ROOM FOR IMPROVEMENT:

How drug consumption rooms save lives

By Jarryd Bartle

BRIEFING PAPER

EXECUTIVE SUMMARY

- Drug consumption rooms are an evidence-based harm reduction intervention which allow people who use illicit drugs to do so within a medically supervised environment.

- The use of drug consumption rooms in other jurisdictions has been shown to reduce drug-related deaths, reduce health burdens and decrease public injection and syringe litter.

- Supervised Drug Consumption Rooms are effective at engaging hard to reach, highly marginalised populations with drug treatment, healthcare and other services. People in treatment use less illegal heroin and other drugs, potentially reducing the scale of the illegal drugs market.

- Concerns that drug consumption rooms will increase drug use, attract substance users to an area or increase local crime are not supported by research.

- A large majority (89%) of drug users are willing to use a drug consumption room.

- The UK is falling behind the rest of the world, including countries such as Australia, Canada, Denmark and France which are increasingly adopting drug consumption rooms as part of drug harm reduction strategies.

- This paper recommends that the UK prioritises the introduction of an integrated drug consumption room in an area identified as being of increased risk of drug-related harms.

- Drug consumption rooms currently sit in a legal gray zone, leading to a lack of willingness by local authorities to introduce this proven harm reduction strategy. This could be addressed by:
    1. An explicit statement by the Home Office that the operation of DCRs is a matter for local authorities; specific rules could then be agreed by police forces, the Crown Prosecution Service (CPS), health bodies and local authorities; and
    2. The UK Parliament passing legislation that makes it explicitly legal to take controlled substances within such facilities in specified circumstances.

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Supervised drug consumption rooms (sometimes referred to as 'safe injecting rooms' or 'overdose prevention centres') allow people who use illicit drugs to consume substances whilst under the supervision of trained staff.

Drug consumption facilities aim to reduce risks of disease transmission, overdose and public nuisance whilst also providing a location for people who have substance dependence to access treatment, employment, and housing support services.

The UK currently does not have any supervised drug consumption rooms, although proposals for facilities have been made by local agencies in West Midlands,[1] North Wales,[2] Southampton,[3] Glasgow,[4] and Bristol.[5] In 2016, the UK Advisory Council on the Misuse of Drugs recommended that consideration be given to the potential of drug consumption rooms within areas of high injecting drug use in order to reduce drug related deaths.[6] The government response was that no plans existed to introduce drug consumption rooms in the UK.[7]

A 2018 survey of injecting drug users in the UK found that a large majority (89%) expressed willingness to use a drug consumption room and accepted the need for rules within such facilities such as no drug sharing (84.3%), no assistance with injecting (81.8%), compulsory supervision (76.7%) and compulsory hand washing (92.1%).[8]

The following paper will outline the need for drug consumption rooms in the UK, evidence supporting their use and considerations for implementation at a local level.

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1 Jamieson, D (2018) 'Reducing Crime and Preventing Harm: West Midlands Drug Policy Recommendations' West Midlands Police and Crime Commissioner, https://www.westmidlands-pcc.gov.uk/media/477434/West-Midlands-Drug-Policy-Recommendations.pdf.

2 North Wales drug fix room pilot moves forward, BBC News 18 September 2017, https://www.bbc.com/news/uk-wales-41267538.

3 Southampton City Council (2018), 'Reducing Drug Related Litter in Southampton', https://www.southampton.gov.uk/images/drug-related-litter-final-report_tcm63-399510.pdf.

4 Lord advocate fails to back 'fix room' plan, BBC News 10 November 2017, http://www.bbc.co.uk/news/uk-scotland-glasgow-west-41941699.

5 Bristol City Council, Meeting of Full Council Tuesday 20th March 2018, https://democracy.bristol.gov.uk/mgAi.aspx?ID=10608.

6 Reducing Opioid-related Deaths in the UK, Advisory Council on the Misuse of Drugs, 12 December 2016.

7 ACMD Recommendations and Government Response, 12 July 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/634059/ACMD_response_drug_related_deaths.pdf.

8 Butler, G Chapman, D and Terry, P (2018) Attitudes of intravenous drug users in London towards the provision of drug consumption rooms. *Drugs: Education, Prevention and Policy*, 25(1), pp. 31-37

Illicit drug use has substantial costs, including healthcare service costs, costs of drug-related crime, disorder and antisocial behaviour, loss of productivity and profitability in the workplace and the impact on family and social networks.[9] In 2010-11, the Home Office estimated that the total cost of illicit drug use in the UK was £10.7 billion per year.[10]

Drug use is a significant cause of premature mortality in the UK.[11] In England and Wales, the number of premature deaths from drug misuse registered in 2017 was 2,503[12] while Scotland saw 934 drug-related deaths during the same year: 8% more than 2016 and more than double the number from 2007[13]. The substance with the largest number of associated deaths in the UK is heroin, a statistic which has remained steady for over two decades. [14]

In 2017/18, 53% of people seeking treatment for substance misuse in England were doing so for opiate dependence,[15] the largest substance of concern. Around 1% of opiate clients will die from overdose whilst actively involved in treatment.[16] The median age of opiate clients recorded as having died in 2017-18 was 45.[17]

Between 2012 and 2015, drug-related deaths rose by a statistically significant amount each year, driven mostly by heroin deaths.[18]

Around 90% of hepatitis C infections diagnosed in the UK are acquired through injecting drug use. [19] Moreover, the prevalence of hepatitis C amongst people who inject drugs has remained steady over the last decade. [20] Sharing of injecting equip-

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9 'Chapter 3 – The burden of illicit drug use' in Drugs of dependence: the role of medical professionals, 18 December 2012, https://www.bma.org.uk/-/media/files/pdfs/news%20views%20analysis/in%20depth/drugs%20of%20dependence/drugsofdepend_chapter3.pdf.

10 Health matters: preventing drug misuse deaths, 15 September 2017, https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths.

11 Office of National Statistics, 2017, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations.

12 Ibid.

13 National Records of Scotland, 3 July 2018, https://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/17/drug-related-deaths-17-pub.pdf.

14 Crawford, C Clare, T Sharpe, C and Wright, C (2018) *United Kingdom Drug Situation:Focal Point Annual Report 2017* Focal Point at Public Health England

15 Ibid, p12.

16 Ibid, p19.

17 Ibid, p18.

18 Office of National Statistics, above n9.

19 Public Health England, Health Protection Scotland, Public Health Wales and Public Health Agency Northern Ireland (2016) *Shooting Up Infections among people who injected drugs in the UK, 2015 An update: November 2016*, Public Health England.

20 Ibid, p13.

ment is the single biggest factor in hepatitis C transmission amongst people who inject drugs.[21]

One of the drivers for the NHS in Glasgow wanting to open a Drug Consumption Room is a localised cluster of over 100 HIV infections in recent years amongst people sharing needles primarily in the homeless community.

Given the stagnant set of drug-related harms in the UK – particularly among injecting drug users – there is a strong need for harm reduction interventions such as drug consumption rooms to address vulnerable populations.

DRUG CONSUMPTION ROOMS

Drug consumption room (DCRs) provide people who use drugs with sterile injecting equipment, medical care and referral services. Staff are trained and equipped to reverse overdoses.

DCRs have been operating across Europe for the last three decades. Many of the initial consumption facilities were implemented to manage the HIV/AID epidemic of the 1980s – in which sharing of needle equipment was a chief concern.[22]

Current facilities operate in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, and France. Consumption facilities have also been implemented in Canada (Vancouver, Montreal, Toronto and Ottawa) as well as Sydney and – most recently – Melbourne, Australia. Most countries have multiple drug consumption facilities in areas of need (Table 1).

In many countries, DCRs are not limited to injecting drug use, for example sites may also offer facilities for smoking or sniffing of powdered drugs. However, the vast majority of facilities primarily cater to injecting users with the most common injected substance being heroin.[23] This is also likely to be the case in the UK as heroin remains the most commonly reported injected drug across all UK countries.[24]

DCRs operate under the policy goal of 'harm reduction' which seeks to reduce the health, social and economic harms of drug use to individuals, communities and societies.[25]

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21 Turner KM, Hutchinson S and Vickerman P (2011) The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: pooling of UK evidence. 106 Addiction 1978–88.

22 *EMCDDA* (2018) Drug consumption rooms: an overview of provision and evidence, Perspectives on drugs, EMCDDA, Lisbon, June 2018, http://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms_en.

23 Ibid

24 Public Health England, above n16.

25 EMCDDA (2010) Harm reduction: evidence, impacts and challenges, EMCDDA, Lisbon, April 2010, http://www.emcdda.europa.eu/publications/monographs/harm-reduction_en.

Table 1: Global Prevalence of Drug Consumption Rooms[26]

Country	Number of drug consumption facilities
Netherlands	31 facilities in 25 cities
Germany	24 facilities in 15 cities
Spain	13 facilities in 7 cities
Switzerland	12 facilities in 8 cities
Denmark	5 facilities in 4 cities
Norway	2 facilities in 2 cities
France	2 facilities in 2 cities
Australia	2 facilities in 2 cities
Canada	2 facilities in 2 cities
Luxembourg	1 facility in 1 city

DCRs primarily seek to attract hard-to-reach populations of users, especially the homeless and those with co-morbid mental health issues - as they are more likely to use on the streets or in other risky and unhygienic conditions.[27] However, in some cases clients who are more socially stable also use DCRs for a variety of reasons, for example because they live with non-using partners or families.[28]

DCRs are implemented in areas where local need is identified through consultation with local stakeholders including community health organisations and local residents.[29] People who use these facilities bring their own drugs for consumption under supervision in a clinical, hygienic setting, away from public spaces.

Although there are variations between drug consumption facility models, commonalities include:[30]

- A minimum age for entry;
- Screening and assessment of clients on entry;
- Free provision of sterile injecting equipment such as needles;
- Availability of medically trained staff, trained and equipped (e.g. with Naloxone) to reverse overdoses;
- Consent and co-operation of local police to operate the facilities; and
- Referral connections with other key services such as treatment, counselling, legal advice and housing services.

26 Correct as of April 2018.

27 EMCDDA, above n19.

28 Hedrich, D. and Hartnoll, R. (2015), 'Harm reduction interventions', in El-Guebaly, N., Carrà, G. and Galanter, M. (eds), Textbook of addiction treatment: international perspectives, Section IV: main elements of a systems approach to addiction treatment, Springer, Milan, pp. 1291–313.

29 Ibid.

30 EMCDDA, above n19.

Different approaches are taken in different regions, for example Barcelona has both fixed and mobile drug consumption facilities whilst Paris has a facility imbedded into a medical complex.[31]

According to a 2017 survey of DCR operators, most employed nurses (80%) and/or social workers (78%) within facilities. Others employed health educators / rescue workers (35%), paid peer-workers (24%), psychologists (13%), case managers (11%) and students (11%). Just less than half required a doctor/clinician onsite (46%).[32]

The key to DCR's success is their ability to adapt to local needs and to integrate effectively with local health services with similar goals.

EVIDENCE IN SUPPORT OF DRUG CONSUMPTION ROOMS

The UK Government has accepted the public health case for opening drug consumption rooms[33]. A number of evaluations have been conducted assessing the impact of DCRs on indicators of concern. Key findings have found that DCRs:

- Reduce drug-related deaths due to overdose at a local level;[34] [35]
- Reduce emergency call-outs in areas of concern;[36]
- Decrease visible public injecting and needle litter;[37] [38]
- Increase referrals to drug treatment centres;[39] [40]

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31 Belackova, V., Salmon, A. M., Schatz, E., Jauncey, M. (2017). Online census of Drug Consumption Rooms (DCRs) as a setting to address HCV: current practice and future capacity, Amsterdam, Sydney: International Network of Drug Consumption Rooms, Correlation Network, Uniting Medically Supervised Injecting Centre, http://www.drugconsumptionroom-international.org/images/survey_2017/INDCR_report.pdf.

32 Ibid.

33 Home Office Accepts Public Health Case for Safer Drug Consumption Facility, Glasgow City Council, 04 June 2018, https://www.glasgow.gov.uk/index.aspx?articleid=22874.

34 Poschadel, S., Höger, R., Schnitzler, J. and Schreckenberg, D. (2003), 'Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland', Nr 149, Schriftenreihe des Bundesministeriums für Gesundheit und Soziale Sicherheit, Baden-Baden.

35 Marshall, B. D., Milloy, M. J., Wood, E., Montaner, J. S. and Kerr, T. (2011), 'Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study', The Lancet 23 April, 377(9775), pp. 1429–37.

36 Salmon, A. M., Van Beek, I., Amin, J., Kaldor, J. and Maher, L. (2010), 'The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia', Addiction 105, pp. 676–83.

37 Wood, E., Kerr, T., Small, W., et al. (2004), 'Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users', Canadian Medical Association Journal 28 September, 171(7), pp. 731–4.

38 Salmon, A. M., Thein, H. H., Kimber, J., Kaldor, J. M. and Maher, L. (2007), 'Five years on: what are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre?' International Journal of Drug Policy 18(1), pp. 46–53.

39 Wood et al, above n32..

40 DeBeck, K., Kerr, T., Bird, L., et al. (2011), 'Injection drug use cessation and use of North America's first medically supervised safer injecting facility', Drug and Alcohol Dependence 15 January, 113(2–3), pp. 172–6.

- Effectively engage marginalised target populations of substance users, including homeless and co-morbid clients;[41][42]
- Improve both hygiene and safer use behaviours amongst clients;[43][44]and
- Reduce needle sharing and other injecting risk behaviour.[45][46]

Supervised consumption facilities have generally been accepted by local communities and businesses in areas where they operate,[47] largely due to decreases in public injecting and syringe litter.[48] [49] [50]

It is difficult to quantify the impact of drug consumption facilities on overall rates of HIV and Hepatitis C due in part to the facilities' limited coverage of the target population and also to methodological problems with isolating their effect from other interventions.[51]

A lengthy evaluation of drug consumption facilities in Switzerland, between 1993 and 2006, showed reductions in injecting drug use as well as improvements in health outcomes among those who use illicit drugs. [52]

The Glasgow City Integration Joint Board from Health and Social Care Partnership (HSCP) developed a convincing business case for a local DCR in 2017.[53] Using activity data from 2014-2016, 350 people who inject drugs from the Glasgow city area were identified and found to account for:

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41 Hedrich et al, above at n17.

42 Potier, C., Laprévote, V., Dubois-Arber, F., Cottencin, O. and Rolland, B. (2014), 'Supervised injection services: what has been demonstrated? A systematic literature review', Drug and Alcohol Dependence 145, pp. 48–68.

43 Small, W., Wood, E., Lloyd-Smith, E., Tyndall, M. and Kerr, T. (2008), 'Accessing care for injection-related infections through a medically supervised injecting facility: a qualitative study', Drug and Alcohol Dependence 98(1–2), pp. 159–62.

44 Small, W., Van Borek, N., Fairbairn, N., Wood, E. and Kerr, T. (2009), 'Access to health and social services for IDU: the impact of a medically supervised injection facility', Drug and Alcohol Review 28(4), pp. 341–6.

45 Milloy, M. J. and Wood, E. (2009), 'Emerging role of supervised injecting facilities in human immunodeficiency virus prevention', Addiction 104(4), pp. 620–1.

46 Stoltz, J. A., Wood, E., Small, W., et al. (2007), 'Changes in injecting practices associated with the use of a medically supervised safer injection facility', Journal of Public Health (Oxford) 29(1), pp. 35–9.

47 Thein, H.-H., Kimber, J., Maher, L., MacDonald, M. and Kaldor, J. M. (2005), 'Public opinion towards supervised injecting centres and the Sydney Medically Supervised Injecting Centre', International Journal of Drug Policy 16(4), pp. 275–80.

48 Salmon et al, above n33..

49 Wood et al, above n32..

50 Vecino, C., Villalbí, J. R., Guitart, A., et al. (2013), Safe injection rooms and police crackdowns in areas with heavy drug dealing: evaluation by counting discarded syringes collected from the public space, Addiciones 25(4), pp. 333–8

51 Hedrich et al., 2010, above n24..

52 Dubois-Arber, F., Balthasar, H., Huissoud, T., et al. (2008), 'Trends in drug consumption and risk of transmission of HIV and hepatitis C virus among injecting drug users in Switzerland, 1993–2006', Eurosurveillance 22 May, 13 (21).

53 Miller, S (2017) Glasgow City Integration Joint Board, https://glasgowcity.hscp.scot/sites/default/files/publications/IJB_15_02_2017_ItemNo13_-_SCF_and_HAT.pdf.

- 1587 Emergency Department attendances with a total resource use of slightly over £200k;
- 3743 acute inpatient bed days with a total resource use of slightly over £1.5m;
- 19 day case admissions with a total resource use of approximately £9600; and
- Total resource use for all activity in acute hospitals during this 2 year time period totalled slightly over £1.7m.

The case also noted the estimated the average lifetime cost of HIV infection was £360,000 per person. If this cost was applicable to the 78 new HIV cases in people who inject drugs in Glasgow from 2015 and 2016, this would translate to a lifetime cost of £28,080,000 to the health system (although it's important to note that not all of these cases would likely have been avoided).

The economic case concludes:

> By reducing the use of unscheduled care and crisis services, by contributing to reductions in blood borne virus spread, by reduced drug related offending and by improved effective engagement meeting complex needs, investment in the proposed safer drug consumption facility and heroin assisted treatment service has the potential to contribute to savings in other services in Glasgow.

ADDRESSING CONCERNS

The critics of DCRs commonly raise concerns about attracting substance users and crime, as well as potentially enabling illegal behaviour.

In its evaluation of the evidence, the UK Home Office found that concerns of a 'honey pot' effect of drug consumption rooms – attracting both substance users and crime – were unfounded.[54] In areas where DCRs have operated for some time, local residents were more likely to perceive a reduction or neutral impact on crime.[55]

The effect of the Sydney supervised injecting facility on drug related property crime and violent crime in its local area was examined using time series analysis of police-recorded theft and robbery incidents and found no evidence that DCRs increased local crime.[56]

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54 UK Home Office (2014) Drugs: International Comparators, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/368489/DrugsInternationalComparators.pdf.

55 Ibid.

56 Freeman, K., Jones, C. G., Weatherburn, D. J., et al. (2005), 'The impact of the Sydney Medically Supervised Injecting Centre (MSIC) on crime', Drug and Alcohol Review March, 24(2), pp. 173–84.

Similarly, a Vancouver study comparing the year before versus the year after a DCR opened found that the establishment of the facility was not associated with a marked increase in crime.[57]

The potential for legal ambiguities with drug consumption facilities is a further issue that has been raised. In both Canada and Australia there have been legal challenges to DCRs.[58] Such challenges can be avoided by enabling legislation which permits DCR operations, as well as agreements between service providers and local police regarding the prosecution of DCR clients for illicit drug use or possession.[59]

In 2012, the United Nations International Narcotics Control Board (INCB) has objected to DCRs on the basis that they facilitate illicit drug use and thereby enable dealing and trafficking.[60] Although, this position has softened more recently.[61]

The United Nations Office on Drugs and Crime in 2002, considered whether DCRs potentially contradicted aims of international conventions not to incentive the abuse of drugs, noting:[62]

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

The Government's remaining concern is that allowing illegal drugs to be consumed on the premises supports the illegal drug market. However research has found no evidence DCRs increase drug use, and that any drugs taken in a DCR would be taken anyway just in the street. Furthermore, there is clear evidence that they get hard to reach people who use illegal drugs into treatment, so helping to stop or reduce their use. So in the longer term DCRs can reduce the size of the illegal drug market.

A 2014 systematic review of DCRs found that there was no evidence that such facilities increased increase drug use, trafficking or crime in areas of operation.[63]

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57 Wood et al, above n32..

58 EMCDDA, above n19.

59 Ibid.

60 International Narcotics Control Board (2012) Annual Report 2012, 99-100.

61 International Narcotics Control Board (2016) Annual Report 2016, 91.

62 UNDCP Legal Affairs Section (2002) [27]-[28], http://www.undrugcontrol.info/images/stories/un300902.pdf.

63 Potier, C., Laprévote, V., Dubois-Arber, F., Cottencin, O. and Rolland, B. (2014), 'Supervised injection services: what has been demonstrated? A systematic literature review', Drug and Alcohol Dependence 145, pp. 48–68

Drug policy think tank VolteFace was commissioned by the Drugs, Alcohol and Justice Cross-Party Parliamentary Group to provide comprehensive evaluation of the feasibility of DCRs, by drawing on the experience of policymakers in Glasgow and Dublin.

For both cities, the following factors were noted as key for the successful implementation of DCRs in the UK:[64]

- Placing DCRs in localities with a high concentration of people who use drugs, as this population is unlikely to travel far after purchasing substances;
- Sourcing alternative funding streams for DCRs given significant strain on current treatment budgets;
- Clearly communicating the flow-on benefits of DCRs to local communities including decreased drug-related litter and public injecting as well as to maintain consistent, ongoing community consultation;
- Media and political engagement, with a focus on educating stakeholders that DCRs are a humanitarian, evidence-based intervention;
- Highlighting the consistencies of DCRs with recovery-oriented practice and international conventions;
- Clear legal guidance on the operation of a DCR and the likely decisions by law enforcement including cooperative agreements with local police;
- Limiting risks involved in DCR operations including strong Good Samaritan legislation exempting liabilities for DCR workers; and Maintaining consistent hours of operation.

A report of best practice models for DCRs in Europe by the European Harm Reduction Network noted the benefits of an 'integrated model' of consumption facilities where DCRs are interlinked with allied services.[65]

Integrated DCRs are based in drug service centres alongside counselling, medical testing, needle and syringe, psychosocial, housing and employment services. However, mobile DCRs, which have 1-3 injecting booths, within a vehicle to be taken to sites – may be preferable in targeting transient and very vulnerable populations.

Given current evidence on feasibility it's recommended that an integrated DCR be implemented in an area of high levels of injecting drug use as an initial pilot of DCRs in the UK.

While amending the Misuse of Drugs Act 1971 to make provision for supervised drug consumption facilities is the clearest long-term route to reform, pilot DCRs could be set up following an explicit statement by the Home Office that the opera-

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64 McCulloch, Liz (2017) Back yard. An investigation into the feasability of estsblishing drug consumption rooms. London: Volteface, http://volteface.me/publications/back-yard/5-feasibility/.

65 Schäffer, D, Heino, S and Weichert, L (2014) Drug consumption rooms in Europe: Models, best practice and challenges, European Harm Reduction Network, Amsterdam

tion of DCRs is a matter for local authorities. The Independent Working Group on Drug Consumption Rooms explained this approach:[66]

> Pilot DCRs could be set up with clear and stringent rules and procedures that were shared with – and agreed by – the local police (and crime and disorder partnerships), the Crown Prosecution Service (CPS), the Strategic Health Authority and the local authority. An 'accord' might be established that action would not be taken against the DCR, its staff and, in normal circumstances, its users. The local police and CPS would need to agree that they would not charge users for possession offences within the DCR or on their way to the DCR. Of course, they would arrest users suspected of other offences in the usual way. Such local agreements have allowed DCRs to be set up in Frankfurt.

Last year, three Police and Crime Commissioners wrote to the Home Office assuring the Government that they could manage the policing issues around DCRs.[67]

CONCLUSION

The UK has currently falling behind in drug harm reduction. There is substantial evidence to support the implementation of drug consumption rooms within the UK in areas of need. The UK still demonstrates a high level of drug related harms amongst injecting drug users.

International evidence has clearly demonstrated that drug consumption rooms are both effective and locally feasible as a measure to reduce drug-related harms.

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66 IGW on Drug Consumption Rooms (2006) The Report of the Independent Working Group on Drug Consumption Rooms, https://www.jrf.org.uk/report/drug-consumption-rooms-summary-report-independent-working-group.

67 Police commissioners urge Home Office to drop opposition to addicts' 'fix rooms', The Scotsman 02 July 2018, https://www.scotsman.com/news/police-commissioners-urge-home-office-to-drop-opposition-to-addicts-fix-rooms-1-4762383.