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Overdose prevention centres in the UK



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In response to the drug related death crisis in the UK, more than 80 prominent medical, academic, and third sector organisations have called for the introduction of pilot overdose prevention centres (also called drug consumption rooms).¹ The government, however, has repeatedly indicated it has no plans to introduce them, and overdose prevention centres are not mentioned in its 10-year drug strategy. Here, we question the arguments used to defend this position with relevance for other countries debating the introduction of overdose prevention centres.

First, regarding the argument that there is insufficient evidence to show that overdose prevention centres are beneficial. These centres have been introduced in at least 14 countries across more than 130 sites (with an unsanctioned mobile site operating in Scotland between 2020–21).² They provide a safe environment for the most vulnerable to use drugs under the supervision of trained professionals, who intervene in the event of an overdose; and an opportunity to provide evidence-based interventions, including naloxone, oxygen, psychosocial support, and needle and syringe programmes. Observational evidence shows fatal overdoses decreased in areas where overdose prevention centres were introduced alongside other beneficial outcomes, including reductions in self-reported high-risk injecting practices and increased engagement with drug treatment services.^{3,4}

There are no randomised controlled trials (RCTs) showing that overdose prevention centres reduce drug-related deaths.⁴ As overdose prevention centres are complex community level interventions, and deaths are a relatively rare outcome, a fully powered RCT would be very large and expensive. Given the observational evidence in favour of overdose prevention centres and the clear understanding of the mechanisms by which they would prevent drug-related deaths, it is not justifiable to oppose their introduction until RCTs, which might never be conducted, are available.

Many public health interventions have been introduced without RCTs when their mechanism of action is clearly understood. The inconsistent requirement for more rigorous evidence in the case of overdose prevention centres might relate to moral perceptions of illicit drug use. However, RCTs did not

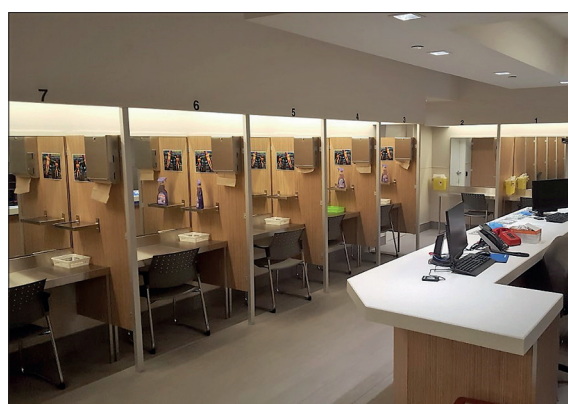
show the effectiveness of opioid agonist therapy to reduce mortality or blood borne virus transmission, which is recommended on the basis of observational evidence and clinical experience.⁵

Second, regarding the argument that overdose prevention centres condone illicit activities; it is important to note that these centres are a harm reduction intervention, meaning they aim to reduce the negative outcomes of a behaviour, without necessarily condoning or condemning that behaviour. There is no evidence overdose prevention centres are associated with increased initiation or frequency of drug use, whereas they can promote engagement with drug treatment services, which might support drug use cessation.³

Historically, other harm reduction interventions have been opposed on the basis of moral arguments that they condone drug use. In response to the 1980s HIV epidemic for example, the introduction of needle and syringe programmes in the UK was controversial. However, they became widely accepted as their important role in reducing blood borne virus transmission was recognised.⁶ Arguments that overdose prevention centres condone drug use are comparable to objections to needle and syringe programmes, which are no longer considered credible, while harm reduction approaches generally are promoted by the highest coordination forum of the UN.⁷

Thirdly, regarding the claim that a range of offences would be committed by overdose prevention centre providers; the liability of providers is subject to debate, in the UK at least. Although statutory protection would be preferable, local areas might consider overdose

For the UK 10-year drugs strategy see <https://hansard.parliament.uk/Commons/2021-12-06/debates/54065168-8B45-47B1-BEEB-1BA4B49DB4AF/Ten-YearDrugsStrategy>



Courtesy of the Transform Drug Policy Foundation, Bristol, UK, 2022

prevention centre pilots if local law enforcement agencies have agreed to facilitate their introduction.⁸ Internationally, overdose prevention centre providers have productive relationships with the police⁹ and in the UK, there is support for their introduction from some police forces and police and crime commissioners.¹ Regardless, if a legal framework did preclude the provision of overdose prevention centres, without adequate justification, recognition of this should prompt changes to the legal framework, rather than opposition to the sites.

Overdose prevention centres are not a so-called silver bullet to reduce drug-related deaths.¹⁰ Their introduction would, however, be a reasonable incremental response to a drug-related death crisis, which would facilitate and enhance the effectiveness of other interventions. They are one component of a multifaceted toolkit, which could be suitable in areas with high rates of drug-related harm. Further research on overdose prevention centres is required to evaluate their impacts and cost-effectiveness. However, when facing the risk of serious harm, the precautionary principle compels us to not delay action while awaiting scientific certainty.¹¹ If considering an experimental and potentially dangerous treatment, the safest response would be to delay its introduction. Overdose prevention centres, in contrast, offer a new setting to deliver widely accepted and evaluated treatments, with no evidence they increase crime or drug use. The safest response to prevent harm is to support, and not oppose their introduction.

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*Adam Holland, Magdalena Harris, Matthew Hickman, Dan Lewer, Gillian W Shorter, Jason Horsley, Martin Powell, Maggie Rae
adam.holland@bristol.ac.uk

Department of Public Health, Environments, and Society, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London WC1H 9SH, UK (AH, MHa); Population Health Sciences, Bristol Medical School, University of Bristol, Bristol, UK (MHi); Department of Epidemiology and Public Health, University College London, London, UK (DL); Drug and Alcohol Research Network, School of Psychology, Queens University Belfast, Belfast, UK (GWS); National Institute for Health Research Evaluation Trials and Studies Coordinating Centre, Southampton, UK (JH); Transform Drug Policy Foundation, Bristol, UK (MP); Faculty of Public Health, London, UK (MR)

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