**Title Page (not for review)**

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**Similar Problems, Divergent Responses: Drug Consumption Room policies in the UK and Germany**

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**Abbreviated title**: Drug Consumption Room policies in the UK and Germany

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**Abstract**

Drug Consumption Rooms (DCRs) enable the consumption of pre-obtained drugs under supervised conditions. While 24 DCRs exist in Germany there are none in the UK, despite similar levels of drug-related harms. The first official, German DCRs were introduced in Hamburg and Frankfurt in the mid-1990s. A key influence was the appearance of ‘open drug scenes’ in such cities over this time, whereby large numbers of users congregated in parks or shopping centres. This led to powerful coalitions of politicians, police and treatment agencies and DCRs were seen as a professional response to these problems. In the UK, there have been two high profile recommendations for the piloting of DCRs which have been rejected by the Government for a number of reasons including lack of evidence, legal problems and negative media responses. In explaining the different situations in the two countries, key factors are the potential for city-level policies; the stigma attached to drug users in media reporting; and the historical development of open drug scenes. Chance has also played a part, particularly in the UK. Drug policy is rarely a government priority and drug policy decisions are therefore affected by wider political goals and pressures in unpredictable ways.

**Key words:** drug consumption rooms; Germany, UK.

**Similar Problems, Divergent Responses: Drug Consumption Room policies in the UK and Germany**

Drug Consumption Rooms (DCRs) are supervised healthcare facilities that enable the consumption of pre-obtained drugs under safer and hygienic conditions (Hedrich et al. 2010; Schatz & Nougier, 2012). The first official DCR was opened in Berne, Switzerland in June 1986 and by the mid-2000s there were 12 DCRs across seven Swiss cities, 24 rooms in 15 German cities and 30 in 23 Dutch cities (Havinga & Van der Poel 2011; Schäffer *et al.*, 2014). DCRs have also been implemented in Spain, Australia, Canada, Luxembourg, Norway, Denmark and most recently (albeit temporarily), Greece. At the time of writing there are also advanced plans for the introduction of pilot projects in France. However, there are no official plans for the introduction of DCRs in the UK.

Much of the research on DCRs has focused on effectiveness (e.g. Hedrich *et al*., 2010; Andresen & Boyd, 2010). There has been considerably less focus on why DCRs have been set up at particular points in time, in particular cities around the world. From a technical/rational perspective (Woods 2014; Peacey 2014; Ritter & Bammer, 2010), such policy decisions would be made through a sequential process of defining problems and causes, selecting the best policy solution and implementing it. However, it has been increasingly recognised by social policy theorists that such linear, ‘top-down’ models are rarely seen in reality. Such models have been eschewed in favour of theories of *governance,* which emphasise complexity and the role of a variety of actors in policy formulation and implementation (e.g. Hudson & Lowe, 2004). Moreover, given the disproportionate and distorted media interest in drugs and drug users (Reinarman, 1997), the space for calm, evidence-based, top-down drug policy is, we would argue, considerably less than in many other areas of social policy. Furthermore, DCRs lie at the radical end of drug policy, requiring that a state which has made the possession of controlled substances an offence provides a space for drug users to use these controlled substances.

The initial aim of this paper is to focus on how policy and practice decisions have been made in two countries that, while appearing to have similar problems with regard to injecting drug use, have taken markedly different paths in their responses to these problems. It then attempts to identify the key factors lying behind these divergent policy responses and in so doing, draws on the published literature but also on the personal knowledge and experience of the authors, who have been close to policy and practice decisions on DCRs in the two countries over the past two decades.

**Similar problems?**

Comparing drug user populations is problematic: ‘problem drug use’[[1]](#footnote-1) being a hidden, illicit and stigmatised behaviour that can be measured in different ways. Nevertheless, data collated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on opioid use show prevalence estimates of between 3.17 and 3.76 per 1,000 of the adult population in Germany in 2011 and between 7.91 and 8.36 in the UK in 2010-11 (EMCDDA, 2014). Figures for overdose deaths from the same source show 944 such deaths in Germany in 2012 and 1,666 in the UK in the same year. Similar rates of new HIV infection or AIDS diagnoses were found in a comparison of European data over 1993 to 2003 (EMCDDA, 2013).[[2]](#footnote-2)

Statistics at national level may mask local areas of need. DCRs are recommended as a response to particular, local needs, rather than a universal service (Independent Working Group on DCRs, 2006) and all have been located in cities with high concentrations of injecting users and drug-related problems. Both Germany and the UK have a high proportion of their populations living in urban areas compared with the rest of the world (Population Reference Bureau, 2012) and contain city areas with active drug markets and high numbers of people who inject drugs (PWID). In the UK, Glasgow and London have higher estimates of problem drug users (Information Services Division, 2011; Hay *et al.*, 2006): in Germany, Hamburg, Frankfurt, and Berlin have been so-identified (Pfeiffer-Gerschel *et al*. 2013).

In summary, available data suggest similar situations in the two countries, with substantial numbers of PWID and drug-related deaths, and concentrations of users in particular urban areas, but that these problems appear to be slightly worse in the UK. We now turn to focus on the histories of the development - and non-development – of DCR services in the two countries.

**The German story**

Prior to introduction of official DCRs in Germany, staff working in low-threshold facilities were faced with the contradiction of, on the one hand, providing sterile injecting equipment to increase safer use and on the other, sending drug users back onto the street to use (Schuller & Stöver 1989). Before the first official DCRs opened in 1994, a number of drug services in several cities (e.g. Bremen) had already been tolerating the on-site use of pre-obtained drugs since the mid-1980s (Stöver 1991). This practice could be construed as illegal and in 1993, the city of Frankfurt commissioned a legal review by a prosecuting attorney in order to check whether DCRs would be in line with the narcotic law (Körner 1993). The result of this review was positive and led to the financial support of DCRs in Frankfurt and Hamburg. Legally it was an interim solution, but nevertheless, cities started to implement and finance DCRs. It took another seven years for the operation of DCRs to be approved by federal law, through the 3rd amendment to the German narcotic law, which came into force on 1 April 2000 (§10a BtmG):

Anyone who wants to operate a facility that provides drug addicts with the opportunity or allows them to consume narcotics that have been brought with them and have not been prescribed by a physician, on its premises, requires the permission of the highest responsible state agency.

In order to get this permission, services had to adhere to 10 minimum standards aimed at ensuring safety and control. These included regulations governing the provision of equipment, emergency care, referral, the prevention of criminal offences, cooperation with the police, defining the target group, the presence of trained and qualified staff, and monitoring and documentation.

A number of discrete reasons led to the German acceptance of DCRs. First, there was the spread of infectious diseases (HIV/AIDS and hepatitis) among PWID and the high rate of drug-related deaths in Frankfurt, Hamburg and Berlin over the 1980s. This led to the adoption of a harm reduction paradigm by drug service providers and the introduction of unofficial DCRs as described above. However, perhaps the most important influence was the appearance of open drug scenes. In the late 1980s to early 1990s, open drug scenes developed in a number of German cities, initially leading to ineffective public order responses. For example, in Frankfurt, the police chased the drug users from one end of a park to the other (‘junkie-jogging’). Faced with the clear failure of enforcement efforts, public health responses were demanded vociferously and, crucially, supported by the police.

The momentum to implement DCRs therefore appeared primarily to come from the dynamics of open drug scenes: their visibility and their effects on the economy of a city. Drug scenes tended to be located around central train stations or in shopping areas or parks, and shop-owners and residents in these areas demanded action. Local politicians in cities like Hanover, Hamburg and Frankfurt also viewed open drug scenes as tarnishing the image of their cities and feared that they would have a negative impact on tourism and business. The Police saw DCRs as holding the potential to end widespread, drug-related public nuisance by taking drug users out of public spaces. There was therefore a powerful coalition of support for DCRs, each ‘partner’ driven by rather different motivations: politicians, fearful for the image of their cities and associated economic impact; the police, who had run out of ideas on how to control public order problems; and treatment agencies, driven by the desire to prevent the spread of infectious diseases and overdose deaths.

The German mass media reported quite positively on the implementation of DCRs. This was remarkable, because there had been considerable previous criticism of drug services. DCRs were perceived by the media as a professional response to socially damaging behaviour: a perception given legitimation by police support for these services.

The implementation of DCRs in Frankfurt and Hamburg constituted the first wave of implementation. In order to evaluate DCRs in Germany, the Federal Ministry of Health funded a respective study. Results from this evaluation confirmed that drug consumption rooms met their aims in terms of reaching their main target groups and contributing to the reduction of drug-related deaths and emergency cases (ZEUS, 2002). Since 1999 more than 400,000 consumption events had taken place in DCRs each year (ZEUS, 2002, p. 155). The 5,426 emergency cases that occurred between 1995 and 2001 were all successfully managed, including resuscitation where needed. Only one drug-related death has ever been notified (January 2015 in Berlin). These positive results, alongside supportive arguments from professionals, led to the implementation of DCRs in other cities, where the existence of open drug scenes was not so obvious (Jacob, Rottmann and Stöver, 1999). In Germany, there are now 24 drug DCRs operating in 15 cities, in six German states (Berlin, Hamburg, Hesse, Lower Saxony, North Rhine-Westphalia and Saarland). While Hamburg operates five and Frankfurt am Main four, many other cities have to manage with fewer facilities and also with considerably restricted opening hours. As such, two mobile consumption rooms each are operated in Berlin and Cologne. The other cities only run one DCR.

A major challenge that remains is the expansion of DCR provision in Germany. For instance, the service providers and some (opposition) political parties in Bavaria have repeatedly demanded the introduction of DCRs over a number of years but the state government has continued to reject the idea (Paritätischer Wohlfahrtsverband 2010).

***The UK story***

In 2002 the Home Affairs Select Committee (HASC)[[3]](#footnote-3) recommended that:

…an evaluated pilot programme of safe injecting houses for [illicit] heroin users is established without delay and that if, as we expect, this is successful, the programme is extended across the country.

However, the UK Home Office had already made clear the Government’s opposition to DCRs (Home Affairs Committee, 2002):

* ‘International legal position means that the rooms could be (but have not been) open to legal challenge.
* The Government could be accused by the media and others of opening "drug dens".
* No guarantee that public or political tolerance will be the same as Switzerland.
* Will directly increase health service costs as they would be a new service provision requiring additional capital and revenue costs.
* Still leave the possibility of unsafe injecting during the hours they are closed.
* There may be problems in some areas on occasion with drug dealers congregating near to venues, leading to reduced local tolerance for the presence of injecting rooms in their neighbourhood.
* Likely to raise the issue of policing low level dealing in the vicinity of injecting rooms.’

The statement went on to explain that ‘the current Government position is that injecting rooms for illicit drugs should not be introduced in this country whilst we have no evaluations of those developed in other European countries.’ On these grounds, the Government rejected the HASC recommendation. Many of these objections would apply elsewhere in Europe, including Germany. However, the point that there might be less public or political tolerance in the UK as that found in Switzerland[[4]](#footnote-4) suggests that the UK Government feared that British communities might be particularly intolerant. Likewise the concern that the Government might be accused by the media of opening "drug dens" may indicate fears about the particularly stigmatising approach taken by the British media on drug issues (Lloyd, 2010, p.54).

However, these initial objections listed above were not the only ones offered. In a later interview with *Druglink* magazine, the then-Home Secretary, David Blunkett stated:

Where there are ‘shooting galleries’ I am ruling those out

because at the moment we need much stronger evidence that

firstly, they would ease the problem and secondly that they

wouldn’t cause such a backlash and undermine our

progressive step-by-step policy in terms of prescribing. And

thirdly, that people wouldn’t try and develop these as a type of

attraction (Druglink, 2003, p. 10)

The need to avoid undermining the policy on prescribing refers to the Home Office’s plans to trial heroin prescription, which were eventually realised in the RIOTT trial (Strang *et al.*, 2010). The UK Government of the time clearly did not want any confusion over ‘shooting galleries’ to undermine these plans which, unlike DCRs, carried the potential to contribute to New Labour’s crime reduction agenda (Lloyd & McKeganey, 2010). The term ‘shooting galleries’ has dogged public discussion of DCRs in the UK. It is a phrase that immediately conjures up negative associations and its use by a Government minister was presumably calculated to have just this effect. Finally, the idea that DCRs might be used as ‘a type of attraction’ is confusing. Clearly the *raison d’ȇtre* of DCRs is to attract PWID.

In the following year, the Home Office revisited the legal issues. Its response to the HASC had allowed that while DCRs could be open to legal challenge, they had not been hitherto. However, in commenting on plans for a proposed mobile DCR in Cardiff, the Home Office stated that:

The UK will not contravene or undermine UN conventions or

the Misuse of Drugs Act. We believe facilities for supervising

the consumption of illegal drugs would fall foul of these.

Therefore, no authority could be given to the piloting of

initiatives to supervise the consumption of illegal drugs.

(<http://news.bbc.co.uk/1/hi/wales/4053921.stm>)

These same words were used in the Government’s progress report on the HASC’s recommendations (House of Commons, 2005). However, with regard to the evidence base, this progress report admitted that ‘early evaluation does seem to indicate that such facilities can prevent overdose fatalities and reduce harm to drug misusers.’

The grounds for rejecting DCRs therefore changed appreciably over the period 2002 to 2005. There were new concerns expressed about the legal situation and the need to distinguish DCRs from supervised heroin prescription. By contrast, concerns about the evidence base appeared to have subsided. By this point, the evidence base on DCRs had grown appreciably: in particular, an authoritative review of the evidence had been published by the EMCDDA (Hedrich, 2004). A number of important publications had also emerged from the well-conducted evaluations of the facilities in Sydney and Vancouver.

Reflecting this growing evidence-base, the Joseph Rowntree Foundation (a UK charity) supported the setting up of an Independent Working Group on Drug Consumption Rooms (IWG, 2006). The IWG was set up to review the evidence on the effectiveness of DCRs, relevant need in the UK and obstacles to DCR implementation. The IWG membership included senior police officers, professors and a barrister, and was chaired by Dame Ruth Runciman, a widely-respected figure in the drug field. The IWG’s report (IWG, 2006) recommended that DCR pilots should be set up and evaluated in the UK. The national debate that followed the report represented the highest profile that the idea has attained in the UK. Articles were included in all the national, and many of the local, newspapers and the story was covered on television and radio news bulletins.

The Home Office rejected the idea immediately but the then-opposition leader, David Cameron, was more supportive:

*I certainly wouldn’t rule them out because anything that helps us get users off the streets and in touch with agencies that provide treatment is worth looking at.’*

Reasons for the Government’s negative response are likely to include the problems faced by the Labour Government at the time of the report’s release. As Hunt & Lloyd (2008) have pointed out, the Government was ‘reeling from one high-profile crisis to the next…not an ideal time for endorsing new initiatives that are likely to produce more controversy’ (p.99). While preparatory meetings in Westminster before the report’s release suggested that a policy window (Kingdon, 1995) may have been opening, by the time of the report’s release this window had slammed shut.

Since the IWG report, a number of individual cities have identified a need for a DCR and, in some cases plans have progressed to the identification of a potential site and source of funding. However, such plans have hitherto floundered, usually due to local police pressure (in some cases reflecting Home Office pressure on them). At the time of writing, a recommendation for the setting up of a DCR in Brighton, following an independent review of drug strategy for the area (Independent Drugs Commission for Brighton and Hove, 2013) has been recently rejected.

**Conclusions: explanations for diverging pathways**

Given broadly similar problems at national level in Germany and the UK, why have there been such diverging pathways in terms of the utilisation of DCRs as a response to such problems? With regard to the British experience, one feature has been the consideration of the idea at *central* UK government level. From a national perspective, introducing DCRs may not be an attractive prospect for any government. The candid response to the HASC from the UK Government of the time demonstrates how politicians feared being accused by the media of opening "drug dens". While the stated premises for rejection may have varied in the years that followed, it seems likely that the underlying problem has been (and continues to be) the perceived unpopularity of such an approach and the associated political consequences. By comparison, the German experience has been one of *local* developments that have eventually gained support through federal law. Many of the debates about DCRs have played out accordingly at the local level, rather than in the national media and federal government. While there have been local developments in cities around the UK, hitherto they have come to nothing. This may reflect the limited local powers and autonomy in the UK, compared to the situation in Germany.

Another highly significant difference between these two accounts is the presence of large open drug scenes in Germany, which appear to have had no counterpart in the UK. Germany, and a number of other countries such as Switzerland, have experienced the colonisation of parts of their cities by drug users. These gatherings have been associated with serious health and public order problems and have played a pivotal role in persuading communities and local politicians that something had to be done to move users into services such as DCRs. Why such drug scenes have not developed in the UK is not immediately clear: it could reflect different approaches to policing. It might also reflect the British climate.

The police are crucial to the successful operation of a DCR (e.g. IWG, 2006): in refraining from arresting DCR service users on the way to the facility and in working in partnership with DCR staff to ensure public order is maintained in the area immediately surrounding a DCR. The police response to the idea of DCRs in Germany has been broadly positive, in marked contrast to the response of most police chiefs in the UK. This may reflect differences in the level of autonomy (as discussed above) or differences in philosophy or approach. It may also be that the initial support of German police forces was *in extremis* – i.e. the overriding need to control open drug scenes forced them to accept DCRs as a potentially effective, if unpalatable, solution.

A further interesting difference concerns direct action. The Non-Government Organisations running the German projects in the 1980s initially took the risk of allowing drug users to inject on their premises, despite the lack of legal safeguards. This does not appear to have happened in any systematic way in the UK. At least in part, this may reflect a widespread misunderstanding of the legal situation in the UK: in particular, the extent to which the manager of a DCR can be prosecuted under the Misuse of Drugs Act (1971) for allowing drug consumption to take place on the premises.

The way that DCRs have been debated in the media appears to have been very different between the two countries. In the UK, whenever the issue has been discussed, much of the reporting has been negative, with frequent references to ‘shooting galleries’, with all the stigma and confusion that that term induces. This undoubtedly reflects the historical tendency of the British press to stoke up fears around drug use and drug users. As Reinarman (1997) said of the, similar American situation, “the mass media has engaged in … the routinization of caricature – rhetorically recrafting worst cases into typical cases and the episodic into the epidemic” (p.101). Indeed, these tendencies were explicitly cited by the UK Government in rejecting the HASC recommendation in 2002. By comparison, in most cases, the mass media in Germany have responded positively to the implementation of DCRs, viewing them as professional services aimed at easing the problematic and sometimes devastating, living conditions of drug users. Furthermore, the achievements of DCRs have successfully been brought to the foreground, in terms of the reduction of infectious diseases, mortality and especially the bridging function of DCRs into other drug services (e.g. Frankfurter Rundschau 23.1.1999, page 32).

Finally, there is also the role of chance or serendipity. The UK appeared to come very close to a DCR trial in 2006 but at the critical moment, the winds of political fortune changed and a once-confident Government was in turmoil (Hunt & Lloyd, 2008). Drug policy is rarely the central priority of any European government and drug policy decisions often reflect wider political goals and pressures: especially when they are made at central government level.

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1. Defined by EMCDDA as ‘injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines’ (EMCDDA, 2007). [↑](#footnote-ref-1)
2. In quoting these figures, we do not wish to gloss over the considerable difficulties involved in comparing such rates, given non-standard methodologies across countries. However, to our knowledge, they are the best data available. [↑](#footnote-ref-2)
3. The Home Affairs Select Committee is a cross-party group of politicians charged with examining aspects of Home Affairs policy [↑](#footnote-ref-3)
4. Why Switzerland was selected in this way is not immediately clear: DCRs were also operating in a number of other countries including Germany and the Netherlands. [↑](#footnote-ref-4)