# Room for improvement

Shorter, G. (2023). Room for improvement. *The Psychologist*, *36*(5), 38-41.
https://www.bps.org.uk/psychologist/room-improvement

**Published in:**
The Psychologist

**Document Version:**
Publisher's PDF, also known as Version of record

**Queen's University Belfast - Research Portal:**
Link to publication record in Queen's University Belfast Research Portal

**Publisher rights**
Copyright 2023 The British Psychological Society
This work is made available online in accordance with the publisher’s policies. Please refer to any applicable terms of use of the publisher.

**General rights**
Copyright for the publications made accessible via the Queen's University Belfast Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

**Take down policy**
The Research Portal is Queen's institutional repository that provides access to Queen's research output. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact openaccess@qub.ac.uk.

**Open Access**
This research has been made openly available by Queen's academics and its Open Research team. We would love to hear how access to this research benefits you. – Share your feedback with us: http://go.qub.ac.uk/oa-feedback

Download date:08. Dec. 2023

# Room for improvement

Dr Gillian Shorter calls for a trial and evaluation of an official 'drug consumption room' following the Glasgow unofficial pilot run by Peter Krykant

I was on the phone with Peter Krykant, a Drug Worker from Glasgow who has just opened the UK's first and only drug consumption room. We talk of the overdose crisis, of the 6401 deaths in the UK in 2021: what it means where I am in Northern Ireland, what it means in Glasgow. We talked of a 17-year-old girl who died anonymously, alone, and from a preventable death, a drug overdose. So common are these deaths, this lost life goes unreported in the news. She had an entire life ahead of her, a life that could be changed and shaped. Peters' drug consumption van could have helped. It had opened in 2020, and then closed due to lack of sustainability and support in 2021.

Each one of these deaths is someone's daughter or son, someone's sister or brother, someone's someone. These are preventable deaths, easily reversible by a timely health intervention, such as an injection of live-saving naloxone (Miller et al., 2022). In 2016, the Advisory Council for the Misuse of Drugs, an expert panel which advises government on drug-related issues recommended Drug Consumption Rooms (DCRs) be trialled to see if they can reduce overdose deaths. Since then, over 70 organisations have called for an official trial. It is 2023, and despite significant cross-party and cross-stakeholder support in the UK – we continue to wait for this trial.

Today, we know Peter's van has successfully intervened in nine overdoses, supervised over a thousand injection events, some of which have been captured in a proof of concept evaluation I led (Shorter et al., 2022; see tinyurl.com/2msp92hs). But we still wait for that pilot. There are some glimmers of hope: Belfast City Council have recently passed a resolution to discuss DCRs for Belfast. But every moment of delay across the UK costs lives.

### What are drug consumption rooms?

Professionally supervised healthcare facilities, DCRs are places where drug users can consume drugs in hygienic conditions and receive help, advice and support (EMCDDA, 2018). These are clinical spaces where people take their own drugs, using hygienic equipment, under the supervision of trained staff equipped to intervene in an overdose. They aim to reduce morbidity and mortality, public drug use, drug related litter, and promote access to healthcare, social care and drug treatment. Depending on the service, need, and funding, they might offer needle exchange, counselling, wound care, HIV testing and vaccination, naloxone kits, opioid substitution treatment and referral to treatment providers. But more than this, they offer kindness and acceptance through simple interventions like a cup of tea, an address for post, laundry facilities, telephone, support with finance, food and social integration.

The logic of a DCR is that those who use drugs are safer and less likely to die of an overdose if they are watched when drugs are consumed. Should there be any signs of an overdose, a swift and effective intervention can occur, and a life be saved (Pardo et al., 2018; Wood et al., 2001). Worldwide, no-one has ever died of an overdose in a DCR. However, political challenges on drug consumption rooms have made it difficult for policymakers, healthcare professionals and service providers to offer this intervention. This is despite UN Conventions which take a prohibitionist stance on drugs, yet make exceptions for health and scientific advances which save lives (APPGDPR, 2015).

In the UK, no official DCRs exist. On overdose prevention day, 31 August 2020, Glasgow-based Drug Outreach Worker Peter Krykant opened the UK's first DCR, a mobile van in Glasgow. There have been many attempts at 'official' facilities. In 2018, MP for Glasgow Central Alison Thewliss brought a Private Members Bill to Parliament to lift the risk of prosecution and to introduce a pilot DCR and evaluation in her Scottish constituency. At the time she said,

> 'one of my constituents mentioned to me that Glasgow already has drug consumption facilities: they are behind the bushes near his flat and in his close when it rains. Right now, they are also in bin shelters, on filthy waste ground and in lonely back lanes. They are in public toilets and in stolen spaces where intravenous drug users can grasp the tiniest modicum of dignity and privacy for as long as it takes to prepare and inject…' (House of Commons, 2018).

The Home Office responded,

> 'there is no legal framework for the provision of drug consumption rooms in the UK and we have no plans to introduce them. The UK's approach on drugs remains clear, we must prevent drug use in our communities and support people dependent on drugs through treatment and recovery' (BBC News, 2018).

We are at an impasse. How can we reduce drug overdoses and reduce harm in those who are already dependent but unable or unwilling to engage in treatment at present?

Mark Gillies

The van provides sharps boxes and sterile equipment

Mark Gillies

Peter and Gillian outside the House of Commons campaigning for overdose prevention centres, at an event hosted by Jeff Smith MP

### Why are drug consumption rooms controversial?

DCRs are often viewed through a moral lens, although they are healthcare facilities. Goffman (1963) noted that people stigmatise others as unworthy of help due to 'blemishes of character' or through 'tribal stigmas' in which we see them as different to ourselves; that we might never be 'that' person who takes drugs. It may well be cognitively more comfortable to 'other' people who use drugs in our assessment of their need (Neale et al., 2011).

However, a better understanding of the life circumstances of individuals can lead to less stigmatising attitudes towards those who use drugs (Sumnall et al., 2020). There is little evidence against DCRs in reports or journal articles (Pardo et al., 2018). However, the very principle of a DCR can delay their opening. Successful DCRs in other countries consider the needs of those who use the service, alongside local businesses, residents and policymakers. Over 100 sites worldwide have been successful in achieving their service objectives through a collaborative approach to opening and operation that promotes a one community approach where all voices are heard and valued.

The evidence for DCRs outside the UK is that they reduce overdose deaths, improve access to other forms of health care and reduce unsafe drug use behaviours (Irvine et al., 2019; Kennedy et al., 2017; Pardo et al., 2018; Tyndall, 2003). Sites often host other harm reduction strategies such as take-home naloxone distribution or injecting advice (Irvine et al.,

2019). They reduce the need for expensive emergency healthcare (Salmon et al., 2010) and reduce the cost of HIV and Hepatitis C (Behrends et al., 2019; Belackova & Salmon, 2017). They promote connections to withdrawal management services, counselling, and medication assisted treatment (Gaddis et al., 2017; Tyndall et al., 2006). Pardo et al. (2018) summarised: much evidence of benefit, little evidence of harms.

A key critique of this evidence is a lack of more rigorous, experimentally controlled research designs (Belackova et al., 2019); for instance, there are no randomised trials comparing DCRs to a control group. Equipoise is an ethical justification for a randomised trial for which we do not know if either trial arm will be better than the other. We know that there is evidence DCRs work elsewhere, so it would be unethical to run a trial (Maher & Salmon, 2007). Evaluation should focus on whether DCRs might lead to better outcomes than the current status quo (e.g. cost effectiveness of enhancing an existing service containing a DCR compared to the same service without this). This is particularly important as healthcare resources are scarce, and it is important to know if DCRs are worth the investment.

> "We can use our psychological knowledge to develop models addressing overdose deaths and reducing the impact of drug addiction and addiction-related health inequalities in our communities"

### Engaging with concerns

Public concerns on DCRs are valid, and as psychologists, we have a duty through effective engagement and communication to alleviate worry and psychological discomfort using the emerging evidence base (Sumnall et al., 2020). For example, there can be concerns around drug related crime, drug dealing, drug related litter or open drug consumption. Yet DCRs have been found to improve public order and reduce crime (Kennedy et al., 2017). A review by Potier et al. (2014) showed DCRs did not increase public drug injecting, drug trafficking, or drug-related crime in the surrounding environments. Leon and colleagues (2018) reported a 28 per cent decrease in the number of individuals found street injecting following the opening of a site. Police officers can divert individuals towards DCRs and off the streets and alleyways away from the public eye, away from schools, and away from businesses into safe, sterile environments. In countries with DCRs, business associations have reported improvement in their trading area around drug consumption sites as cited in a report from the West Midlands Police and Crime Commissioner (2020). A DCR is likely to be more effective where there are high levels of injecting drug use; it does not increase drug use but changes its local geography, moving it away from open public settings to a health setting, thus representing an opportunity for businesses to flourish without street injecting in the alleyways around their premises.

The UK Government's approach to drug policy rests on pillars of prohibition and abstinence and the belief that drugs are harmful to those who use them and to wider society. Some consider contradicting or lessening the prioritisation of drug criminalisation and abstinence-based approaches dilutes the ability of criminal justice and treatment systems to 'protect' people from harm. There is no evidence that DCRs encourage the initiation of drug use or encourage drug use beyond tolerance and advice on safer practices (EMCDDA, 2018). However, DCRs are not an abstinence approach, and some feel money is better invested in treatment and not initiatives that permit drug use. There are complex reasons people are unable or unwilling to engage with treatment. We know that behaviour change is complex and influenced by what we know and what we can do (capability); people around us and our physical environment (opportunity); and our beliefs, what we want, how we see ourselves, how we regulate our emotions, and our habit (motivation) (Michie et al., 2014).

It is possible to hold the position that people may be better off not consuming drugs, that drugs have an impact on society, and still prioritise health and dignity over judgements on behaviour or our personal wishes for someone else's behaviour change. By meeting people where they are at, we can facilitate the capability, opportunity, and motivation to engage with successful treatment or any positive change (Miller & Rollnick, 2012). DCRs forge therapeutic relationships which are welcoming and accommodating, building the psychological resource that makes positive, healthful changes a realistic prospect. Drug dependence is not a simple matter of willpower. There are structural brain changes and disruption of neural pathways affecting executive function, decision making and learning. This complex interaction with psychosocial factors can maintain use (Harris et al., 2020). Someone who uses drugs and is not ready for help still deserves to live. Doors can open to treatment from DCRs, and there is evidence that referral works, but DCRs might only lead to positive outcomes such as overdose prevention, safer injecting practices, health and wellbeing improvement, dignity, and social connectedness. In all, evidence from elsewhere is promising, but we still would need to pilot and evaluate a service here in the UK.

### An untold and hidden harm

In observing the delays implementing ACMD recommendations to pilot a facility, we may forget that the burden of drug-related deaths is a heavy price for family and loved ones to bear. Those who work with people who use drugs as support workers, in low threshold services, in hostels, in treatment centres, police officers and people who use drugs have witnessed multiple traumas from overdose deaths. Failing to prevent overdose deaths is an extraordinary burden on many in society. In many cases, the media report the deaths of those with an easy to tell story of promising futures; there are many more whose futures may have been unknown, and now will never come to be.

For Peter Krykant and his team of volunteers in Glasgow and their mobile DCR service, there were added tolls. On 24 October 2020, police searched his van under the Misuse of Drugs Act, having tolerated the van providing safe injecting support in central Glasgow for months. Rudi Fortson QC, a legal expert in the UK noted that while there is not a single rule of law that forbids DCRs, certain actions may expose organisers, managers and staff to risk of investigation, prosecution, or civil suit (Fortson, 2017). This was an extraordinary pressure for volunteers to face in a healthcare service funded by donations.

Peter closed the van in May 2021 when the stress of running a service on donations and the lack of wider adoption forced closure. A 'letter of comfort' from the Lord Advocate assuring non-prosecution in Scotland could have alleviated much of this stress and potentially allow for a funded, official service to be evaluated. Local memorandums of understanding with policing colleagues could also offer support to those running or using a service.

### What can we do as a psychological community?

As psychologists we can mobilise across subdisciplines to stand up for the most vulnerable in our society. We can use our psychological knowledge to develop models addressing overdose deaths and reducing the impact of drug addiction and addiction-related health inequalities in our communities. It is time to speak up on behalf of all of those who witness drug overdoses and have dealt with the grief and trauma from drug-related deaths.

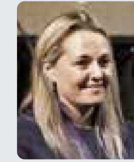
Psychologists with health, social, and forensic expertise alongside those involved in clinical and counselling practice dealing with addiction and trauma can unite to develop answers to the increasing drug death toll. Our expertise is needed by drug workers, healthcare workers, families and loved ones of those who have died, volunteers, police officers, emergency personnel and housing workers. These individuals have little time to engage with current psychological theory and research which could reduce stigma, suffering, or intervene to stop overdose deaths. It is time for research to pilot and evaluate DCR interventions in the UK, reporting quantitative and qualitative outcomes longitudinally, embedded locally, with a transparent and replicable national evaluation strategy.

Our discipline's commitment to open science will result in transparent, independently verifiable outcomes which may or may not show improvements as a function of DCRs, but at least we will know. With the highest drug overdose deaths on record in the UK – and continued poverty and housing pressures – it is time to act. Maybe DCRs do not offer the solution for all, but with so much grief and trauma from another record year of deaths, surely it is time to trial and evaluate evidence-based solutions that have brought change in Switzerland, Greece, Canada, Australia, Netherlands, Spain, Portugal, Luxembourg, Belgium, Norway, Finland, France, Germany, Ukraine and Denmark.

### A link with poverty

I've always been a harm reductionist – long before I even knew what one was. Even from childhood, family, friends, myself, the emphasis has always been on reducing harm from alcohol and drugs, at a personal level, now a research one for the past 18 years. My first exposure to a drug related death was a cousin of a friend at school who drank too much water following ecstasy use. Another preventable death. Since then there have been too many more. The dialogue about DCRs is one I'm familiar with – I've had many conversations about a research-led pilot in Northern Ireland. Westminster is always the sticking point. Peter and I have become friends following the evaluation of his site, researchers and providers working together. It took extraordinary courage to put his reputation and liberty on the line in pursuit of helping a forgotten community in Glasgow. Since that first call, we keep in touch.

People who inject drugs are often our forgotten community members, not public order problems to be solved, but those who often carry the burden of some of the heaviest health and social inequalities without the resources to combat some of these challenges. It is time to see people who use drugs in our plans to tackle poverty. The nexus of poverty, drug use and homelessness results in a life expectancy in the mid-40s (Thomas, 2014). As the Misuse of Drugs Act turns 52 in 2023, is it now time to consider piloting and evaluating novel solutions and come together as a psychological community, to improve the health and wellbeing of some of the most vulnerable individuals in our society?



Dr Gillian W Shorter, *Senior Lecturer in Clinical Psychology, Queen's University Belfast*
g.shorter@qub.ac.uk
@gwshorter

Twitter @PeteKrykant_OPC

*This is an updated version of Gillian's article for our website in December 2020:* bps.org.uk/psychologist/room-improvement *See that version for references, and* tinyurl.com/2msp92hs *for 'The United Kingdom's first unsanctioned overdose prevention site; A proof-of-concept evaluation'*