# Guidance on standards for the establishment and operation of drug consumption rooms in the UK

Neil Hunt

December 2008

**This report provides essential guidance for local multi-agency partnerships that are contemplating establishing and operating a drug consumption room (DCR) in the UK.**

A number of local partnerships across England, Wales and Scotland are currently discussing whether or how DCRs might help address their local drug problems. At present there are no DCRs in the UK, however, evidence elsewhere suggests that they can be valuable for engaging marginalised drug users, reducing overdose deaths and can have a beneficial impact on community safety in areas where public drug use is widespread.

This guidance:

- helps meet a need to define minimum operational standards, identified within the original *Report of the Independent Working Group on Drug Consumption Rooms* (JRF 2006);
- addresses international and domestic legal issues, including duty of care;
- examines the commissioning process, operational policies and procedures and monitoring and evaluation.

JOSEPH ROWNTREE FOUNDATION

www.jrf.org.uk

# Contents


Preface 3

**1 Introduction 4**

**2 Legal concerns 6**

**3 Negligence and the ‘duty of care’ 12**

**4 The commissioning process 14**

Notes 24

References 25

Appendix 26

Acknowledgements 27

About the author 29

# Preface

This guidance has been developed for local multi-agency partnerships within the UK that are contemplating the introduction of drug consumption rooms (DCRs) (e.g. Drug and Alcohol Action Teams or Crime and Disorder Reduction Partnerships).

While the author is very grateful for the helpful comments received from a number of individuals, the views expressed in this guidance should not be taken as necessarily representing the views of those whom we have consulted.

Any DCR that is established in the UK should comply with the law and fulfil its duty of care. This guidance is intended to support local partnerships that decide to establish DCRs to do so in ways that meet these requirements.

Any information found in this guidance is intended for guidance only. While the Joseph Rowntree Foundation has taken all reasonable care in the preparation of the contents of this guidance it disclaims (to the extent permitted by law) all warranties, express or implied, as to the accuracy of the information contained in this guidance. You should take appropriate steps to verify any information upon which you wish to rely.

# 1 Introduction

By providing facilities that enable the supervised, hygienic consumption of pre-obtained illicit drugs, drug consumption rooms (DCRs) aim to enhance the safety, health and well-being of drug users and reduce the nuisance associated with public drug use. In these respects DCRs have the potential to contribute to government strategies to reduce drug-related harm (Department of Health, 2007) and promote safer communities (Home Office, 2001).

There is sometimes confusion between DCRs and other services. DCRs are distinct from drug treatment services that prescribe and supervise the administration of pharmaceutical heroin (diamorphine) but do not provide facilities for the consumption of *illicit* drugs. DCRs also differ from low-threshold hostel/housing services that tolerate drug use among their occupants but do not provide the level of supervision of drug use that is characteristic of DCRs. This guidance has been developed for DCRs.

Although some countries provide services for people who smoke/inhale heroin or crack cocaine, DCRs mainly provide services for injecting drug users. Any pilot in the UK should relate to local needs; however, the nature of drug problems and needs within the UK means that any initial pilots are envisaged to be for injecting drug users. The guidance is therefore written from this perspective.

At the time of publication, drug consumption rooms (DCRs) operate in eight countries (Australia, Canada, Germany, Luxembourg, the Netherlands, Norway, Spain, Switzerland). No DCRs currently operate in the UK; however, the report of an independent working group (IWG) established by the Joseph Rowntree Foundation (JRF) found that there was evidence both of need within the UK and of their effectiveness elsewhere (JRF, 2006). This recommendation echoed the earlier conclusion of the Home Affairs Select Committee that there should be an evaluated pilot programme of 'safe injecting houses' (Home Affairs Select Committee, 2002) and has since been reinforced within three further independent reports (Turning Point, 2007; Reuter and Stevens, 2007; RSA, 2007).

The JRF report concluded that:

> *Although legislative change would be the safer option for piloting DCRs in the UK, there are arguments for delaying any such change until the pilots have been evaluated and their effectiveness assessed. Amending or introducing legislation would prove a wasted effort if the pilots were then shown to be ineffective. Furthermore, the implementation and operation of pilot projects may provide valuable insights into the particular type of legal protection that might be required.*
>
> *However, it is clear that there would be some dangers in setting up DCRs under the current law. These dangers would be minimised by the imposition of a set of clear rules governing the behaviour of users and staff. To this end, it is recommended that a set of minimum standards is developed which forms part of the clinical governance for pilot DCRs and is subject to regular audit. (JRF, 2006, p 107)*

As such, a path that may enable DCRs to be piloted appears to be open, yet there is an identified need for guidance about how such facilities might be established and operate. The guidance here has been developed in response to this need.

Although no guidance has previously been available in the UK, DCRs have operated elsewhere for 20 years (EMCDDA, 2004) and this international experience provides a valuable basis for developing guidance. In particular, the rigorous scrutiny that has surrounded the introduction of DCRs in Australia and Canada means that considerable thought has gone into the development of operational policies and protocols that address the risks that may arise. Furthermore, the report of the IWG and the technical reports that underpin it provide useful points of reference for considering minimum standards and guidance.

This guidance has therefore been developed with reference to the published literature on DCRs, along with operational policies and procedures and management protocols from existing services. These have been examined in the light of the findings and recommendations of the Independent Working Group established by the Joseph Rowntree Foundation and specific issues as they relate to the UK. Finally, the guidance has been considered by a reference group of people from areas within the UK where a potential need for DCRs has been identified and where there is some local debate about their introduction, i.e. some of the stakeholders who may have the most immediate need for guidance.

The guidance that follows has three main sections:

- legal concerns – aspects of operational policy that need to be addressed to reduce identifiable risks relating to criminal law;

- negligence and the 'duty of care' – aspects of operational policy concerning good practice and risks relating to civil law;

- the commissioning process – a summary of steps that should be considered in localities where the introduction of DCRs is contemplated.

# 2 Legal concerns

Both international agreements and domestic legislation have implications for operational policies within DCRs. The relevant law has recently been reviewed in detail by Fortson (2006a, 2006b) for the JRF, whose reviews were drawn upon directly in the production of *The Report of the Independent Working Group on Drug Consumption Rooms* (JRF, 2006). The guidance here does not duplicate the debates and discussion contained within those reports, which are best consulted in the original if detailed analysis is required. Rather, the main conclusions of the report of the Independent Working Group are summarised and used as a basis for proposed minimum standards for DCRs in the UK.

## The UN Conventions

In international terms, the UN Conventions of 1961, 1971 and 1988, to which the UK is a signatory, provide the main basis for debates about the acceptability of DCRs and their operation. However, the Conventions do not directly discuss DCRs as these services have largely been developed and introduced since 1988. The Conventions are therefore mute on DCRs as a form of intervention, and debates about the legitimacy of DCRs have largely been conducted with reference to the Conventions' wider scope and intent.

On the one hand, an increasing number of countries which are signatories to the Conventions have introduced DCRs, with the implication that they consider the operation of DCRs as being both Convention-compliant and worthwhile. On the other hand, a UN body – the International Narcotics Control Board – has consistently expressed the view that DCRs breach the Conventions, a view that has nevertheless been contradicted in a written opinion of the Legal Affairs Section to the United Nations Drug Control Programme (Fortson, 2006a, p 4).

Against this background of divided opinion, the IWG concluded that the Conventions need not be an impediment to the introduction of DCRs:

> *The IWG concludes that well-run DCRs would not act contrary to the primary objects of the three United Nations Conventions. The extent to which DCRs might contribute towards meeting some of the Conventions' objectives concerning user welfare, rehabilitation and reintegration would depend on the extent to which other services were provided and referrals made. An 'integrated' model of DCR provision, which includes a range of health, treatment and social integration services, would seem to be most Convention compliant. (JRF, 2006, p 75)*

In practice, countries that are signatories to the Conventions interpret them within domestic legislation and it is this domestic legislation that determines questions of legality. The UK is a signatory to all three Conventions and has corresponding law. This provides the primary reference point for consideration of whether or how DCRs might operate in the UK.

## UK legislation

The main instrument by which the UN Conventions are incorporated within UK law is the Misuse of Drugs Act 1971 and the Regulations made thereunder (as amended). However, this is not the only legislation that is applicable and Fortson (2006b) also identified and appraised the implications of other areas of law that have potential relevance to the operation of DCRs.

Fortson identifies a number of legal risks, i.e. areas where a prosecution might arise. One way in which these risks could be managed or averted is through new primary or secondary legislation; however, the Government continues to question the case for introducing DCRs, making the legislative route unlikely.

Consequently, this guidance is written on the basis of current law. Under these circumstances the IWG identified a series of implications for reducing the risk of prosecution for people operating DCRs. The implications fall into two main categories:

- issues that could be addressed within a local 'accord';

- activities that should be prohibited within DCRs in the UK.

**Issues that could be addressed within a local 'accord'**

Criminal charges are not necessarily brought if a decision to prosecute is judged not to be in the public interest. Where a DCR is expected to reduce public nuisance and improve public health such a judgment might apply. Judgments of this sort can sometimes be formalised in an agreement or 'accord' between local stakeholders that defines general expectations regarding the implementation of the law. An accord can be written or verbal. It does not alter or overturn the law or in any way remove the powers of the police, but provides a guide to the expectations that services could generally have about the police response to a specified situation. In a locality where there is a desire to establish a DCR an accord could be developed to govern expectations surrounding its operation and to reduce the identifiable legal risks. Such agreements between law enforcement, social services and health services often underpin services elsewhere (EMCDDA, 2004). There are also similar precedents for the use of local agreements governing the delivery of other aspects of UK drug services in order to minimise legal risks, notably where services have distributed injecting paraphernalia such as swabs, citric acid or filters for injection as harm reduction measures: distributing any of these was in contravention of section 9a of the Misuse of Drugs Act until 2003.[1]

It is worth noting that informal accords also operate with virtually all drug services across the UK. In practice, the police could easily increase their rates of arrest and conviction for Misuse of Drugs Act and other offences if they targeted people as they were entering or leaving drug treatment services. However, this would undermine the operation of treatment services. Within local partnerships there is therefore usually an understanding that drug users will not be targeted in this way. This does not mean that police would never arrest someone on or near drug treatment premises; sometimes they do. Indeed, occasionally this happens at the instigation of the treatment services themselves, e.g. where there is concern about violent crime. Nevertheless, this sort of understanding recognises the tension between the duty of the police to enforce the law and treatment services' role in working with people who, by definition, routinely break the law through crimes such as drug possession that are integral to their drug problem.

The IWG discusses the possible role of an accord, precedents for its use and potential problems as follows:

> *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 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.*
>
> *There are potential problems and risks associated with such an approach. The accord would be agreed between the particular individuals managing the local agencies at that time. A change of senior staff could lead to its collapse. There is also nothing to prevent local citizens or businesses from initiating a private prosecution. However, provided DCRs institute the type of rules referred to above and are properly insured, the IWG is of the view that risks and problems can be kept within acceptable limits. (JRF, 2006, pp 79–80)*

As indicated, the development of an accord will require a local, multi-agency partnership between criminal justice services, health services and the local authority. This is also consistent with Hedrich's review (EMCDDA, 2004), which identifies the need for strong local partnerships of this sort if DCRs are to be effective. *For this reason it is not envisaged*

*that DCRs could or should currently be developed in the absence of a local multi-agency partnership that is capable of developing such an accord.*

The first requirement for the establishment of a DCR in the UK is for provision of the service to occur within the context of a local multi-agency partnership (involving criminal justice services, health services and the local authority) that is willing to develop and agree a local 'accord'.

### Possession of drugs

Possession is, self-evidently, a necessary part of the process of self-administration of pre-obtained illicit drugs. Consequently, by definition, the offence of possession under section 5(2) of the Misuse of Drugs Act (MDA) will be committed routinely by people using a DCR. For a DCR to function as intended it would therefore be necessary for the offence of possession to be addressed within the local accord. Practically, this would need to include offences occurring both within the DCR and where they are committed by users of the service who are travelling to it, as the routine prosecution of people going to a DCR would be counter to its effective operation. This requirement would have no bearing on people carrying quantities of drugs for supply, and would only apply to drugs the use of which is permitted at the DCR.

As a result of drugs being lost or left behind by clients using the service it is probable that staff would come into possession of drugs from time to time. Drug services generally have procedures for disposal of drugs and similar policies would be required within a DCR.[2] The accord provides an opportunity to clarify expectations in these circumstances.

The accord should clarify expectations regarding the implementation of the law relating to possession by drug users within and on their way to the DCR and agree that they should not routinely expect to be prosecuted under section 5(2) of the MDA. The accord should similarly clarify expectations for staff where possession occurs in association with their duties.

### Production of drugs

There is also a risk that the routine aspects of the preparation of drugs for injection (e.g. crushing tablets or converting heroin or cocaine base to an injectable salt form with an acidifier) could be interpreted as an act of 'production' – an offence under section 4 of the MDA (Fortson, 2006b). Under this interpretation, anyone managing the premises of a DCR is also vulnerable to prosecution under section 8 of the MDA for knowingly permitting or suffering production of a controlled drug. This interpretation of production would therefore conflict with the aims of a DCR and should be addressed within the accord.

The accord should clarify expectations regarding the interpretation of section 4 and section 8 of the MDA and agree that the routine preparation of drugs for injection will not be interpreted as an act of 'production'.

### Administering a 'noxious thing'

Anyone injecting someone else with illicitly obtained heroin (whether or not they have requested them to do so) is guilty of administering 'a noxious thing', contrary to section 23 of the Offences Against the Person Act 1861. To do so also constitutes an offence of supply under the MDA.

Neither staff nor service users should ever physically assist someone to inject themselves.

Giving safer injecting advice to people using a DCR is an integral part of the role for staff (as it is for existing needle exchange staff) but there is uncertainty as to the extent to which it is legally permissible for a member of staff to advise or otherwise assist a drug user to self-inject a controlled drug. As giving safer injecting advice is an integral part of the role of workers within a DCR

this ambiguity should be addressed within the accord.

> The accord should establish that staff who are giving safer injecting advice within their role will not be interpreted as administering 'a noxious thing' under section 23 of the Offences Against the Person Act 1861.

If a user dies as a consequence of taking an illicitly obtained substance (or as a result of the consumption process), anyone who assisted with that drug-taking or process is at risk of being charged with manslaughter. This interpretation is more likely if direct, physical assistance with injecting is given but, again, there is some uncertainty whether giving someone safer injecting advice, or otherwise facilitating injecting by providing a DCR, could be interpreted in this way.[3]

> The accord should establish that staff who are giving safer injecting advice in accordance with the agreed procedures of DCR should not expect to be prosecuted for manslaughter in the event of a client's death.

### Supplying paraphernalia

Until recently it was an offence under section 9a of the MDA to provide a range of items that are sometimes distributed to promote better injecting hygiene, e.g. filters, cookers, water for injection, citric and ascorbic acid. Although these can now be distributed legally (subject to the terms of the Misuse of Drugs Regulations 2001, reg. 6A), the distribution of other paraphernalia for injecting that might be provided in a DCR is still illegal (e.g. tourniquets that can potentially be shared; matches/lighters that are used for 'cooking up'; or foil as part of measures to promote a transition from injecting to smoking). The inability to provide such equipment potentially inhibits the effective operation of a DCR.

> The accord should establish that staff that who are providing paraphernalia for drug administration, other than that allowed under the MDA, as part of their role should not expect to be prosecuted under section 9a of the Act.

### Anti-social behaviour

Fortson (2006b) also provides a commentary on 'closure orders' under the Anti-social Behaviour Act 2003 and notes several points:

> *The procedure may be invoked where the production, supply or use of any Class A drug causes disorder or serious public nuisance.*
>
> *Whereas s.8 (of the MDA) requires the offending activity to have actually taken place on premises, the process for obtaining a closure order only requires reasonable suspicion on the part of the Applicant, that supply, production, or use, is occurring on premises.*
>
> *The Closure Order process is civil in nature. A conviction for a drug offence is not a precondition for the making of an order.*
>
> *Closure Orders are directed against premises – not persons.*
>
> *The Home Office Notes for Guidance give the following examples of circumstances that might be regarded as 'serious':*
>
> - *intimidating and threatening behaviour towards residents;*
> - *a significant increase in crime in the immediate area surrounding the accommodation;*
> - *the presence or discharge of a firearm in or adjacent to the premises;*
> - *significant problems with prostitution;*
> - *sexual acts being committed in public;*

- *consistent need to collect and dispose of drugs paraphernalia and other dangerous items;*

- *violent offences and crime being committed on or in the vicinity of the premises;*

- *number counts of volume of people entering and leaving the premises over a 24-hour period and the resultant disruption they cause to residents;*

- *noise – constant/intrusive noise – excessive noise at all hours associated with visitors to the property.*

*The following should be noted:*

- *The decision to issue a closure order is that of a police officer of the rank of Superintendent or above.*

- *The officer must act in consultation with the local authority.*

- *There must be reasonable suspicion that production, supply, or use, has occurred at the premises within the previous three months.*

- *There must be reasonable grounds to believe that the premises is associated with disorder or serious nuisance.*

- *Reasonable steps must be taken to identify interested parties.*

*It would seem that a civilian has no power to initiate closure proceedings under the 2003 Act, but one approach would be for persons to petition both the local authority and the chief constable to take action against a drug consumption room. It is unlikely that a civil action would succeed to compel the relevant public authorities to initiate closure proceedings, provided those authorities acted reasonably in taking the decision not to intervene.*

In this context, it seems clear that expectations under the Anti-social Behaviour Act relating to a DCR should be addressed within the accord. The Home Office guidance notes on the Act (quoted) also point to activities that ought to receive particular consideration within the management policies of the DCR so that they can be minimised.

The accord should clarify that the ordinary, agreed conduct of a DCR will not be interpreted as causing serious nuisance or disorder under the Anti-social Behaviour Act.

The operational policies of the service should also aim to prevent or minimise activities that might contribute to serious public nuisance, with particular reference to circumstances that may trigger a closure order. Opportunities to do so exist through (a) the development of a code of conduct that is binding on attenders and with sanctions for people who do not adhere to it, (b) management policies relating to the permitted number of clients using the service, activity levels and opening hours, and (c) management policies relating to drug litter in the immediate vicinity.

**Activities that should be prohibited within DCRs in the UK**

Several of the legal risks already discussed point to activities that should be prohibited within a DCR. These relate to the supply of drugs from one person to another and the administration of drugs from one person to another.

If someone shares drugs with someone else they are committing an offence of 'supply' under section 4 of the MDA. If acts of supply take place, the managers of the service are also open to prosecution under section 8 of the MDA. 'Supply' also occurs if person A injects person B. Because heroin has been held to be a 'noxious thing', administering an illicit drug to someone else is also an offence under section 23 of the Offences Against the Person Act 1861. Finally, should death occur after a person assists someone else to inject they may be guilty of manslaughter. This generates

several requirements for the management of a DCR.

People using the DCR should be prohibited from supplying or providing drugs to other attenders while they are within the service. This would extend to the sharing of 'deals' that have been bought jointly. People using the service should be advised that the sharing of 'deals' must not take place within the DCR. Not complying with this expectation should be subject to sanctions that include exclusion from the service.

Use of the DCR should be restricted to people who can administer drugs to themselves. No one (staff or users of the service) is permitted to administer drugs prohibited under the Misuse of Drugs Act to anyone else.

The implications of section 8 of the MDA have sometimes been discussed with reference to DCRs. The Act as originally worded made it an offence for anyone knowingly to permit or suffer various activities on their premises including preparing opium for smoking, or smoking cannabis, cannabis resin or prepared opium. The Act was later amended by section 38 of the Criminal Justice and Police Act 2001 to include 'administering or using a controlled drug which is unlawfully in any person's possession at or immediately before the time when it is administered or used'. However, this section was never brought into force and has since been repealed under the Drugs Act 2005. The original offences under the MDA still exist and mean that (a) preparing opium for smoking and (b) smoking cannabis, cannabis resin and prepared opium should not be permitted in a DCR. Although these activities would probably not be envisaged within a DCR it would be prudent for the service to have a rule that explicitly prohibited them.[4]

Activities defined under section 8 of the MDA should be prohibited within the DCR. These include: (a) producing or attempting to produce a controlled drug; (b) supplying or attempting to supply a controlled drug; (c) preparing opium for smoking; and (d) smoking cannabis, cannabis resin and prepared opium.

**Use of services by legal minors**

Almost without exception, DCRs in other countries exclude minors (i.e. people aged under 18 within the UK) from using their services. Consequently, the existing evidence base regarding the effectiveness of services is largely limited to adults and says little about the feasibility or impact of providing services to young people. Furthermore, the socio-legal context of providing drug services to minors is less straightforward than for adults: competence to consent should always be assessed and parental consent should be obtained where possible (NTA, 2007). For these reasons, the eligibility criteria for any pilot implementation within the UK should exclude people aged under 18.

# 3 Negligence and the 'duty of care'

Alongside considerations relating to criminal law, Fortson (2006b) comments:

> *Without statutory intervention, a drug consumption room will be subject to the legal obligations, duties, and requirements that affect other service providers. Those who operate a drug consumption room will have to meet health and safety requirements. Employers will be required to exercise reasonable skill and care in protecting its employees from loss or injury, while (perhaps) being vicariously liable for acts performed by them in the ordinary course of their employment.*

To expand on this, most of the staff employed at a DCR will, to differing extents, owe a duty of care to people using the service. A duty of care is owed where someone is affected by another's actions and that person should have foreseen that he or she would be so affected.

If a duty of care is breached and this causes damage, the provider and member of staff responsible are likely to be liable in negligence. The service user would need to prove that the duty of care was breached. It will have been breached if the standard of care falls below what would be expected from a reasonable body of practitioners professing to have the same skills as the member of staff involved. Not only this, but the service user must also prove that the breach caused the damage suffered, whether that be physical, mental or financial damage. Finally, in order to be successful in recovering damages, the service user must show that the injury suffered was within the risk from which it was the member of staff's duty to protect him or her, i.e. within the scope of the member of staff's duty. The member of staff's duty will vary depending upon their role, for example a doctor's duty will be much greater than a receptionist's duty.

Breach of a duty of care can be by an act or an omission. Although members of staff will not be actively involved in administering illicit drugs, they may become involved if a user needs medical treatment and will then owe a duty of care to that user. Further, it could be argued that by providing advice to users about safer injecting, they owe a duty of care to the users that the information provided is correct. Another example of a duty of care would be to ensure that any spillages, particularly of bodily fluids, are immediately cleaned up.

While individual members of staff are responsible for their actions, if they are acting within their job description the provider will be vicariously liable for them. Any claim in negligence is likely to be brought against the provider rather than the individual as the provider is more likely to have the financial resources to pay any resulting damages award. If the provider uses agency staff, the provider will be responsible for their actions unless it is able to seek an indemnity from the agency. The provider will be responsible for whatever injury is caused by the negligent act. For doctors and nurses, specific guidance on professional liability may be sought from the General Medical Council or Nursing and Midwifery Council, respectively. Similarly, members of other professions who may work in DCRs should consult their own professional regulatory bodies, as necessary.

The provider will also have a duty of care to its staff as their employer. For example, if a member of staff is infected by contaminated blood and it is proven that the provider did not put enough measures in place to protect its staff from such an incident, the provider is likely to be found liable in negligence.

The provider will have to ensure it has adequate insurance to cover any successful negligence claims. If the provider is an NHS body, it should check with the National Health Service Litigation Authority that any claims will be covered under the

Clinical Negligence Scheme for Trusts (CNST). If the provider is contracting with the NHS to provide the service, it should ensure that it has an arrangement with the NHS body that it will be covered by CNST.

If there are arrangements between private providers and the NHS, the organisations involved need to check how indemnities will flow between them and ensure they have appropriate indemnities in place.

The Corporate Manslaughter Act means that organisations can be prosecuted for a criminal offence and would involve separate proceedings in a criminal court. It will be relevant if it is alleged that the way in which an organisation's activities are managed or organised by its senior managers has caused a death and amounts to a gross breach of a duty of care. Service providers will need to be aware of the possible implications for their organisation.

If the DCR is part of an NHS service, the provider will have to comply with the Health Act 2006: Code of Practice for the Prevention and Control of Health Care Associated Infections. This covers infection control matters such as controlling blood-borne infection and the safe handling of sharps. The Code of Practice is enforced and policed by the Healthcare Commission (which will become the Care Quality Commission). If the provider does not adhere to the Code of Practice this can be used in evidence against it in any claim.

When the new Care Quality Commission starts operating its role will be to review, register and inspect health and social care services in England and registration will extend to NHS providers for the first time. DCRs may therefore be subject to some of the Commission's Core Standards. This will need to be explored further with the Commission at the time. If the DCR is being provided by or on behalf of the NHS, the provider will also have to comply with the CNST standards and any local Trust policies.

The provider will be liable for ensuring that health and safety legislation is met, for example the Carriage of Dangerous Goods Regulations 1996 regarding bins for the disposal of sharps and the Control of Substances Hazardous to Health Regulations. The Health and Safety Executive is responsible for monitoring adherence to health and safety legislation.

Under the Occupiers' Liability Act, the provider will owe a duty to all users for any defects or dangers on the property.

Within any organisation that establishes a DCR, the existing systems for 'clinical governance' provide an over-arching framework for managing these risks and concerns. This expectation was identified in the Joseph Rowntree Foundation's original report of the Independent Working Group (JRF, 2006, p 107). Clinical governance arrangements are embedded within the NHS, and the National Treatment Agency for Substance Misuse expects to publish additional guidance for the sector towards the end of 2008. The NHS routinely undertakes many activities to benefit patients that also incur risks. Clinical governance allows these services to be provided in a way that enables: best evidence to shape services; risks to be carefully appraised; and measures to be implemented to minimise these and confer maximum benefit to the population. Although DCRs will be a novel area for consideration, the clinical governance systems that would ultimately shape their effective and safe operation already exist and are experienced in making the complex judgements necessary for the provision of safe and effective services.

# 4 The commissioning process

This final section outlines an illustrative commissioning process and highlights a number of components that are likely to be required where the introduction of a DCR is planned. In practice, the sequence of activities described may vary to some extent according to local circumstances. Nevertheless, there is a general step-wise logic to the stages identified and it will often make sense for one stage to be completed, or at least commenced, before proceeding to the next.

1 One or more agencies initially identify some local need with reference to harm indicators that may be addressed by a DCR, e.g. overdose deaths/public injecting.

2 A local multi-agency partnership is established to appraise the case for a local DCR and steer its introduction if this is judged necessary.

3 A local Communication Strategy is developed to ensure an effective response to media and other enquiries is in place.

4 Consultation with local community members assesses whether a DCR has potential acceptability and begins to clarify issues from the perspective of local residents/businesses.

5 Resources are identified for provision of the service, monitoring and evaluation.

6 A service provider and suitable premises are identified.

7 A local 'accord' is developed with relevant stakeholders.

8 Detailed operational policies for the service are developed and agreed.

9 Arrangements are made for monitoring and evaluation of the service prior to its implementation.

## Assessing local need

International experience suggests that DCRs are not universally required as part of local drug treatment provision. Their introduction has largely been restricted to cities and towns where public drug use is most visible and concerns about drug-related harms are particularly high. Consequently, partnerships contemplating the introduction of DCRs should carefully assess whether their introduction is likely to be justified by local needs regarding (a) the health and well-being of drug users and (b) the nuisance and harms being experienced within local communities. Local priorities vary: health concerns, especially overdose, have been among the more important drivers for the introduction of DCRs in several countries. In others, the public nuisance concerns have been more pressing. Often impacts are sought across both areas.

Indicators of need that are likely to be among the most relevant include:

- elevated rates of problem drug use within the local population;
- high rates of homelessness among local problem drug users;
- elevated rates of fatal and non-fatal overdose (including ambulance calls and presentations at A&E) among local drug users;

- particularly poor injecting hygiene and associated health problems from viral or bacterial infection;

- high rates of discarded injecting equipment and drug litter;

- high rates of public drug use and associated community concern.

A careful assessment of need should simultaneously provide valuable baseline data for evaluating whether the introduction of a DCR has the desired impacts. Although local data on some of the above indicators may exist, the partnership should consider gathering additional high quality data from the outset from (a) the people whom any service is intended to attract and (b) other residential and commercial members of the community affected by public drug use.

Surveys might usefully assess:

- *Local drug users:* Patterns of use and risk behaviours including: incidence of non-fatal overdose; ambulance callouts; presentations at A&E; drug-related anti-social behaviour reports; sharing of injecting equipment; prevalence of blood-borne infections; prevalence of local bacterial infections; treatment utilisation; local norms regarding risk behaviours such as femoral/neck injecting; 'speed-balling' (injecting heroin and cocaine together); injecting crushed tablets; rates of public injecting; injecting equipment disposal practices; and other factors that would influence use of a DCR.

- *Local residents and businesses:* Perceptions and experiences of drug-related nuisance including: public attitude surveys; observations and experiences of public drug use; finding discarded injecting equipment and other drug litter; street dealing; commercial sex work associated with drug use; and crime associated with drug use.

Consideration should also be given to the early involvement of personnel with relevant research and evaluation expertise.

## Developing the multi-agency partnership

Although the project might be initiated by one agency it will require an effective partnership that spans the police and other criminal justice agencies, health and the local authority. A DCR cannot operate in the absence of such a partnership because providing such a service cuts across policing, healthcare and planning concerns.

Local partnership structures (Crime and Disorder Reduction Partnerships/Drug and Alcohol Action Teams in England and their equivalents in different parts of the UK) will provide an important starting point.

The following notes are intended to assist in identifying partners and their respective roles. These are described with reference to England though it should be noted that some details and terminology differ between England, Wales, Scotland and Northern Ireland.

Whereas some partners are likely to be essential members who are involved at all key stages throughout the process, others may more appropriately be consulted in order to agree specific aspects of operational policy.

### Criminal justice

- Police – essential partners because their role includes decisions about whether offences that would occur in association with DCRs should be referred to the Crown Prosecution Service (CPS). The local police Chief Constable and Basic Command Unit Commander need to agree a local accord.

- Crown Prosecution Service – desirable partners. Although in practice it is always the police who determine whether an offence is referred to the CPS it would be inconsistent with general good practice for the CPS not to be informed and consulted about the development of a local DCR.

- Probation – partner to be consulted as they will almost certainly have clients who use the service. Clear information-sharing arrangements (along with any limits to these)

should be agreed with reference to existing agreements.

**Health**

- The local Primary Care Trust – an essential partner as they are likely to have a key role within commissioning and agreeing care pathways and with an oversight regarding arrangements for clinical governance.

- Treatment providers involved in provision of the DCR – if a clear lead comes from the PCT/ commissioning team, the provider may be identified at a later stage through a tendering process. However, the process might equally be initiated by a provider service (either NHS or a voluntary organisation with its own funding) that identifies a need for a DCR and wishes to provide the service. Under these circumstances, they will be a central member of the partnership.

- Other local drug treatment providers – partners to be consulted to ensure clear treatment pathways and arrangements for referral to and from the service exist.

- Ambulance services – partners to be consulted as inter-agency arrangements will be necessary to agree systems for responding to emergencies.

**Local authority**

- The local Crime and Disorder Reduction Partnership (CDRP) or its equivalent – an essential forum at which inter-agency agreement is necessary.

**Community**

- Neighbourhood groups – partners to be consulted where local groups are identifiable.

- Business groups, e.g. Chambers of Commerce – partners to be consulted where local groups are identifiable.

- Drug user groups – partners to be consulted where local groups are identifiable.

- Local religious and faith groups – partners to be consulted where local groups are identifiable.

- Local drug charities – partners to be consulted where local groups are identifiable.

**Research**

- Specialists with relevant research and evaluation expertise – partners to be consulted if other members of the partnership do not have sufficient expertise.

When developing the partnership, consensus about the merits of piloting a DCR may not exist initially and there is likely to be a phase of appraising the evidence and assessing whether partners agree that a DCR has some prospect of conferring benefits in the local area.

As part of this process the partners may find it useful to:

- read the JRF IWG report;

- gather information on local need (see 'Assessing local need' earlier in this chapter);

- share information through papers/presentations on (a) evidence concerning the effectiveness of DCRs, (b) legal issues and (c) operational and organisational choices that arise;

- visit established services elsewhere in order to better understand how they operate;

- consult members of the local community in which the DCR is likely to be established.

## Where to situate the DCR

For a DCR to have good prospects of being effective it must be in a suitable location. Factors that lead a multi-agency partnership to consider introducing a DCR, such as high levels of public drug use and associated nuisance or a high prevalence of drug-related health emergencies,

may point to the general locality in which the service should be situated.

DCRs have been established near open drug scenes (such as 'Needle Park' in Zurich) and in areas where there is a long-standing drug market (such as Kings Cross, Sydney), which, in turn, often intersect with commercial sex markets. Proximity to the place where people purchase drugs has been identified as an important factor in the use of DCRs. (EMCDDA 2004). It should be noted that experience in Hamburg suggests that efforts to relocate drug scenes/drug-using populations by providing DCRs in other areas away from drug markets may not be successful and just result in poor service utilisation. (EMCDDA 2004).

Hedrich (EMCDDA 2004) aalso comments that:

> *The location of consumption rooms needs to be compatible with the needs of drug users but also to take account of the needs and expectations of local residents. A reduction in the number of public consumptions can contribute to improvements in the neighbourhood by helping to reduce public nuisance associated with open drug scenes. However, facilities near illicit drug markets are not able to solve wider nuisance problems that result from these markets. (EMCDDA, 2004, p 70)*

Given that resistance to the establishment of a DCR among a proportion of local residents/businesses has occurred in most areas where a DCR has been introduced, this should be anticipated in the UK. Areas that might best favour the introduction of a DCR are likely to be those where community concern about public drug use is high and the problem is perceived as long-term and embedded.

The IWG also recommended that UK pilots might best be implemented in 'well-run needle and syringe exchange projects' (JRF, 2006, p 106). Providing these were sufficiently close to the local drug market this setting should be considered because it offers important benefits including:

- valuable opportunities for integration with other services and improving the quality of treatment;
- efficiencies arising from shared use of buildings and services;
- opportunities for staff to rotate between services, increasing their knowledge and skills and also reducing any risk of 'burn-out';
- the possibility that community resistance and planning problems will be less of an impediment where services already exist.

## Developing a local accord

The establishment of a local multi-agency group that includes all key stakeholders is an essential prerequisite for the development of an accord as it is unlikely that the police would enter into an accord in the absence of clear support for the initiative from health and local authority partners.

Points to note about an accord are:

- Although an accord guides local expectations, police officers always retain discretion as to how they fulfil their role with regard to functions such as arrest.
- It is an agreement between named individuals in post at a particular time and is not binding on others in the event of personnel changes.
- The signatories should have sufficient seniority and authority to enter into an accord in the locality in which a DCR is established.

Drawing together the analysis in Chapter 2, the following wording is suggested as an example to assist partners when agreeing their own local accord.

## Agreeing operational policies and procedures

It is essential that DCRs are established with high quality arrangements for clinical governance. This has a direct bearing on health and safety, the fulfilment of the 'duty of care' and the quality and effectiveness of the service. To this end, operational policies and procedures need to be carefully specified in advance of the establishment

## Example accord

This accord relates to the operation of the drug consumption room operating in (insert place) and has been developed to enable the drug consumption room to achieve its goals of improving the health and well-being of the people who use it and to reduce nuisance within the local community.

Drug users who are registered with the service should not ordinarily expect to be prosecuted under section 5(2) of the Misuse of Drugs Act 1971 when they are travelling to or from the service or on its premises. (The immediate local area deemed to relate to 'to or from the premises' could be specified as part of the accord.)

Provided they are acting in accordance with the service's agreed policy on 'the management of found drugs', staff of the DCR should not ordinarily expect to be prosecuted under section 5(2) of the Misuse of Drugs Act 1971 if they are in possession of drugs covered by the Act in connection with their duty.

The routine preparation of drugs for self-administration within the DCR (for example, adding an acidifier such as citric acid to heroin) will not ordinarily be treated as an act of 'production' for the purposes of section 4 or section 8 of the Misuse of Drugs Act 1971.

Staff employed in the DCR who are giving safer injecting advice within their role will not ordinarily be treated as administering 'a noxious thing' for the purpose of section 23 of the Offences Against the Person Act 1861.

Staff who are giving safer injecting advice or otherwise acting in accordance with the agreed procedures of DCR should not ordinarily expect to be prosecuted for manslaughter in the event of a client's death as a consequence of the self-administration of the drug in question.

Staff of the DCR providing paraphernalia for drug administration that is not permitted under section 9a of the Misuse of Drugs Act 1971 as part of their role (for example, a tourniquet or lighter) should not ordinarily expect to be prosecuted.

The ordinary, agreed operation of the DCR will not be interpreted as causing serious nuisance or disorder under the Anti-social Behaviour Act.

Signed on behalf of the police service

Title _____

Name _____

Signature _____

Date _____

of the service. As innovators in the UK, any early service that is introduced should anticipate this and recognise that it implies a substantial piece of work as part of the project planning.

It is not possible or appropriate to detail the policies and procedures that will be required as these will depend substantially on local factors including the detailed objectives of the service and its organisational context; they therefore need to be tailored accordingly. Nevertheless, experience elsewhere[1] points to aspects of the operation of a DCR that deserve consideration when local policies and procedures are developed.

A judgement should be made with regard to Models of Care (NTA, 2006) (NTA 2006) aand the tier of services into which DCRs best fit. Many features of DCRs correspond closely with Tier 2 open access services, rather than more structured Tier 3 services. In turn, this has implications for likely expectations concerning clinical information

systems, any reporting to the National Drug Treatment Monitoring System (NDTMS) and limitations to the extent to which structured/care planned interventions will be appropriate.

**The range of services**
An operational protocol should specify what services are provided. Possibilities include:

- vein care and safe injecting advice;
- sexual health information;
- basic first aid;
- wound management;
- testing for blood-borne infections;
- immunisation against hepatitis A and B;
- drug overdose management and the intensity of medical interventions offered on-site;
- one-off support and crisis counselling;
- assessment and referral for primary health care, drug treatment and social welfare assistance;
- provision of injecting equipment.

**Staffing**
It is essential that sufficient staff are employed, and that these have the necessary competencies and clarity about their roles. Consideration should be given to the avoidance of 'burn-out'. Factors to consider include:

- processes for verification of professional competencies;
- staff skill mix, staffing ratio and minimum staffing levels for operation;
- line management arrangements and responsibilities;
- staff training (including any universal expectations, e.g. basic life support skills, management of aggression and critical incidents, child protection).

**Security**
Clear security systems are essential for the safety of service users, staff and the local community. When adapting local facilities to local needs, consideration should be given to:

- use of security guards;
- building alarms;
- entry to the building (e.g. use of intercoms);
- flow of clients through the building – direction and number;
- arrangements for access and contact with emergency services;
- use of duress alarms/walkie-talkies;
- observation using CCTV;
- safety of clients in toilets (notably risk of overdose).

**Assessment and new client registration**
Assessment is essential to determine the eligibility of potential attenders and provide high quality care:

- The range of information to be gathered for new clients should be specified. This needs to balance the need for information that underpins care, while avoiding collecting so much that assessment becomes a deterrent to service utilisation.
- A client recording system should be agreed that has proper arrangements for communicating information between personnel who need access to it, confidentiality and agreed systems for any information-sharing with other parties such as social services, police and probation. The system should be consistent with the requirements of the Data Protection Act and duties that arise with regard to Article 8 of the

Human Rights Act (i.e. respect for private and family life).

- Agreement is needed as to how clients are identified on assessment and on their return to the service.

- Any code of conduct on which use of the service is conditional (and corresponding sanctions) should be explained and agreed.

**Eligibility to use the service**
Areas for consideration include:

- age and policy towards legal minors, i.e. under age 18;

- previous history of injecting, including policy towards people who are assessed not to have injected previously, but who plan to start injecting;

- pregnancy, including how this is assessed;

- policy regarding people with accompanying children or immediate responsibility for children;

- intoxication (alcohol and other drugs), including how this is to be assessed and managed, e.g. the use of temporary exclusions from the service;

- policy in relation to people receiving structured treatment elsewhere, e.g. opioid substitution treatment;

- procedures for managing someone who is deemed ineligible to use the service.

**Client conduct and sanctions**
It is essential that there are clear policies concerning service users' conduct and that (a) these are explained clearly to anyone using the service and (b) the person agrees to abide by them. Policies should include clear sanctions that are applicable if policies are violated. A written code of conduct that is explained and agreed at assessment may be useful. Areas that should be addressed include:

- supply of drugs to others;

- injecting others;

- violence/aggression;

- use of weapons and search policy;

- harassment of other users of the service;

- conduct in the vicinity of the service (especially those relevant to the Anti-social Behaviour Act);

- smoking policy;

- policy on intoxication and overdose risk.

Sanctions for violation of policies should be clearly specified. They should be proportionate and need to balance the obligation to manage a safe, effective environment with the desire to operate a service that is as inclusive as possible of a marginalised population. Some behaviour, such as serious assault, may warrant immediate suspension from the service either permanently or temporarily. Other transgressions may be better managed with a series of warnings that are recorded. There should be provision for formal review of any sanctions.

**Client consent**
Areas for consideration where written consent/ agreement may be required include:

- compliance with the code of conduct;

- confirmation of eligibility details, e.g. age;

- participation in any evaluation;

- confidentiality and information-sharing;

- care planning;

- confirmation that the client acts, and use the facilities of the DCR, of their own free will;

- confirmation that the client accepts full responsibility for events and consequences

arising out of their self-administration of the drug in question.

**Visits by returning clients**

A system is required for identifying returning clients and linking them to their assessment information and any care plan. Some options include:

- the use of ID or pass cards;
- passwords;
- other unique identifying codes such as those used within the NDTMS.

Policy should determine:

- whether clients are required to show that they have drugs for consumption on entry to the premises. In some DCRs this is used as part of the assessment for each visit. Visual inspection of the drugs to be used may help reduce risks of overdose and the management of adverse reactions. Confirmation that the person is holding drugs can also help avoid harassment of clients by others;
- whether any specific drugs or their formulations are prohibited on grounds of health and safety;
- whether any specific injection sites (e.g. femoral vein) are prohibited on grounds of health and safety;
- any time limits on the duration that anyone spends in each stage of the DCR or for their visit as a whole;
- requirements regarding hand-washing by service users;
- the system for providing the client with the required injecting equipment and what this comprises. This should be determined with reference to legal constraints on paraphernalia provision and the local 'accord'.

**Client incidents**

Clear systems are required for managing client incidents:

- A policy is required for dealing with clients who do not adhere to the code of conduct and sanctions should be agreed.
- Arrangements for documenting and communicating incidents to relevant personnel are required.

**The injection process**

The injecting environment (i.e. the booth or shelf) should be designed to facilitate hygienic administration, dignity and safety. Issues to consider include:

- the surfaces on which drugs are prepared;
- light;
- privacy;
- the ease with which the area can be cleaned between visits;
- the ability of staff to observe the process;
- facilities for safe disposal of equipment immediately after the injection. Used injecting equipment should not be carried away from the area. Facilities for sharps and waste disposal should be provided within the area.

Policies should determine:

- the advice staff can give about venous access and safer injecting;
- whether attenders can share an area;
- infection control and the management of blood spills, vomit, other body fluids and used equipment;
- how to deal with and dispose of drugs that are found within the service.

**Medical emergencies**
An aim of DCRs is to ensure that, when they arise, medical emergencies are dealt with well:

- A policy is required for identifying overdose or other medical emergencies and determining when to intervene.

- Facilities should be provided for drug overdose or other medical emergencies. DCRs vary in the extent of medical intervention provided on-site. Among the candidates for inclusion are:
  - 'ambubags' for 'bagging' with air;
  - oxygen;
  - resuscitation equipment as would be available in a casualty setting;
  - drugs used for managing medical crises including naloxone.

- All staff should have training in the recognition and immediate management of overdose- and stimulant-related crises.

Policy should determine:

- the roles and number of staff to be involved during an emergency;

- communication with ambulance services;

- the extent of medical interventions offered by DCR staff;

- the safe management of other attenders in the event of an emergency and whether new clients should temporarily be prohibited from being admitted;

- how emergencies should be documented in the client record and communicated to other personnel.

**Other clinical procedures**
Any clinical procedures should be managed, documented and communicated to standards consistent with those used in corresponding clinical settings, e.g. community drug services. Probable procedures include:

- wound care;

- testing for blood-borne infections;

- immunisation against hepatitis A and B.

**Aftercare**
Protocols for operation of the immediate aftercare should consider how they:

- provide clients with access to relevant health and welfare information;

- enable staff to monitor the clients' mental state and safety;

- enable referral to other services that may be required: e.g. counselling; primary care services concerned with general medical care, with blood-borne infections and with sexually transmitted infections; detoxification and drug treatment services;

- assess the clients' plans for the rest of the day and advise on the dangers associated with further drug use (including alcohol).

**An intelligence-sharing protocol**
The sharing of intelligence between agencies on the operation of the DCR and its clientele is likely to be needed to ensure co-operation of all agencies involved.

- A framework for what can and cannot be shared and how that intelligence can be used should be developed and agreed.

**The local environment**
Reducing public nuisance is an objective of DCRs. Maintaining good relationships with local citizens, businesses and other stakeholders is important for the successful operation of DCRs. Services vary in the way they engage with the wider community and the extent of their role. Consideration should be given to:

- how the service engages with local residents and businesses, which may benefit from regular, agreed arrangements where possible;

- how the service liaises routinely with stakeholders, including the police, emergency services, the local authority, the health authority and treatment providers;

- whether the service assumes a role regarding discarded injecting equipment in the vicinity;

- whether the service becomes involved in emergencies in the immediate vicinity.

## Monitoring and evaluation

As DCRs are untried in the UK, it is essential to evaluate the impact of any services that are first introduced. Without doing so, no judgement can be made about their effectiveness, their value for money and whether they may be a worthwhile addition to services. As the IWG commented:

> *The IWG views it as imperative that these pilot DCRs would be properly evaluated. Detailed process and outcome evaluations would need to be conducted. Perhaps most important, and sometimes overlooked, would be the need to collect detailed data before pilots were to commence and comparative data from sites where DCRs were not to be introduced. These data should include a user survey, community survey (including local residents and businesses) and statistics on ambulance call-outs, hospital treatment and drug-related deaths. It would also be important to map the flows of users through the local area and to conduct a more qualitative assessment of the history and nature of drug use in the locality. Police intelligence on local drug markets will also be vitally important information which will help evaluators to judge how things may have changed after the introduction of a DCR but should also help in deciding on the location of the pilot project. (JRF, 2006, p 100)*

Inter-agency partnerships that are contemplating a pilot implementation of a DCR are encouraged to contact the Joseph Rowntree Foundation, which is interested to explore ways of ensuring that any evaluation is properly supported and co-ordinated and able to draw fully on the work of the Independent Working Group.

Any new service is likely to be subject to intense scrutiny and early evaluations may define the place of DCRs within UK drug policy. It is therefore essential that any evaluation is undertaken with a high degree of rigour. Consequently, it will be desirable to involve personnel with relevant academic/research experience at an early stage of project planning: opportunities may otherwise be missed.

The experience of the Vancouver Supervised Injecting Site is also telling. Because they were able to draw on a previous and ongoing study of the local drug-using population, the investigators conducting the evaluation of the Vancouver facility were able to assess a range of aspects of the service with greater depth than has generally been possible in studies elsewhere. Although local need should be the main determinant of whether a pilot DCR is introduced, the prior existence of research that looks at risk behaviours, the prevalence of health problems and treatment engagement among local injecting drug users, and that can serve as a baseline, should be regarded as an asset that further favours a location, as it offers the possibility of both more rigorous evaluation and value for money.

Many measures that could indicate need for a DCR might be expected to change as a result of its operation. Such indicators may serve as baseline measures within any evaluation. The Appendix identifies potential components of any evaluation.

# Notes

## Chapter 2

1 www.exchangesupplies.org/drug_information/articles/paraphernalia_and_the_law.html. Accessed 7 July 2008.

2 This scenario also arises in clubs and bars where it is addressed within the Home Office guidance on *Safer Clubbing* (Webster, 2002).

3 On existing case law, such an outcome is unlikely: see the House of Lords decision in *R v Kennedy* [2007] UKHL 38, and the recent Court of Appeal decisions in *R v Burgess* [2008] EWCA Crim 516, and *R v Keen* [2008] EWCA Crim 1000.

Any smoking that involves tobacco would, in any case, be prohibited due to the smoking bans that are now in force across the UK.

## Chapter 4

1 We have primarily referred to: (a) Vancouver Supervised Injection Site: Policies and Procedures Manual (2004); (b) Sydney Medically Supervised Injecting Centre: Internal Management Protocols (2002). These documents are the services' internal management policies and are not in the public domain. They have nevertheless been key points of reference for this guidance.

# References


Department of Health (2007) *Reducing Drug Related Harm: An Action Plan*. London: Department of Health

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2004) *European Report on Drug Consumption Rooms*. Lisbon: EMCDDA

Fortson, R. (2006a) *IWG Paper E. Harm Reduction and the Law of the United Kingdom*. York: Joseph Rowntree Foundation. Available at www.jrf.org.uk/bookshop/details.asp?pubid=749

Fortson, R. (2006b) *IWG Paper F. Setting up a Drug Consumption Room: Legal Issues*. York: Joseph Rowntree Foundation. Available at www.jrf.org.uk/bookshop/details.asp?pubid=749

Home Affairs Select Committee (2002) *The Government's Drugs Policy: Is It Working? Third Report of Session 2001–02, Vol. III*. London: The Stationery Office

Home Office (2001) *Communities Against Drugs*. London: UK Anti-Drugs Co-ordination Unit, Cabinet Office

JRF (2006) *The Report of the Independent Working Group on Drug Consumption Rooms.* York: Joseph Rowntree Foundation

National Treatment Agency (NTA) (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*. London: National Treatment Agency for Substance Misuse

NTA (2007) *Assessing Young People for Substance Misuse*. London: National Treatment Agency for Substance Misuse

Reuter, P. and Stevens, A. (2007) *An Analysis of UK Drug Policy*. London: UK Drug Policy Commission

The Royal Society for the Encouragement of Arts, Manufactures & Commerce (RSA) (2007) *Drugs – Facing Facts: The Report of the RSA Commission on Illegal Drugs, Communities and Public Policy.* London: The Royal Society for the Encouragement of Arts, Manufactures & Commerce

Turning Point (2007) *At the Sharp End: A Snapshot of 21st Century Injecting Drug Use.* London: Turning Point

Webster, R. (2002) *Safer Clubbing: Guidance for Licensing Authorities, Club Managers and Promoters*. London: Home Office and London Drugs Policy Forum in partnership with Release

# Appendix

## Evaluation components for consideration

The following list is indicative of the range of ways in which the evaluation of DCRs has been approached elsewhere.

### Surveys of DCR attenders

- Identify changes to knowledge, attitude and behaviour among attenders.

### Process monitoring

- Quantify activity levels such as number of new client registrations, injections managed on-site, overdoses managed, referrals made and 'honey pot' effects.
- Determine whether attenders are from the locality in which the service is being provided.

### Surveys of the local injecting drug user population as a whole

- Identify uptake of the service and characteristics of attenders/non-attenders.
- Identify service delivery factors that promote or impede service utilisation.

### Surveys of local residents and businesses

- Identify changes in perception and experiences of drug-related nuisance and attitudes to the service.

### Population-level mortality data

- Provide trend data on drug-related deaths and any association with the introduction of the service in the longer term.

### Economic analyses

- Describe operating costs which can contribute towards cost-effectiveness studies in the longer term.

### Neighbourhood surveys/litter counts

- Provide before-and-after evaluation of public injecting and drug-related litter.

### Ambulance/hospital data

- Indicate impacts on overdose- and injecting-related emergencies/health problems.

### Drug treatment data

- Indicate treatment referral, uptake, engagement and rates of treatment participation for drug treatment and treatment of allied problems such as hepatitis C or HIV/AIDS that may be attributable to the DCR.

### Arrest/conviction data

- Provide before-and-after measures that contribute to an assessment of any possible impact on local crime.

### Drug market data

- Provide data that may contribute to explanations of change and confounding factors, e.g. effects of drug enforcement, changes to drug price/purity and other changes within drug trends.

# Acknowledgements

This guidance was developed in close consultation with members of the Drug Consumption Rooms Co-ordination Group, who consistently provided thoughtful and detailed comments throughout. As we developed the guidance and negotiated issues that were unfamiliar, their contributions were invaluable. Considerable thanks are due to each of them. I am also very grateful to members of the Independent Working Group for their comments on early drafts and, in particular, to Rudi Fortson, who has generously given of his time in commenting on legal issues.

The Drug Consumption Rooms Co-ordination Group was chaired by Charlie Lloyd of the Joseph Rowntree Foundation, to whom I am grateful for his consistent support, encouragement and well-judged advice. That the guidance should be published at all – in a national policy environment that is far from enabling – deserves much credit and is very much due to his personal commitment and efforts. Additionally, he made the whole process enjoyable, which is no small consideration.

The Joseph Rowntree Foundation has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of the Foundation.

Joseph Rowntree Foundation
The Homestead
40 Water End
York YO30 6WP
www.jrf.org.uk

Further copies of this report, or any other JRF publication, can be obtained from the JRF website (www.jrf.org.uk/bookshop).

A CIP catalogue record for this report is available from the British Library.



First published 2008 by the Joseph Rowntree Foundation



ISBN 978 1 85935 683 8 (paperback)
ISBN 978 1 85935 682 1 (pdf)




28

# About the author

Neil Hunt is an Honorary Research Fellow in the Centre for Research on Drugs and Health Behaviour at the London School of Hygiene and Tropical Medicine and Honorary Senior Research Associate in the European Institute of Social Services, University of Kent.