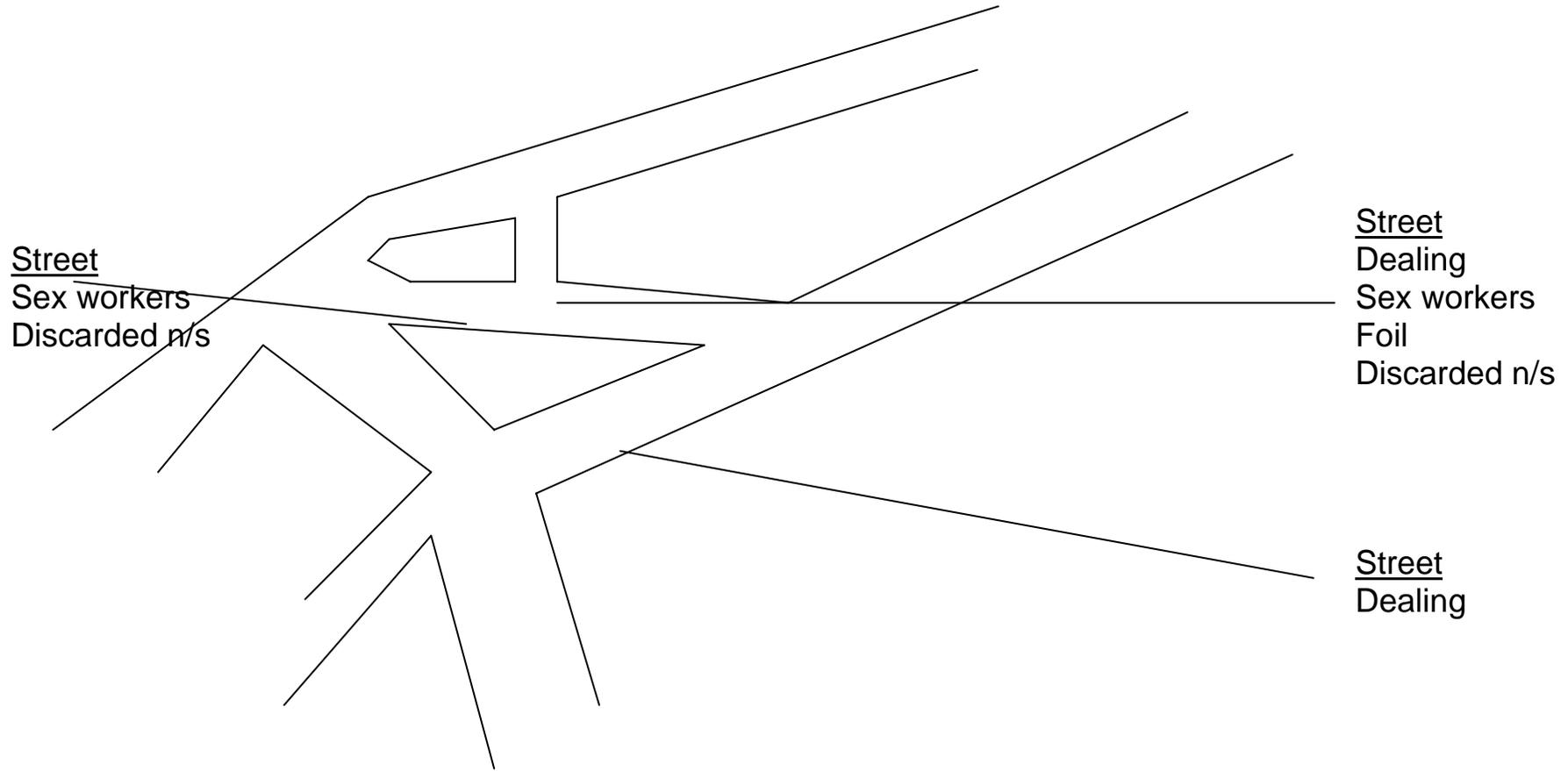
Cemetery
Discarded n/s

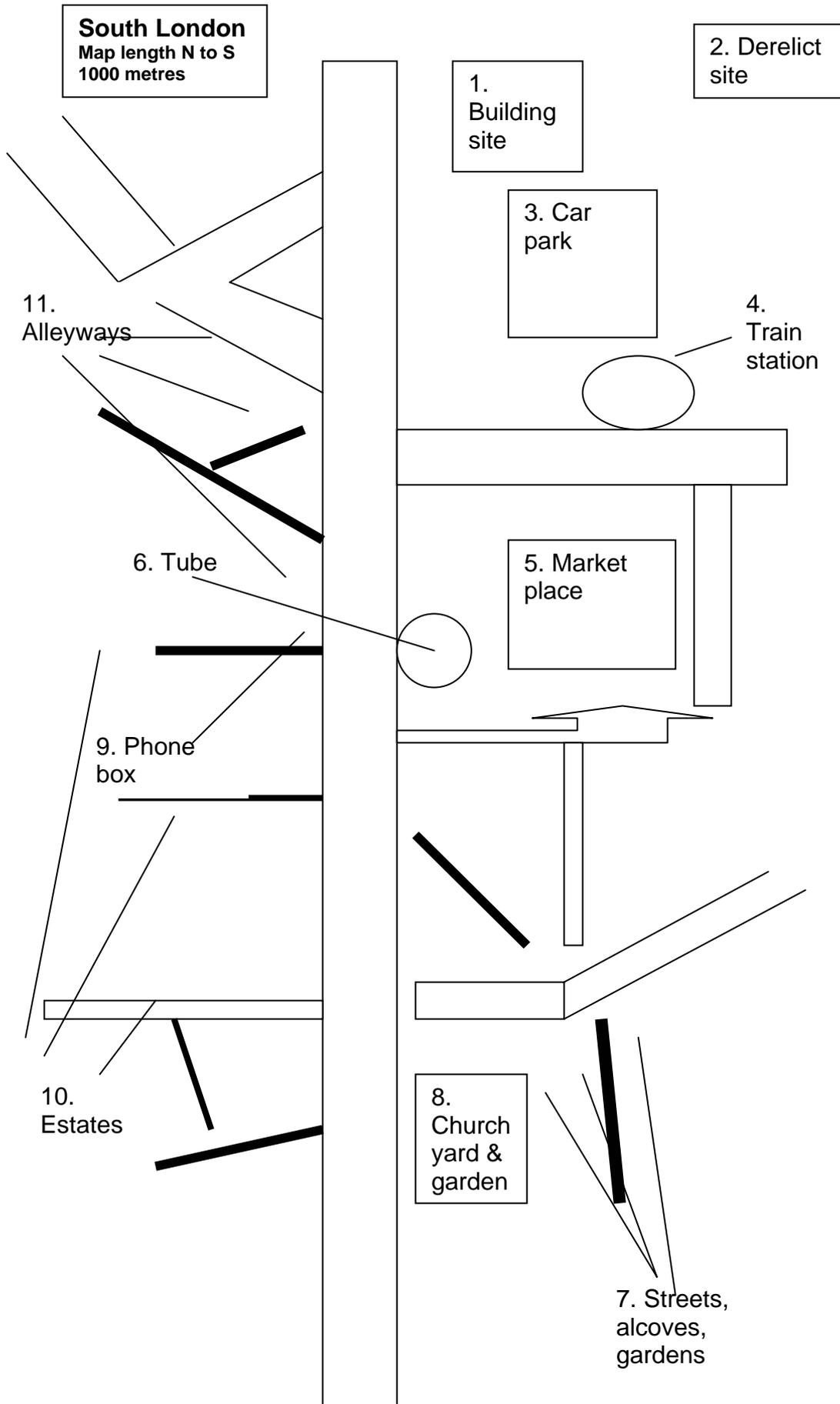
Park
DUs loitering
Injecting
Discarded n/s

Playing Field
Injecting
Dealing
Sex workers
Discarded
n/s

Street
Dealing

Bristol Site 2
Map length W to E 400 metres





Key to signs for South London Map

1. Building site

Discarded n/s, other injecting litter, crack pipes/cans, foil, wraps

2. Derelict site

Discarded n/s, other 'homeless' litter, human waste

3. Car park

Discarded n/s, other injecting litter, crack pipes/cans, foil, wraps, human waste

4. Train station

Foils, wraps, crack pipes/cans, discarded n/s, threatening/aggressive behaviour

5. Marketplace (and surrounds)

Dealing, foils, wraps, threatening/aggressive behaviour

6. Tube station (and surrounds)

Begging, dealing, threatening/aggressive behaviour

7. Streets, alcoves, front gardens

Injecting, smoking, discarded n/s, other injecting litter, used condoms, wraps, crack pipes/cans, human waste

8. Churchyard and gardens

Injecting, discarded n/s, used condoms, human waste

9. Phone box

Smoking, foils, crack pipes/cans

10. Estates (e.g. communal areas, gardens, stairwells, bin and storage sheds)

Injecting, smoking, discarded n/s, other injecting litter, foils, crack pipes, blood, used condoms, vomit, phlegm, human waste, other 'homeless' litter, former crack house, threatening/aggressive behaviour, noise

11. Alleyways

Injecting, smoking, discarded n/s, other injecting litter, wraps, other 'homeless litter', human waste