Why is a pilot Safer Drugs Consumption Facility (SDCF) being opened in Glasgow, and how is it intended to reduce harm from problem drug use in the area?

Taking Away the Chaos, a public health analysis published in 2016, identified a population of people who were injecting drugs in Glasgow City Centre[1]. Public drug use is the result of severely unmet need. Without access to appropriate clean, safe spaces and harm reduction services, people are forced to lanes, car parks, and public toilets to use drugs, however unsafe it may be.

At the time of the report, an estimated 400-500 people were thought to be injecting in public places. These figures came just one year after a significant HIV outbreak, in which 47 people amongst Glasgow's injecting population were diagnosed. The report showed a significant link between this outbreak and public injecting. As well as the increased risk of contracting a bloodborne virus, people who inject in public are particularly vulnerable to abscesses, wounds, deep vein thrombosis, as well as overdose and drug-related death.

Building on what they learnt, and drawing on international evidence of what has worked to reduce the risks associated with public injecting, Glasgow Health and Social Care Partnership developed their proposal for a SDCF.

What were the key legal, policy and political barriers to opening the pilot facility?

Getting to this point has taken time. The Misuse of Drugs Act (MDA) has again proven itself to be a barrier to an evidence-based, public health approach to drug use, which has left us stuck in an ineffective and harmful 'War on Drugs' ideology.

The current legal framework criminalises most drugs. Instead of encouraging people towards the support they need to prevent harm or to address the issues behind their drug use, we prosecute and punish them. Although not illegal to use, the MDA makes it illegal possess, supply, or allow the use of controlled substances on a premises. This legal framework ultimately put people who would use

[1] https://www.stor.scot.nhs.uk/entities/publication/f5720c3f-0641-4873-a0b5-5df48c2b50fd

the facility, as well as those who would run it, at risk of prosecution. Despite the extensive body of evidence which demonstrates the effectiveness of safer consumption facilities, we have struggled to move away from the legislation that makes effective harm reduction illegal.

Public attitudes, misconception, and the stigma surrounding drugs and people who use them have also resulted in social and political resistance to harm reduction approaches such as the SDCF. The Misuse of Drugs act drives stigma and fear by framing drug use as an inherently dangerous and criminal issue rather than a public health concern. We are conditioned to view people with problematic drug use as criminals, rather than people facing severe inequality and in need of support. This stigma is reinforced by the arbitrary classification system of drugs, driven by a sense of morality rather than evidence of harm, which makes the distinction that some drugs, like alcohol and tobacco, are fine, whilst others, and the people who use them, are bad. As such, we have seen resistance to calls for a SDCF – some see it as helping, even encouraging people to do something that they shouldn't be doing, and it is framed as an enabler of crime and a step away from the punitive measures that we have been falsely led to believe are effective and morally right.

Thanks to the determination of Glasgow's Health and Social Care Partnership and other advocates, permission was granted by the Lord Advocate for a pilot safer consumption facility, with legal protection for those who use and operate the service.

How can the medical effectiveness or impacts of the pilot facility be measured, and what does 'success' look like?

Giving people the opportunity to use clean and proper equipment in a safe environment has been shown to result in a reduction in public injecting. One Lisbon based study found that people who reported injecting and public drug use had a high level of willingness to use safer consumption facilities, citing hygiene, privacy, and security as key motivators[2]. Given the estimated 500 people in Glasgow who were identified as injecting drugs in unsafe public spaces in the city centre, we can expect that a similar level of willingness to use the pilot facility exists.

In its first week, the Glasgow SDCF was used 131 times[3] - 131 instances of potential public injecting and its harms prevented, which we would argue is a success. We can hope to see fewer instances of bloodborne virus, infection, and overdose in the population identified as injecting in Glasgow's city centre, as well as a reduction in the population itself.

At the time of the Taking Away the Chaos report, the rise of street injecting and bloodborne viruses were key concerns, and as such informed plans for the pilot facility. However, as time has moved on, so too have patterns of drug use and methods of consumption.

Based on our work in alcohol and other drug services, have seen an increase in the number of people smoking heroin. This increase is in part due to legislation that allows needle and syringe provision services to provide foil to people who inject drugs to encourage smoking rather than injecting in a bid to reduce the harms associated with injecting[4]. The needs of people who smoke drugs are not met in this SDCF model. Whilst less harmful, the inhalation of drugs still carries the risk

[2] https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-019-0319-1
[3] https://www.bbc.co.uk/news/articles/cy08y71n71no
[4] https://www.sciencedirect.com/science/article/abs/pii/S0955395921002747#:~:text=In%20Scotland%2C%20smoking%20heroin%20instead,Glasgow%20%26%20Clyde%2C%202015).

of respiratory issues, unsafe homemade pipes, as well as pipe sharing and viral infections[5]. Harm reduction measures such as safe inhalation pipe provision and supervision are more important now than they were previously, but are not included in the range of support provided at the Glasgow SDCF as a result of Scotland's indoor smoking ban, as well as legislation in the Misuse of Drugs Act which prohibits the provision of drug smoking pipes.

We have also seen a significant increase in the number of people smoking and injecting cocaine. Based on the most recent figures, around 60% of people reported injecting cocaine, an increase of 23%[6]. In our experience, people using cocaine need to inject much more frequently throughout the day as its effects wear off much quicker than heroin. We do not believe the facility is currently equipped to accommodate those who need to frequently inject drugs like cocaine. It is our understanding that the facility has been designed with injecting heroin users in mind and thus designed to only be used once per day.

This ultimately limits the potential success of the facility. The SDCF is a breakthrough that should be celebrated, however, it is already outdated, and offers little in the way of support for the growing number of people who inhale drugs, or use drugs other than, or in addition, to heroin.

We need to remember that this is not just a medical intervention, and we should not undermine the social and psychological impact of the SDCF.

For many, the SDCF will facilitate access to other services including further treatment and independent advocacy on housing and welfare rights. We know that people who use drugs face barriers to accessing services like this, often driven by stigma. Some findings suggest as little as 35% of people with problematic drug use are accessing treatment[7]. The facility presents the opportunity

[5] https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-024-00938-7#:~:text=Pipes%20used%20for%20crack%20cocaine,among%20a%20marginalised%20underserved%20population.
[6] https://www.scotpho.org.uk/risk-factors/drugs/data/health-harm/
[7] https://audit.scot/uploads/docs/report/2022/briefing_220308_drugs_alcohol.pdf

to improve contact with people that services struggle to reach by letting them know that there is a place for them in the treatment system where they can reduce their harm and take positive steps on their own terms.

People who use drugs are some of the most excluded people in our society, often facing housing insecurity, homelessness, social isolation, and stigma. This exclusion is further deepened by criminalisation, which drives people into isolated and unsafe settings and reduces their likelihood of seeking support. By offering access to services such as housing and welfare advice, the SDCF has the potential to address some of the broader social factors that contribute to the exclusion and vulnerability of people who use drugs[8]. A perceived lack of belonging to their community, driven by stigma, among people who use drugs is also associated with social exclusion. People who use safer consumption facilities have reported reduced isolation and increased belonging[9].

Viewing the SDCF as a purely harm reduction intervention misses the broader impact it can have on health and social inequalities.

[8] https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-024-01099-3
[9] https://onlinelibrary.wiley.com/doi/full/10.1002/ajs4.230

What lessons can be learned from international contexts when considering the medical effectiveness of the facility?

The first safer consumption facility was opened in Berne, Switzerland in 1986, and we now have almost 40 years of evidence to support their role as an effective response to problematic drug use.

A comprehensive overview of safer consumption facilities by the European Monitoring Centre for Drugs and Drug Addiction provides an insight into their effectiveness[10]. The ability of safer consumption facilities to reach and contact highly marginalised populations has resulted in immediate improvements in hygiene and safer use, minimising the risk of bloodborne viruses and death. Use of these facilities is also associated with an increased uptake in treatment such as detoxification and opioid substitution.

Perhaps the biggest lesson to be learned from international facilities is the importance of adaptability. Whilst facilities tend to target people who inject drugs, many areas have seen a decrease in the prevalence of heroin injecting and an increase in opioid substitution treatment. Instead, like in Scotland, the number of people inhaling drugs has increased, as has the need for safer smoking facilities.

Drug related deaths as a result of opioid inhalation have informed the expansion of safer inhalation facilities across the country[11][12]. Supervised inhalation facilities were welcomed by people who had been smoking outdoors, and were reported to reduce the harms of public drug use and overdose. Safer smoking supply kits with pipes and harm reduction information distributed to people in Victoria, Canada had similar benefits. Kits reduced the need for sharing pipes, limiting the risk of

[10] https://www.euda.europa.eu/publications/pods/drug-consumption-rooms_en
[11] https://www.ohtn.on.ca/rapid-response-a-review-of-supervised-inhalation-services-in-canada/
[12] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.publichealthontario.ca/-/media/Documents/H/2023/harm-reduction-services-smoking-inhaling-drugs.pdf?rev=255f0227310e46448c8c30ace7b6ef02&sc_lang=en

infection, and were also associated with an increase in demand for information about drug treatment, housing, welfare support, and naloxone kits.

As stated previously, services in Scotland have often focused on support for injecting opioid users, excluding a significant amount of people who smoke drugs, or only partially meeting the needs of people with poly-method drug use. We can be adaptable, but there needs to be a will to change. In 2014, legislation was amended to allow the lawful supply of foil to heroin users as a harm reduction measure. We hope that an increasing body of evidence on the benefits of safer inhalation can influence similar legislation – but we need to be able to adapt quicker than we currently can.

Again, speaking to the non-medical element of safer consumption facilities, we are aware that a key concern of the public in particular has been the potential for increased anti-social behaviour in the facilities surrounding area. International evidence tells us that safer consumption facilities are associated with a decrease in public injecting and discarded needles, and are not associated with an increase in crime. Consultation with local key actors was noted to minimise community resistance.

We hope that effective communication with those in the community can be maintained to strengthen support for the facility.

What is the current legal position of the SDCF?

The current legal position of the SDCF feels precarious.

The Lord Advocate concluded that it would not be in the public interest to prosecute people using the facility for the possession of illegal drugs. Whilst a positive and necessary step in securing the facility, this does not address the wider legal position of people using the service, who still have to break the law to buy and possess drugs. Without addressing the criminalisation of people who use drugs, they will remain without the right support, disadvantaged, and stigmatised. We appreciate that drastic legal reform is unlikely to happen anytime soon, however, the legal framework outwith the SDCF remains critical in determining outcomes for people who use drugs.

We are concerned about the exclusion of safer inhalation support as a result on Scotland's indoor smoking ban. As David Liddell of SDF has stated, focusing solely on the heroin aspect of drug use is not enough[13] . Our worry is that this will not be overcome, and that we will be left with a SDCF that is unable to address the needs of the growing population of people who inhale drugs, or who use drugs other than heroin.

The Lord Advocate's decision to not prosecute people for possession only applies to the pilot facility, and is not the result of actual legislative change. This adds to the precariousness of the SDCFs legal position, and leaves the impression that this is just an acceptance of calls for the facility rather than a real willingness to change how we approach problem drug use. We are concerned that if Glasgow does not see a significant drop in drug related deaths, public and political support will decrease and threaten the future of the facility.

[13] https://sdf.org.uk/david-liddell-treatment-focus-on-heroin-misses-wider-issues-deaths-involving-cocaine-and-other-drugs-rise-again/

What does a long-term, sustainable legal framework for a SDCF look like? What legal and/or policy changes would be required from the UK Government to implement such a model?

It should not take this long to respond to crisis.

At the very least, we need a review of the MDA, and a commitment to do everything we can under this framework. The MDA can be flexible, as demonstrated in 2014, however this flexibility can only go so far.

We ultimately believe that the MDA is incompatible with a public health approach to drug use – it is unclear, contradictory, discriminatory, and ineffective. Our understanding of drug use has evolved, as has the evidence base on what is effective in preventing and responding to harm – it's only right that our legal framework changes too.

The Scottish Government is vocal in its desire to take a public health approach to drug use. A Caring, Compassionate, and Human Rights Informed Drug Policy for Scotland[14] outlines what a public health and harm reduction approach could look like.

A public health approach to drug use would recognise drug dependency as a health condition, guaranteeing people the same right to treatment as those with other health conditions. Problematic drug use is one of the leading causes of population health loss in Scotland, and is driven by extreme inequality, yet it is the only condition that we criminalise people for experiencing.

The drugs death crisis is severe, and the Scottish Government has identified actions that we could take to act now. It calls for a reclassification of drugs based on evidence of their harm, safer drug consumption facilities, an extensive drug checking network, and the legal provision of all drug paraphernalia. These are evidence-based, low-threshold responses that we know are effective and that could be implemented under the MDA.

But we need large-sale reform. We need to be led by bold, innovative leaders who are willing to move forward.

30 countries have adopted some form of decriminalisation. Whilst the evidence is still developing, most studies indicate that decriminalisation directs more people into treatment, reduces criminal justice costs, and minimises the negative impact that a criminal conviction can have on a person that uses drugs. This won't solve the drug death crisis on its own, however, the Scottish Government is

[14] https://www.gov.scot/publications/caring-compassionate-human-rights-informed-drug-policy-scotland/pages/1/

now calling for decriminalisation in order to provide a framework for better support, treatment, and harm reduction, as opposed to punishment.

A Caring, Compassionate, and Human Rights Informed Drug Policy for Scotland also calls for exploration into the possibility of strict regulated supply, which would regulate the drug market, making it safer and easier to control.

The SDCF can only be as effective as the legal framework it exists within. For as long as there is an element of criminalisation in our approach to drug use, individuals will continue to face stigma, the justice system, and barriers to accessing support, exacerbating the harm they already face and limiting the ability of services like the SDCF to reach their full potential.

We support the approach to drug use outlined in the Scottish Government's report and echo calls for immediate action and large scale reform. The People's Panel on reducing drug harm and deaths in Scotland has also called for 'brave and bold' action[15].

As a nation, we are calling for change - action needs to be taken sooner rather than later.

[15] https://healthandcare.scot/stories/4047/drugs-harm-scotland-people-panel

What lessons can be learned from international contexts, when considering a sustainable legal model for a SDCF?

The recognition that punitive drug policies cause harm has been recognised, resulting in a shift towards health based, harm reduction approaches[16].

Safer consumption facilities had been debated in Denmark since the 1990s, when the country experienced a sharp increase in drug-related deaths[17]. Proposals to introduce SDCFs were rejected, with ongoing debates surrounding their legality[18].

However, in 2012, just 8 months after their election, the new coalition government put an end to this debate, and soon passed legislation that would make it legal to consume controlled drugs within supervised facilities in a bid to put an end to marginalisation, exclusion, poor living conditions, and high levels of drug related deaths.

13 years on, drug related deaths in Denmark continue to fall[19] , whilst Scotland only now manages to open its first pilot facility.

It goes without saying – we would benefit from emulating the Danish Government's commitment to an evidence-based response to the drug death crisis. We need bold and brave leaders to take the evidence and share it, to challenge misunderstanding, misperception and prejudice. To lead the whole country in a conversation on what our legal system is for, and how we should use *our* resources to prevent and reduce harm. To commit to policy that is based on the evidence of what works, rather than outdated morality-based opinions that fail to understand the systemic drivers at work.

[16] https://www.gov.scot/publications/international-approaches-drug-law-reform/

[17] https://pmc.ncbi.nlm.nih.gov/articles/PMC8965187/#:~:text=Furthermore%2C%20DCR%20legislation%20states%20that,confiscate%20drugs%20from%20DCR%20users

[18] https://pmc.ncbi.nlm.nih.gov/articles/PMC8965187/#:~:text=Furthermore%2C%20DCR%20legislation%20states%20that,confiscate%20drugs%20from%20DCR%20users.

[19] https://www.gov.scot/publications/international-approaches-drug-law-reform/