

The United Kingdom's first unsanctioned overdose prevention site; a proof-of-concept evaluation

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Abstract

Background: The United Kingdom (UK) is currently experiencing a public health crisis of drug-related deaths. The government has rejected recommendations to open overdose prevention services, under the Misuse of Drugs Act 1971. To report on the operation and use of an unsanctioned overdose prevention service which operated in Glasgow city centre from September 2020 to May 2021.

Methods: Description of the service, with analysis of data collected on its use.

Results: The service operated for nine months without permission or funding from official sources. We report on the 894 injections supervised and recorded, and nine successful interventions with overdose events (seven opioid/two cocaine). Powder cocaine injection predominated either alone (60.6%) or with heroin (22.1%). Injection was mostly in the groin (68.0%) or arm (16.8%). More injections were recorded by males (70.1%). Around 65% of injection events featured an individual who was also on a buprenorphine/methadone prescription.

Conclusion: It is feasible for an overdose prevention service to operate successfully in the UK without being shut down by the police or with negative consequences for the community. Future sites in the UK must tailor to the substances used by their potential clients, international trends (e.g. for fentanyl use) did not apply here. There is an urgent need and demand for these services in the UK to reduce harm, prevent and intervene during overdose, and provide vital psychosocial support for health and wellbeing in a highly marginalised population.

Keywords: Harm Reduction, Drug Consumption Room, Supervised Injection Site, Overdose prevention

Introduction

An overdose prevention site (OPS) provides a safe, supportive, and hygienic environment where controlled drugs, obtained elsewhere, are consumed under observation from staff who can advise, intervene in overdose events, and provide sterile injecting equipment. Such services exist in at least 13 countries (HRI, 2020). Different terms are used in different places, including drug consumption room, supervised/safe injecting facility, or enhanced harm reduction service. In Canada, a distinction is made between supervised injecting facilities and overdose prevention sites (Kerr et al., 2017). The latter are a 'novel and nimble' response to an ongoing public health emergency (Wallace et al., 2019). They tend to be less formally structured, provide a lower level of clinical intervention, and are quicker to set up. In the UK, the terms are used interchangeably (Faculty of Public Health, 2021; Sherman, 2019).

Repeated studies have shown such services are safe and can reduce overdose deaths, public injecting and drug related litter, injecting risk behaviours associated with infectious disease transmission, and ambulance call-outs, without increasing crime (Belackova et al., 2019; Pearce-Smith, 2019; Potier et al., 2014; Pardo et al., 2018). This includes research from unsanctioned OPS in Italy and the USA (Bergamo et al., 2019; Davidson et al., 2021; Kral et al., 2020).

The UK, especially Scotland, is experiencing record levels of drug-related deaths with 1339 reported in Scotland in 2020 (National Records of Scotland, 2021). Glasgow, Scotland is currently experiencing a large outbreak of HIV among people who inject drugs, with particularly high levels of cocaine and public injecting associated with increased risks of HIV and viral hepatitis, overdose, and soft tissue infections (Trayner, McAuley, et al., 2020; McAuley et al., 2019). Studies have shown people who inject drugs are highly willing to use services which offer a safer place to do so (Butler et al., 2018; Trayner et al., 2020).

As the impact of drug-related deaths mounts, several expert and political bodies have recommended OPS be opened in the UK (ACMD, 2016; Faculty of Public Health, 2021; Health and Social Care Committee, 2019; Royal College of Physicians, 2018; Scottish Affairs Committee, 2019). The UK Government has repeatedly stated this is not possible on legal grounds. In responding to the Health and Social Care Committee, for example, it stated,

'[t]here is no legal framework for the provision of Drug Consumption Rooms (DCRs) in the UK and we have no plans to introduce them. A range of offences would be committed in the course of running drug consumption rooms, by both service users and staff, such as possession of a controlled drug' (UK Government, 2021).

Local agencies in Glasgow (Glasgow City Health and Social Care Partnership) were planning to open an OPS with a co-located heroin-assisted treatment service. This plan was paused in 2018 when the former Lord Advocate of Scotland (the most senior law officer in the country) raised legal barriers to service provision. He stated,

'[i]n order to render a [DCR] lawful, it would be necessary to obtain exemption from the Misuse of Drugs Act 1971. The subject matter of this Act is reserved to the UK Government' (Wolffe, 2019).

Here, we report briefly on an unsanctioned OPS that operated in Glasgow between September 2020 and May 2021. We also present the data collected by voluntary OPS staff on use of the service and reflect on what this means for the development of UK harm reduction services.

Early data collection focused on drugs being injected at the service and those recently used (including prescribed) to understand polydrug use risks and provide support. With OPS staff, we extended this form to include gender, age, housing status, injection site (e.g. arm, groin), whether they had naloxone, health concerns, number of previous visits, and self-reported health (scale: 0=worst possible to 10=best possible health). The forms were anonymous and completed by OPS staff during each visit. Not all injections were recorded (at busy times, the priority was service provision). Volunteers consider well over 1000 injections were supervised. We obtained ethics approval for this research from Queen's University Belfast EPS research ethics committee (EPS20_261). We did not collect identifying or longitudinal information to minimise administrative burden on the OPS staff. We received no funding for this research.

The unsanctioned OPS in Glasgow

The OPS was opened by Peter Krykant, with no financial or other support from local or national governmental agencies. He acquired a second-hand minibus and equipped it with basic first-aid equipment, needles and sterile equipment, and naloxone. It opened on 31st August 2020 (International Overdose Awareness Day), parked at a single site in Glasgow city centre. The first supervised injection took place on 11th September 2020. Service

provision increased from one day per week (10am - 3pm) initially, to approximately four days per week in February 2021. That month, the original vehicle had mechanical problems and was replaced with a converted ambulance. This provided higher capacity. Peter Krykant and other volunteers staffed the OPS. No staff were paid. Personal donations and online crowdfunding provided some funding for operational costs.

The OPS received attention from the international media and local police from opening. Police did not intervene to prevent the operation of the OPS, although they occasionally monitored the location or responded to comments from the public. In October 2020, an incident led to Mr Krykant being charged with an offence under section 23 of the Misuse of Drugs Act 1971. In this incident, police officers wanted to enter the vehicle to search three people. They accused Mr Krykant of obstructing their search; a charge he denied. The charge was subsequently dropped. The service users were searched and found not in possession of controlled drugs. No arrest or charge was brought against Mr Krykant or any other user or volunteer of the OPS for any of the offences that the UK government and the previous Lord Advocate had claimed would be committed in OPS operation.

As local people who inject drugs and OPS staff got to know each other, the needs of the target group went beyond a safe space to inject drugs (Shorter, 2021). The OPS was a place to distribute donated clothes and food, informal psychological support, naloxone, sterile injecting equipment, and information on safer use. For example, volunteers arranged a replacement for a wheelchair which had had a wheel missing, and provided new clothing for those who needed it.

In staffing the service without official funding or support, volunteers faced risks to their liberty, their professional standing, their earnings from other sources, and their mental health. The medical school of a local university warned its students not to volunteer at the service, as they would be in danger of being barred from practice if convicted of a criminal offence. Running the OPS without stable funding, heavily reliant on the work of one person, was unsustainable. The OPS closed in May 2021. As of autumn 2021, the ambulance is touring the UK to help show how OPS work.

Use of the OPS

Table 1 demonstrates an increase in people using the service over time, and the growing confidence of highly marginalised people to regularly use the service. In nine months of operation, 894 injection events were recorded at the service. OPS volunteers reported

attending to nine overdose events involving eight individuals: seven opioid overdoses, and two involving powder cocaine. First aid was provided, and an ambulance called on two occasions, with one of these cancelled in collaboration with the patient and service. Those whose overdose involved opioids were given naloxone (one nasally, the others via injection). There were no deaths, and no reports of other adverse medical incidents.

As Table 1 illustrates, people who used the service predominantly injected powder cocaine alone (60.6% of recorded supervised injections) or with opioids (17.2%). Cocaine injecting is associated with higher frequency of injecting, and so increases risk of infectious disease transmission, injection-related injuries, and soft tissue infections (van Beek et al., 2001). We recognise this may differ from other international sites who report fentanyl, methamphetamine, or pill injection and emphasizes the importance of tailoring sites to drug trends in the community they serve. For example, high stimulant use in an OPS would require different equipment, the ability to accommodate multiple visits in a day, knowledge of different overdose signs and risks, and linkage to health support especially wound care. In planning an OPS service tailoring can be achieved through effective consultation with potential service users and use of surveillance data such as treatment or other data sets (e.g. Needle Exchange Surveillance Initiative). In an open OPS, we can supplement this with self-report from clients and real time drug-checking data to identify any shifts required in service provision. Drug checking was not available at the Glasgow site.

The average age of those recorded in these injecting events was 34.6 years and people were mostly groin injecting (68.1%). Nearly all were unstably housed, mostly living in hotels vacant during the COVID-19 pandemic (87.1%) with uncertain accommodation futures as lockdowns eased. Around 65% were already engaged with treatment services for opioid agonist therapy (OAT), of whom 67% were injecting cocaine. The OPS was separate to OAT prescribing services. It may have been a haven for those who are often most marginalised to use cocaine without risking their OAT supply, which some may have been reluctant to disclose to treatment workers. This also highlights the (international) lack of effective treatment options for stimulant users. Future work may explore the intersection between these substances, and how treatment services are used by OPS clients. Average self-rated health was 6.1, although responses ranged from 0 to 10.

People who used the service, for whom data was collected on health and other concerns (n=149), reported concerns related to: abscesses and infections (n=28); mental health (n=22), HIV/antiretroviral drug matters (n=15); mobility issues (n=12); treatment needs (n=10); deep vein thrombosis/blood clots (n=10); being removed from methadone

prescriptions (n=9); alcohol-related brain damage (n=8); injecting site concerns (n=7); police or criminal justice matters (n=5); naloxone/overdose related matters (n=5); everyday needs (n=4); pregnancy and post-partum matters (n=4); and being a victim of violence (n=4). Eight reported positive improvements to health from using the facility.

Although these data are limited to this service, and are ungeneralizable, the characteristics of these users of the OPS illustrate the importance of providing a welcoming, regulated, and safe space for people who inject drugs in areas of demonstrable need.

Insert Table 1 here

Implication for harm reduction in the UK

The legal status of OPS in the UK is complex and open to interpretation (Fortson, 2017). The police retain operational independence from politicians. They can decide whether the public interest requires police intervention in activities of concern. It has been suggested that operators of an OPS would require a 'local accord' providing assurance of non-prosecution from local police and prosecutors (Independent Working Group, 2006). For this unsanctioned OPS in Glasgow, no such assurance was provided, but it was possible to run the service. The OPS closed because of the unsustainability of the funding and staffing model, not because of legal or police action.

Part of the intention of running the OPS was to show it was possible and to encourage moves towards an official service. In this, it appears to have succeeded. The new Scottish Lord Advocate (appointed in June 2021) has stated she is open to a 'fresh consideration' of whether it would be in the public interest to prosecute any offences committed in the operation and use of an OPS (Grant, 2021).

Scotland has a different political and legal environment than the rest of the UK. It recently elected a coalition Government of the Scottish National Party and Green Party, who both support decriminalisation of drug possession and Overdose Prevention Sites. The Lord Advocate with the support of the Scottish Government has recently announced plans to expand diversion away from criminalisation for low-level drug offences (BBC, 2021). The leader of the Conservative Party in Scotland has dropped his previous opposition to OPS (Meighan, 2021).

Conclusion

The unsanctioned OPS in Glasgow in 2020/21 has shown it is possible to run such a service in the UK without being closed down by the police. It showed a demand for low threshold and peer-informed services from people who are highly marginalised, with complex health, psychological, and practical needs (Shorter, 2020; Miller et al., 2022). There is a plan to operate and evaluate a sanctioned service in Glasgow. Members of the Enhanced Harm Reduction Service Working Group, supported by the charity Drug Science, are now working towards an evaluation framework of OPS services in other parts of the UK (Drug Science, 2021). As drug-related deaths climb to ever higher levels, the need for action remains urgent.

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Table 1: Characteristics of injection events of those using the UK's first unsanctioned overdose prevention site (n=894 injection events)

	Valid n ^a	Mean (SD) or n (%)				
Injection events supervised by month (row) frequency of visits where available (column)	894	First use of Overall service^b	Up to 5	Up to 10	Up to 15	15+
September		30				
October		36				
November		23				
December		30				
January		17				
February ^c		136	12	56	13	9
March		438	30	85	52	61
April		146	9	23	4	27
May		38	2	9	6	4
Sex	835					
Male			585 (70.1%)			
Female			250 (29.9%)			
Age (SD)	833	34.6 (8.4) years old				
Housing status	842					
Hotel accommodation			733 (87.1%)			
Own house			54 (6.4%)			
Sofa surfing			28 (3.3%)			
Sleeping rough			10 (1.2%)			
Hostel			7 (0.8%)			
Drugs being injected today (overall and split by sex of person engaging in injection event)	894					
Cocaine (powder)			542 (60.6%)			
Heroin			198 (22.1%)			
Cocaine and heroin			154 (17.2%)			
Area being injected	794					
Groin			540 (68.1%)			
Arm			133 (16.8%)			
Leg			87 (11.0%)			
Hand			6 (0.8%)			
Arm or leg			16 (2.0%)			
Hand or arm			7 (0.9%)			
Anywhere can find a vein			5 (0.6%)			
Receiving Methadone/Buprenorphine treatment	862					
Yes			559 (64.8%)			
No			303 (35.2%)			
Using 'Street Valium'^d	862					
Yes			795 (92.2%)			
No			67 (7.8%)			
Other (named) drugs used	862					
None			786 (91.2%)			
At least one			76 (8.8%)			
Of those using at least one other drug	74 ^e					
Alcohol			32 (43.2%)			
Pregabalin			17 (23.0%)			
Benzodiazepines			9 (12.2%)			
Diamorphine			17 (23.0%)			
Morphine			2 (2.7%)			
Cannabis			1 (1.4%)			
Mean self-reported health score	712		6.1 (2.4)			

0=worst health, 10=best health

^a n relates to a recorded injection event; ^b In February when we expanded data collection forms we asked whether this was their first visit, and if not grouped the number of visits they had ever made to the facility; the number of visits in total would include the number of visits ever made to the facility since it opened ^c Includes 25 injection events for which we did not have the data of the number of visits, ^d Street valium is a benzodiazepine type pill readily and cheaply available, often of unknown strength and specific nature See <https://doi.org/10.1016/j.drugpo.2021.103512>, ^e Four involved more than one other drug, therefore % do not add to 100.