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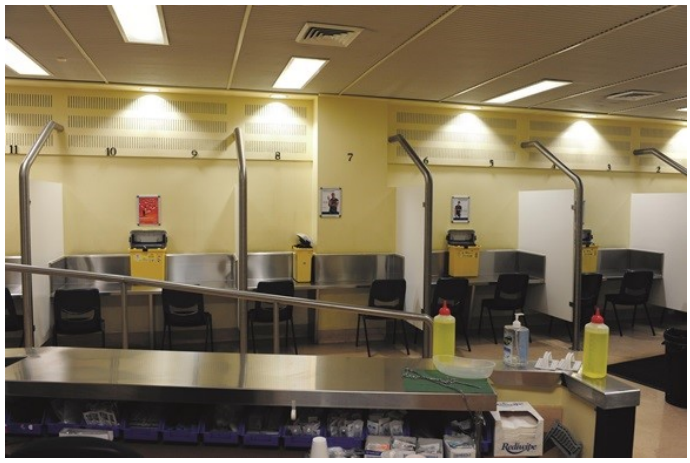
GO Time for safer injecting spaces in Britain?

Drug consumption rooms provide a hygienic and supervised space for users to inject or otherwise consume illicitly-obtained drugs, the overarching aim being to reduce or eliminate public injecting and its adverse effects on the environment, public order, and the health of drug users. Evidence does not support concerns that drug consumption rooms might encourage drug use, delay treatment entry, or aggravate problems arising from local drug markets, suggesting instead that they facilitate safer drug use, increase access to health and social services, and reduce public drug use and associated nuisance. However, cutting across the grain of prohibitionist policies, they remain highly controversial.

There are an estimated 90 facilities across Europe, Canada and Australia, with intermittent calls to see them extended to the UK. In areas blighted by a 'perfect storm' of visible injecting scenes, discarded paraphernalia, and injecting-related overdose and deaths, could drug consumption rooms which provide an alternative to public injecting be part of the solution?

Legal 'fixing rooms': history and current status

Also known as 'medically supervised injecting centres', 'safe injecting facilities', 'safe injecting sites', 'drug injection rooms', and 'drug fixing rooms', drug consumption rooms are legally sanctioned spaces where people can bring their own pre-obtained drugs, and either inject them or inhale them using sterile equipment under the supervision of nurses or other medical professionals ▶ illustration. They are distinct from illegal 'shooting galleries' run for profit by drug dealers, low-threshold hostel or housing services that tolerate drug use among residents but provide no medical supervision, and programmes which prescribe pharmaceutical heroin (diamorphine) for consumption by their patients under medical supervision (1,2).



Cubicles for hygienic, supervised injecting inside a drug consumption room

Though there are no official drug consumption rooms in the UK, until the 1970s there were informal, ad hoc facilities including the 'fixing rooms' of London's Hungerford and Community Drug Projects, and Blenheim in west London which had a toilet where people routinely injected. These stopped running primarily due to the knock-on effects of people using barbiturates, a sedative which can result in 'drunken' behaviour. The increased risk of overdose, and aggressive, chaotic and violent behaviour, meant that staff felt unable to support users safely and felt disillusioned at the facilities becoming 'crash pads' for people turning up already stoned.

The first officially approved supervised consumption room opened in Basle, Switzerland in 1986. Rooms were introduced in Germany and the Netherlands in the 1990s, and in Spain, Australia and Canada in the early 2000s. As of February 2016, there were: 31 facilities in 25 cities in the Netherlands; 24 in 15 cities in Germany; 12 in three cities in Spain; one in Norway and one in Luxembourg (with both countries planning to open second facilities in 2016); five in three cities

in Denmark; and 12 in eight cities in Switzerland ▸ map. Outside Europe there are two facilities in Sydney, Australia and one in Vancouver, Canada.

Today's drug consumption rooms tackle the harms associated with injecting, but some also host clients who smoke crack cocaine, heroin or other drugs. The latter are found across the Netherlands, and in increasing numbers across Germany and Switzerland. Most rooms are integrated into existing, easy-access (or 'low threshold') services, for example for drug users or homeless people. Their 'survival-orientated' services include food, clothing and showers, needle exchange, counselling, and activity programmes. Less common are facilities exclusively for drug consumption room users, which offer a narrower range of services directly related to supervised consumption (1,2). Spain, Germany and Denmark have mobile facilities offering a more flexible service (ie, going where the users are) but with limited capacity.

In 2016 a pilot drug consumption room reportedly opened in Paris near a busy central station where drug crime is common. Annual running costs are estimated at £1.1m, and close to 200 visitors are expected daily. For France's health minister it was "a very important moment in the battle against the blight of addiction", but for a politician from the centre-right opposition, the country was "moving from a policy of risk reduction to a policy of making drugs an everyday, legitimate thing. The state is saying 'You can't take drugs, but we'll help you to do so anyway'" – wildly differing perspectives on the same facility.

Evidence of the need for and impacts of drug consumption rooms tends to be divided into "public harms which affect communities, such as discarded syringes in public parks and toilets", and "private harms which affect individuals, such as overdose death and blood-borne viruses". The extent to which each justifies the introduction of drug consumption rooms differs from country to country. Overdose deaths were a key driving force in Norway, Spain, Canada and Switzerland, while public nuisance and local concerns about drugtaking in public places were important in Canada and pivotal in the Netherlands.

Is public injecting (enough of) a problem in the UK?

Some open drug scenes have become infamous, notably Sherman Park in New York, mythologised in the 1970s film *The Panic in Needle Park* starring Al Pacino, and Platzspitz Park in Zurich, which drew worldwide attention in the 1980s after a decision to allow illegal drug use and dealing there resulted in chaotic scenes of mud and used needles, and an influx of 20,000 users from across Europe.

Less extreme examples of public injecting are a reality in many cities and towns, including in the UK, where of the estimated 356,593 problem drug users in 2006, in England alone about 117,000 were injecting. Yet the same year the Independent Working Group on Drug Consumption Rooms concluded that while there were "high levels of injecting drug use in particular areas of the UK, these did not appear to be associated with the sort of extensive public injecting that had been instrumental in the setting up of some of the European [drug consumption rooms]".

The lesser salience of public injecting in the UK probably reflects several factors: visibility (eg, proximity to places such as shopping centres, tourist locations), concentration (the accumulation of drugtaking in particular areas or micro-locations), number of people and the scale of the associated problems, and the profile of the affected drug users. The extent to which local residents and businesses support drug consumption rooms largely depends on the extent to which they see public injecting as a problem in their area. It means that just as there is visibility, there is *in*visibility too: public injecting problems may be obscured, particularly when confined to a pocket of a city already deprived and neglected, or when it primarily affects deeply marginalised ('hidden from sight') groups, such as those who are homeless.

In turn this means that people and places most in need of drug consumption rooms may not be seen as a priority. Homeless drug users are the prime example. Drink and drug problems disproportionately affect people who are homeless; compared to the general population, if you are homeless there is a far greater chance of experiencing these problems, of injecting drugs, and of dying as a consequence of substance use (1,2,3). Homeless people die on average 30 years before the general population, and a third of these deaths are related to drink and drugs. Homeless injectors would likely be a core demographic of drug consumption rooms due to links between homelessness and high-risk behaviours (such as public injecting, sharing injecting equipment, and poor injecting hygiene), and because unstable housing can preclude or hinder treatment and recovery.

Very few studies in the UK have investigated the extent of public injecting despite location having a significant impact on hygiene, safety and public nuisance. One study found that "public injecting is very common among drug users accessing syringe exchange facilities". Of 398 surveyed at needle exchanges in Glasgow, Leeds and London, 42% said they had injected at least once in public areas, including toilets, streets and parks. This proportion increased with housing instability; while 24% living in their own accommodation had injected in public in the past week, among hostel residents the figure was 49%, and among rough sleepers, 98%. In 2005, 84% of attendees surveyed at five needle exchanges in London and Leeds said they *would* use a drug consumption room if one was available.

Harm reduction advocate Nigel Brundson spent a day walking around Birmingham, photographing evidence of public injecting. He visited three known injecting areas: two were waste-grounds next to car parks, one a main walkway in the centre of town. His images show the ground covered in injecting equipment and general waste, needles alongside garbage and human excrement – in this environment, it would be very difficult to inject in a sterile way ▸ images. Aggravated by the risk of being overlooked by the public or police, hasty unsafe injecting seems more than likely. "No one 'chooses' to inject in these spaces, this is where the most desperate people in our society have been driven", comments Mr Brundson. Alluding to the human cost of *not* having safe injecting facilities, he argues while these are "almost always deemed as 'controversial' ... this isn't the case; the controversial approach would be to not have these spaces."

Scenes of public injecting in Birmingham documented by Nigel Brundson

Could drug consumption rooms be introduced in the UK?

At least since the turn of the millennium, drug consumption rooms have on several occasions been seriously considered in the UK, primarily in response to heroin injecting.

In 2002, a Home Affairs Select Committee on drugs policy recommended that "an evaluated pilot programme of safe injecting houses for [illicit] heroin users [be] established without delay and that if, as we expect, this is successful, the programme is extended across the country". Alongside this the committee recommended an evaluation of diamorphine prescribing for heroin addiction. To support both, the committee recommended "[reviewing] Section 9A of the Misuse of Drugs Act 1971, with a view to repealing it, to allow for the provision of drugs paraphernalia which reduces the harm caused by drugs", and "[amending] Section 8 of the Misuse of Drugs Act 1971 … to ensure that drugs agencies can conduct harm reduction work and provide safe injecting areas for users without fear of being prosecuted".

The 'New Labour' government rejected the recommendation for drug consumption rooms, expressing a number of concerns:
• Potential for public confusion between drug consumption rooms and existing supervised heroin prescribing pilots.
• Potential for drug consumption rooms to be perceived as inconsistent with the government's commitment to being "tough on crime, tough on the causes of crime".
• Potential for the government to be accused by the media and others of opening 'drug dens'.
• Being open to legal challenges.

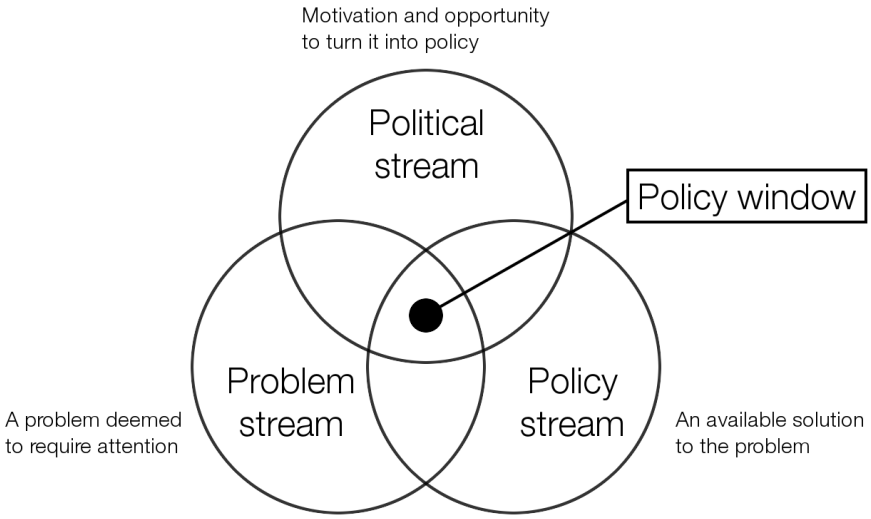
They also said evidence was insufficient to justify implementation – not entirely relevant, as the recommendation was for a pilot to generate evidence in the UK context.

In 2004 the *British Medical Journal* published a paper arguing that "the case for piloting supervised injecting centres in the United Kingdom is strong", and that its rejection should be overturned. The authors reasoned that the supervised heroin prescribing scheme endorsed by the Home Office and drug consumption rooms would appeal to, and benefit, different groups – the former, long-term heroin addicts who have not responded to traditional treatment, the latter, people who are socially excluded and homeless: "neither is a panacea and … holistic provision should include both".

Why the rejection by central government?

Why did the British government say 'Yes' to expanding heroin prescription, approving a trial of three heroin prescription maintenance clinics in London, Brighton, and Darlington between 2005 and 2007, yet say 'No' to drug consumption rooms?

John Kingdon's influential Multiple Streams Theory suggests policy tends to get made in brief windows of opportunity, when three separate streams align: problems; policy options; and political circumstances ▸ diagram. Analysts have argued that political conditions were "not ripe for drug consumption rooms" during New Labour. The government believed their future electoral success largely depended on being (and appearing to voters as) "tough on crime". Drug consumption rooms risked appearing to condone the use of illegally bought drugs. Supervised heroin prescribing, on the other hand, could be framed as "tough on crime", circumventing the need for patients to commit acquisitive crimes to fund dependent heroin use. At this time, even had there been high quality evidence of the effectiveness of drug consumption rooms, it would still have been unlikely to influence policy – it was politically *un*viable.



Depiction of Kingdon's Multiple Streams Theory

Asked about drug consumption rooms as leader of the Conservative opposition and a member of the 2002 select committee, David Cameron said: "Anything that helps get addicts off the streets is worth looking at". When in government, in 2013 his administration issued a flat-out refusal to consider them: "The Government has no plans to allow drug consumption rooms." The 2010 election of David Cameron's Conservative-Liberal Democrat coalition closed the policy window for both drug consumption rooms and diamorphine maintenance. Current Prime Minister Theresa

May leads a majority Conservative government, and it is improbable that she will risk alienating supporters with controversial drug policies.

The next time drug consumption rooms came under review in the UK was in 2006 by the Joseph Rowntree Foundation's Independent Working Group on Drug Consumption Rooms made up of senior police officers, senior academics, GP consultant, and a barrister specialising in drug offences. It noted that the evidence base had grown since the UK government had rejected the idea, and concluded that drug consumption rooms *should* be piloted:

> *"The [Independent Working Group] considers [drug consumption rooms] to be a rational and overdue extension to the harm reduction policy that has produced substantial individual and public benefits in the UK. They offer a unique and promising way to work with the most problematic users, in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society."*

The response to the Independent Working Group report was warm, but the proposition was rejected. The concerns described above were still perceived to stand.

Cities make up their own minds

Cities have often taken the lead in continental Europe, and in Britain too, they have not simply accepted the central government's position. In 2012 an Independent Drugs Commission was set up in Brighton, prompted by a call from a local Green Party MP. The city had an unenviable reputation for generating one of the nation's highest rates of drug-related mortality. The following year the commission agreed that "where it is not possible to stop users from taking risks, it is better that they have access to safe, clean premises, rather than administer drugs on the streets or in residential settings." Brighton's Safe in the City Partnership should, they recommended, consider the feasibility of incorporating "consumption rooms into the existing range of drug treatment services in the city," focusing on 'hard-to-reach' groups and those not engaged in treatment.

The feasibility study was undertaken, but in 2014 the commission's final report concluded "that a consumption room was not a priority for Brighton and Hove at this time – the working group was convinced by the international evidence on the potential benefit from these facilities, but thought that they would have little impact on the types of factors that were contributing to deaths in the city". In addition, "members of the working group were … concerned at the cost implications, in a time of budget pressure, and also advice from the Home Office that opening such facilities would contravene UK law".

A month later, in June 2014 the feasibility working group explained that there was insufficient support at the time to consider drug consumption rooms. Both the Association of Chief Police Officers and Sussex Police were opposed, as were other organisations. This was attributed to a shift "for substance misuse services from a focus on harm reduction to recovery [which] has put a greater emphasis on abstinence from drugs", and to the financial and political climate, in which it was felt unlikely that statutory agencies would consider providing resources unless there was very good evidence of benefits and cost-savings.

These statements reveal multiple reasons for the rejection of drug consumption rooms in Brighton, and some overlap with the issues raised in 2002:

- Perception that they would have little impact on injecting-related mortality.
- Lack of support from key stakeholders.
- Cost implications/budget pressures.
- Advice from the Home Office that drug consumption rooms would be unlawful.
- Lack of evidence about benefits and cost-savings.
- Not in line with current focus on recovery and abstinence (as opposed to harm reduction).

Recently the focus has shifted to Glasgow. In *"Taking away the chaos"*, the local health service and the city's drug service coordinating partnership reviewed the health and service needs of people who inject drugs in public places in the city centre. The review was a response to evidence that the city's injectors were "vulnerable to significant health harms, with those involved in public injecting in the city centre at particular risk", and concerns voiced by local residents and businesses about large amounts of discarded injecting equipment in public places in the city centre and neighbouring areas, compromising community safety and spoiling the environment.

Resulting recommendations were to develop existing services, but also to introduce new services, including a pilot safer injecting facility in the city centre to "address the unacceptable burden of health and social harms caused by public injecting". An HIV outbreak among people who inject (47 new diagnoses in 2015 compared to an annual average of 10) was at the

forefront of the discussions: "Given the scale and persistence of public injecting in Glasgow, these problems are likely to persist or worsen unless new approaches to harm reduction are considered. The potential for the HIV outbreak to continue or spread further, including among people without a history of drug use, is particularly concerning."

Safeguarding injectors' health

Addressed in turn in a 2004 briefing, whether drug consumption rooms will supplement the UK's repertoire of substance use interventions depends on the resolution of three broad areas of controversy which may inhibit policymakers:

- **Principle**: "How do policy makers justify providing a service that enables people to engage legitimately in activities that are both harmful and illegal?"
- **Messages**: "Do [drug consumption rooms] legitimise drug use, encourage more people to use hard drugs or – at the local level – increase drug-related problems in the areas where they are situated?"
- **Effectiveness**: "Do [drug consumption rooms] reduce drug related harms and, even if they do, are they the most appropriate and cost effective way of reducing these harms?"

First and foremost, drug consumption rooms are intended to be a form of harm reduction. Along with needle exchange, overdose education and naloxone provision, they operate on the premise that if people are going to take drugs, they should be informed about the risks, enabled to use drugs as safely as possible, and know what to do if something goes wrong. Harm reduction interventions do not exclude the possibility of people choosing to stop taking drugs or engaging with treatment, but as one writer put it, "may enable … users to live long enough to have the opportunity to pursue effective treatment when they are ready". If they do not work on this level, the case for them is fatally undermined.

Drug consumption rooms can help prevent overdose by enforcing rules about safe injecting and supervising the injecting process, and prevent overdoses becoming fatal by aiding users' breathing and administering the opiate-blocking drug naloxone. In 2004 a report knew of only one death in a drug consumption room since the first opened in 1986 – in 2002, a drug user died from anaphylaxis (an acute allergic reaction) in a German facility. Conversely, a conservative estimate of lives saved by just one facility in Sydney (Australia) was four per year. Though studies generally focus on what happens in the facilities, outside drug consumption rooms reductions have been seen in clients' risk-taking behaviour, and it seems likely that 'safer use' messages could be transmitted to a wider population of users via consumption room attendees.

Professor John Strang, a leading figure in British substance use practice and policy, argued in 2004 that "claims" of harm reduction from drug consumption rooms need to be more robustly tested. Although evidence has grown considerably since then, it remains difficult to evaluate the rooms' impacts in ways that meets the scientific 'gold standard' – the 'randomised controlled trial', which randomly assigns participants to an intervention versus an alternative intervention or no intervention at all. Instead, researchers undertake evaluations in real-world settings, in which the effects of drug consumption rooms are obscured by a complex set of factors not under their control. For example, the calculation of lives saved in Sydney (above) was complicated by "dramatic changes in the availability of heroin", colloquially referred to as the 'Australian heroin drought', which affected the amount of heroin being used, probably resulting in a reduction in associated problems such as heroin-related overdose. But even without a randomised trial, it may be possible to at least estimate the likelihood that an intervention (in this case, a drug consumption room) is having a positive or negative impact. For instance, it may not be possible to determine impacts on the transmission of infectious diseases, but it is possible to observe impacts on self-reported needle and syringe sharing, the key cause of transmission among drug users.

As the report of the 2006 Independent Working Group on Drug Consumption Rooms put it, "the methodological problems involved here should not detract from [drug consumption rooms'] considerable success". On balance, said the report, these services can have a positive impact on the health of their clients, for example through ensuring (relatively) safe and hygienic injecting in the facility, providing personalised advice and information on safe injecting practices, recognising and responding to emergencies, and providing access to a range of other on-site and off-site interventions and support. Overall the evidence from rooms across Europe demonstrates their potential to alleviate injecting-related harms.

However, realisation of this potential may be quite limited. Having a drug consumption room doesn't necessarily mean every injection will occur within its walls, or that every local user will attend it. In 2014 a survey by the International Network of Drug Consumption Rooms found that (among participating organisations) drug consumption rooms across Europe were open for on average eight hours a day, and 20 of the 34 opened on weekends, leaving large periods of time

when clients who would otherwise use the facilities must inject elsewhere. Though they also used drug consumption rooms, in Hamburg over a third of survey respondents had used drugs in public during the past 24 hours, citing among their main reasons waiting times at injecting rooms, distance from place of drug purchase, and limited opening hours.

To encourage regular use and achieve adequate coverage of the injecting population, it is necessary to understand the needs and drugtaking of local drug users, providing sufficient capacity to meet demand and making sure rooms are easily accessible in terms of location and opening hours. Facilities focusing on sex workers, for example, may need to remain open in the evening and at night. The location of consumption rooms should be compatible with the needs of drug users, but also take account of the needs and expectations of local residents.

Acceptance is at the root of benefits and criticisms

Safeguarding the health of a stigmatised and relatively voiceless population is unlikely to be seen to be enough to justify resourcing drug consumption rooms. There must also be no sufficiently strong countervailing harms, especially to the more 'voiced' in the population. Even within the ambit of harm reduction, it is conceivable that drug users will experience reduced harm while the locality and sections of the wider public – if only due to the diversion of resources from other social programmes – experience increased harm. Ambiguity of objectives within harm reduction is nested within a policy frame which may see any form of harm reduction as acceptable (if at all) only as a gateway to the overarching goal of stopping illegal drug use.

According to a 2004 review by the European Monitoring Centre for Drugs and Drug Addiction, there is no evidence that drug consumption rooms increase drug use, encourage riskier use, or increase morbidity and mortality. Even if all that were accepted, for some they would still undoubtedly cross an ideological red line, being seen to facilitate illegal and harmful behaviours.

Drug consumption rooms create a bubble of *acceptance* of drugtaking within a broader context of criminalisation, an essential feature which lies at the root of their support and of their condemnation. Acceptance is unpalatable to detractors, but also helps create an environment in which clients can engage in less risky and more hygienic drug use, and gain access to further support and treatment.

Ethical concerns include condoning drug use, in particular injecting, and undermining prescribing treatments – *doing* rather than mitigating harm. Speaking out against the proposed pilots in Brighton, Kathy Gyngell from the right-wing Centre for Policy Studies questioned the premise of a 'safe space' for injecting altogether, saying that drug consumption rooms are "described as safe despite the very unsafe street drugs used in them, and despite the intrinsic risk of addicts continuing to inject drugs at all". It is true that while drug consumption rooms do provide *safer* spaces for injecting, "dangerous situations that require intervention arise frequently ... (as they do in any drug-injecting context)". The difference is the capacity to respond to these emergencies and prevent them progressing to serious harm or death.

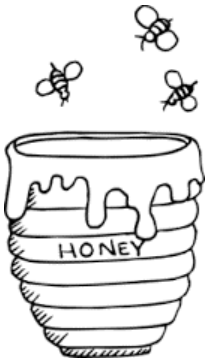
> *Acceptance of drugtaking can clear the path for prevention, treatment and support*

Such concerns are mitigated by the fact that few clients use the facilities only for drug consumption; most at some point use other services. For highly marginalised drug users in particular, consumption rooms can be the first step into the health and social care system, or even drug treatment. Given the nature of the target population – socially excluded drug users, such as street users and older, long-term users who have never been in treatment – it is vital that the house style encourages rather than deters potential clients. The temperament and attitude of staff is important – they should be sympathetic and non-judgemental towards people with multiple problems, yet at same time be clear and consistent about admission criteria and house rules. Just such an environment was found in Danish drug consumption rooms, where staff conveyed a welcoming, non-judgemental attitude and prioritised forging relations with drug users. Both clients and staff saw the rooms as providing a safe haven, one in which acceptance could clear the path for prevention, treatment and support.

Mitigating public crime and nuisance

The primary political justification for drug consumption rooms is to mitigate the public nuisance, disorder and crime associated with public injecting. They are usually sited where concentrated public drug use and discarded paraphernalia spoils the environment, and hampers or undermines regeneration. Failure to address these problems will mean that services which could preserve drug users' lives never open. Being seen to actually aggravate these problems would drain support from an existing service.

Research suggests consumption rooms can significantly reduce public drug use, but how much depends on their accessibility, opening hours and capacity. Compelling evidence comes from Vancouver (Canada), where acceptance of the facility among residents and workers had been generated by the distressing sight of public injecting and injecting-related litter. Despite a large local needle exchange, risky injecting, disease and overdose deaths remained high. After the facility opened there was a significant reduction in users seen injecting in public places, from a daily average of 4.3 to 2.4. Also roughly halved were discarded syringes and injecting-related litter in the surrounding area.



'Honeypot effect' applies to bees, not consumption rooms

One of the concerns about drug consumption rooms is that they will aggravate public disorder and crime in their vicinity by attracting users and dealers from elsewhere – the 'honeypot effect'. In passing, we should note that if this did happen, it would also extend the benefits to non-local drug users. In fact, neither the adverse nor the beneficial results of the honeypot effect materialise in practice. Most consumption room users live locally, and typically they reflect the profiles of people buying drugs in local markets. Facilities located any distance from drug markets tend to attract very few users.

Explaining why, drug users who gave evidence to the 2006 Independent Working Group pointed out that "an addicted injecting heroin user is likely to be primarily driven by the need to obtain their drugs. If they have the money, their first port of call will be a dealer. If there is somewhere nearby where they can safely use their drug (and obtain a clean syringe), then this is likely to be their next step. If they need to go any distance to reach such a place, their need to inject their drug is likely to lead to them using somewhere else (often a public area nearby)".

Though in themselves drug consumption rooms seem not to draw in users from other areas, they may well be drawn if a new drug market grew around a facility. Cooperation with the police should ensure that action against those or other drug markets do not deter drug users from attending approved consumption facilities.

Could there be a legal challenge to drug consumption rooms?

A repeatedly cited barrier to drug consumption rooms has been their supposed contravention of UK drugs laws. In 2013 the Home Office stated, "The Government has no plans to allow drug consumption rooms, which [would break] laws whereby possession of controlled drugs is illegal." But this view seems mistaken; depending on how the facility is run, consumption room staff and managers might be liable, but this need not be the case, and even under existing provisions a carefully managed facility could operate within the law despite its *customers* breaking laws prohibiting possession of controlled drugs. Possible legal challenges might be seen as a big barrier, but given the introduction of drug consumption rooms in eight other countries in Europe, and two outside Europe, clearly it is not insurmountable.

Release, the national centre of expertise on drugs law, has clarified that the UK Misuse of Drugs Act does not make it illegal to allow someone to possess or inject controlled drugs on your premises, but does make it illegal to allow their production or supply or the smoking of cannabis and opium. To inform its work, the Joseph Rowntree Foundation's Independent Working Group on Drug Consumption Rooms commissioned an analysis by a leading expert on UK drugs law. Based on Rudi Fortson's opinion, while some adjustments of the law might further shield rooms from legal challenge, the group was "not persuaded that this would be a necessary and unavoidable first step. Pilot [drug consumption rooms] could be set up with clear and stringent rules and procedures that were shared with – and agreed by – the local police (and crime and disorder partnerships), the Crown Prosecution Service (CPS), the Strategic Health Authority and the local authority."

However, ambiguity over the rooms' domestic and international legal footing has prevailed. To help clarify the issues, Rudi Fortson looked at how Canada's Insite project in Vancouver and Australia's injecting centre in Sydney managed to run within the law in countries with legal systems similar to that of the UK. For more click here.

Signatories to the United Nations' international drug control conventions (including the UK, Australia and Canada) have another issue to consider: whether drug consumption rooms violate their obligations under those conventions. Charged with policing adherence to the conventions is the International Narcotics Control Board or INCB. From in 1999 an extreme condemnation claiming the rooms breach the conventions because they "facilitate illicit drug trafficking", by 2015 the board seemed to admit that if a facility "provides for the active referral of [persons suffering from drug dependence] to treatment services", they might be admitted within the spirit and letter of the conventions. For more click here.

For Rudi Fortson the thousands of words on whether drug consumption rooms contravene UN conventions had missed the wood for the trees. There has, he observed, been a tendency to focus on the parts that impose restrictions and prohibitions, yet "conventions often embody statements of political will, intent, or hope", and in this case prohibition was intended to be at the service of promoting public health and wellbeing, not its opposite. Secondly, none of the three main UN conventions have direct application in the UK; they are interpreted into UK law by parliament, and it is those interpretations on which the courts rely in their judgements.

Contemplating drug consumption rooms...

It seems likely that drug consumption rooms will be piloted in Dublin in the next year. The *Irish Times* has reported that the Minister of State with responsibility for drugs wants to see drug consumption rooms in Ireland, and has the backing of the Taoiseach (head of government or prime minister of Ireland) and the Minister for Health. Legislation has been proposed by Dublin's Ana Liffey Drug Project in collaboration with the Bar Council that would allow people to take drugs in a safe, medically supervised injection centre. The current focus is on Dublin, "where public injecting is a well-established phenomenon, as is overdose", but the legislation could allow them to open anywhere in Ireland.

Proposal for a drug consumption room in Ireland

"A reception area is used to greet, assess and register clients. The main section of the service is an injecting room, with spaces for individuals to inject in privacy, but with medical supervision and interventions available. A social section allows clients to avail of non-medical support and interventions before they exit the service. The service is staffed by a mix of medical and social care personnel, all specifically trained for work in [a drug consumption room] environment".

Ana Liffey Drug Project position paper (June 2015)

This development, and ongoing discussions in Glasgow, have the potential to reinvigorate discussions about drug consumption rooms in the UK, but for now, the closest contemporary Britain comes to having safer injecting centres are the few clinics where patients inject legally prescribed pharmaceutical heroin (diamorphine) under clinical supervision. These clinics are unlikely to engage the target group of drug consumption rooms, but nonetheless provide a service to people with addiction who have not benefitted from typical treatment. Furthermore, it could be argued that they provide an experience- and skills-base for drug consumption rooms in the UK, as they have to exercise the same monitoring of patients, and have the same capacity to respond to overdose incidents, as drug consumption rooms.

Moreover, Britain already has a good-practice blueprint to guide implementation. In 2008, the Joseph Rowntree Foundation published guidance for local multi-agency partnerships looking into opening a drug consumption room. It addressed minimum operational standards identified in the 2006 report of the Independent Working Group on Drug Consumption Rooms, domestic and international legal issues, as well as the commissioning process, operational policies and procedures, monitoring and evaluation – but also stressed that local agreement is absolutely essential, something not generated in Brighton despite the serious nature of the city's problems and overdose fatalities in the area, but which may be seen in Glasgow.

Concluding thoughts

Evidence is stacked in favour of drug consumption rooms being an effective strategy for tackling public injecting and the harms associated with it, particularly among the most vulnerable and marginalised drug users, *and* as long as the context is conducive – when part of a "wider framework of … services that aim to reduce individual and social harms arising from problem drug use; based on consensus and active cooperation between key local actors, especially health workers, police, local authorities and local communities". There is no evidence of the feared adverse consequences on communities or drug use and users. Yet since 2002, proposals to pilot drug consumption rooms in UK cities have fallen flat.

There seem two scenarios in which support for drug consumption rooms could be generated in the future: firstly, if there were to be a policy shift towards harm reduction, not just as a mechanism to engage drug users with treatment, but as a legitimate goal in itself; and secondly, if the UK were to reach a 'tipping point' in the degree of distress and nuisance perceived to be caused by public injecting, or the degree of concern over the concentration of overdose fatalities and infectious diseases in certain locations. In the meantime, the needs of the target group of drug consumption rooms continue *not to be* met by existing services, and the human cost of public injecting – the lack of dignity, and the disproportionate burden on health, wellbeing and safety – keeps adding up.

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- Add your name to the mailing list to be alerted to new studies and other site updates