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Who's asking me? Service user perspectives on safer injecting facilities

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Abstract

This paper discusses the topic of safer injecting facilities with those who are likely to use them. Whilst more countries are adopting this harm reduction strategy, which is widely acknowledged for reducing drug-related death and injury, the UK have been resistant to their implementation. This qualitative discussion paper reflects on the overwhelming global evidence around safer injecting facilities whilst also capturing the voice of those likely to use such facilities. Although there have been several evaluations from recently opened sites in both Australia and Canada, this paper's sole purpose was to have input directly from injecting drug users to help inform local policy and develop local service provision. This paper recognises that the best people to contribute to policy are those who are directly affected by the matter itself. This small and localised piece of research interviewed nine injecting drug users and four drug workers. However, the focus of this paper is to capture the views of those injecting rather than those supporting them. By using thematic analysis, their responses were interpreted and enabled us to recognise three main themes identified by the service users themselves: yes to safe injecting facility, chaos in the injecting community and more than just a clinic. There were points where each of these themes also raised concerns, not only about their own welfare but also that of the wider public. The service users showed insight and sensitivity regarding such a facility but offered pragmatic suggestions that could help shape any possible provision.

Keywords

Drugs, safer injecting facilities, harm reduction, injecting

Introduction

This paper explores the controversial and emotive topic of safer injecting facilities (SIF) as a provision for injecting drug users. Within this work, we will examine the evidence supporting such provisions, but our main focus was to ask local injecting drug users, mainly heroin, what their opinions of them are. We wanted to capture the services users want, need and/or support, encouraging them to consider how they would look if such an initiative were to go ahead locally. SIF and drug consumption room (DCR) have been used interchangeably throughout this paper.

Despite having established harm reduction as a policy and practice since the mid-1980s, collectively, the UK, has not fully come to terms with, or responded appropriately to, drug use and drug-related deaths (Stimson, 2007). We have been consistently torn as to whether to punish, treat or educate drug users, resulting in a complicated approach that flip-flops between desired outcomes (Tyler, 1986). In recent times, economic and social constraints in relation to funding and service provision have seen drug-related deaths increase to the point that we now have one of the highest death rates from opiate overdose, and yet we remain one of the highest consumers of illicit psychoactive substances in Europe (Hill and Salisbury, 2022). The Office for National Statistics (ONS, 2023) highlights, that in England and Wales, deaths by opiate poisoning have increased significantly, contributing to almost half of the total number of drug poisonings in 2022 (2261 opiate deaths). Heroin and morphine are the most frequent opiates identified in the deaths causing 1256 deaths (21.8 deaths per million). In 2013, this figure was 765 (ONS, 2014). In Scotland, deaths related to opiates were 867 in 2022 (National Records of Scotland, 2023).

Given this context, drug services, local government and health services across the country are asking what is to be done about drug-related deaths. One of the more controversial interventions explored has been the use of safer injecting facilities or safe spaces to consume illicit drugs that are monitored and supervised by professional drug workers and health professionals. Whilst there is an established evidence base for SIFs globally (Kennedy et al., 2017), in the UK, the topic remains sensitive as it navigates a complex web and maze of moral, social and economic concerns within busy urban life (Jauffret-Roustide et al., 2022). Within this

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discussion paper, we will explore the experiences and desires of injecting drug users, asking them if they would like, or would use, safer injecting facilities. This builds on the work of both Trayner et al. (2020) and Tweed et al. (2018) who have also researched this area in Scotland have laid the foundation for Scotland to open its first facility in 2024.

Throughout this paper, the voice of the participant will be intertwined with the wider literature from around the globe. There are repeated themes that mirror previous research and reflect the voice of the service user within this paper.

Harm reduction: A pragmatic approach

The UK figure for opioid-related deaths, in 2015, stood at 2677 (ACMD, 2016: 3), an increase of 107% from 2012 to 2015 (Middleton et al., 2016). By 2019, this figure had risen again to a staggering 4393 for drug deaths overall (2160 for opiates), though 21.3% of drug-related deaths had no type of drug recorded (ONS, 2020). In response to the initial figures, the Advisory Council on the Misuse of Drugs (ACMD) (2016) produced a report on Reducing Opioid-Related Deaths in the UK. Several key themes highlighting the possible causes and drivers for the increase in opioid-related deaths are the ageing population of heroin users – combined with complex health care needs (Royal College of Psychiatrists, 2011); the purity of street heroin; and finally cuts to services, alongside changes in commissioning and provision (ACMD, 2016: 23).

Concerns over the 'increasing emphasis' being placed on abstinence and leaving treatment drug free, plus the periods between entering and leaving services, also increase opioid-related deaths (ACMD, 2016: 26). Dennis (2016) and Floodgate (2016) both suggest growing evidence that drug service practices are increasing drug-related harm through punitive measures, such as 'reducing or ending OST (Opiate Substitution Therapy) on the grounds of relatively minor compliance [such as not attending appointments]' (ACMD, 2016: 27). Although injecting varies around geographical areas and 'there appears to be a decline in injecting in England' (ACMD, 2016: 34), individuals who are not in treatment continue to be disproportionately at risk of death, with more needing to be done by treatment services to 'attract and retain vulnerable people' (ACMD, 2016: 28). Middleton et al. (2016: 354) simply state the 'focus on abstinence has failed' and more effective approaches are needed such as naloxone, OST and safer injecting facilities.

Building on historic international research, the pilot projects in both Vancouver and Sydney have been supported by 'well-funded university-based evaluation studies … [and] have resulted in a substantial body of evidence' that helps support the validation and importance of SIF's globally (EMCDDA, 2017: 5; Potier et al., 2014). Evaluations have been conducted from a wide field of research and interest, all with specific curiosity around the effectiveness of DCRs (Potier et al., 2014). In terms of social and integrated responses, medically supervised drug consumption rooms (DCR) or supervised injecting facilities (SIF) have been widely used in Europe and more recently Canada and Australia and are supported by the ACMD. Many myths prevent the support of this intervention, such as increasing drug use, increasing crime and generally having a detrimental effect on the area in which the facility is sighted (Miller et al., 2023). However, research suggests there is little evidence to support the claims and, in fact, there is a reduction in overdose deaths, transmission of blood-borne viruses (BBV) and an increase in the use of primary care and treatment (ACMD, 2016: 36). Evidence also shows that having a space to safely inject decreases the issue of public injecting as well as the issue of discarded needles (EMCDDA, 2017). Projects working in Barcelona saw 'a fourfold reduction … in the number of unsafely disposed syringes' (Vecino et al., 2013), and others have also noted a decrease in public injecting (Salmon et al., 2006). However, caution should be given when considering such a facility as in their before and after study, Kerr et al. (2006) did acknowledge some concerns that there had been an increase in crack smoking with some participants who were using the SIF. They suggested this was unlikely a result of the facility as they did not allow crack smoking on premises; however, it could be argued that such facilities could, inadvertently, introduce drug users to each other, and this could increase the risk for certain groups. Such outcomes need robust analysis, and research needs to provide that critical oversight and thought. Whilst reducing harm to many of the users of such facilities, there needs to be protection for others who could have their risk increased.

DCRs do however show success in engaging with the most vulnerable groups of users (BMA, 2017; Hedrich et al., 2010; Potier et al., 2014), especially for those whose injecting practice puts them at significant risk of harm by injecting in unhygienic conditions with unsterile equipment such as the homeless population. 'The primary goal is to reduce morbidity and mortality' of the individual user and their peers (EMCDDA, 2017: 2), but the indirect effects, such as discarded equipment as discussed above, of opening such a facility could also reduce risk to the public and those who inject.

There is evidence to suggest that DCRs do 'contribute to reducing drug-related deaths' (Poschadel et al., 2003; Marshall et al., 2011), this was highlighted by the widely studied DCR in Sydney who found that when the site was opened, fewer call outs to emergency services were made for drug-related overdoses (Salmon et al., 2010). This was because overdoses can be managed on-site by medically trained professionals who are able to intervene.

Evidence from Canada clearly shows increased referrals to detox, OST and other forms of treatment from people attending the DCR (DeBeck et al., 2011; Wood et al., 2006) showing such facilities are demonstrating real benefits for engaging people in treatment services. Kerman et al. (2020), whilst recognising caution and evaluation needs to be ongoing, also discuss the wider health and social benefits for people who engage with DCRs, highlighting several areas of interest regarding emotional connectedness. This was similar to our findings in terms of what injecting drug users would hope to see in such facilities.

Many of the concerns around DCRs that have been highlighted by the public are anecdotal – even mass media reports on the subject are, so far, balanced, and this shows that we would need to work closely with key stakeholders to get any messages across as we progress the idea in the UK (EMCDDA, 2017: 3; Thein et al., 2005).

Though literature on this topic has been available globally for some time, there is a key detail lacking in UK literature – Would Injecting drug users in the UK use such a facility?

Methodology

In undertaking this research, we used a qualitative approach, based on a reflexive thematic analysis as developed by Braun and Clarke (2022). Within our method, we are exploring a small data set and making small claims that aim to contribute to a wider discussion. The use of thematic analysis is a solid basis for exploring small data sets and developing coherent themes that are identified and situated with a wider discourse. This research paper is written from the philosophical position that harm reduction as a theory, policy and methodology for practice works; harm reduction is a pragmatic response to a persistent and concerning social issue within the UK (Hill and Salisbury, 2022). We make the unashamed case that harm reduction as a position is reasonable and that it also represents a healthy interaction between good social welfare policy, public health and human rights. Themes were identified through scrutiny of the data collected, highlighting key terms and quotes, and also using reflection and discussion to draw out the identified areas. No software was used for the data analysis process, this was done by the research team.

Research questions

- Do those who inject in the city support a safer injecting facility?
- How could such a facility benefit the injector?

Data collection methods

Ethics were sought and approved using internal ethics application compliance procedures at Leeds Beckett University. All participants were supplied with an information sheet, which was also explained by the researcher, and a consent form. Each person was able to refuse to take part and had the option to withdraw their contribution if they changed their mind. Needle exchange clients were asked to participate during their use of the needle exchange. All participants were either injecting heroin, crack or both. Data was collected through one-to-one interviews where participants agreed to take part. The interviews used a semi-structured interview technique. The interview process allowed for confidential and complex information to be shared in a supportive and anonymous manner.

The total number of semi-structured interviews conducted was nine. Although four staff members were also interviewed, it was the voice of the person injecting that we sought to focus on. Within small-scale qualitative research, we look at quality not quantity (Vasileiou et al., 2018); it is our position that small truths can be discerned and connected to wider social, political and economic discourse contributing to a broader discussion around safer Injecting facilities. We are not making large generalisable claims or looking for the saturation of data. Within the process of thematic analysis, we are identifying coherent and congruent themes that tell a story of those involved with the consumption of substances, and in doing so, we would like to contribute to a wider discussion on harm reduction (Braun and Clarke, 2022). We are not telling the story of all injecting drug users but those that we have interviewed.

Other challenges did impede this research; data collection was started just before the Covid outbreak and had to be put on hold for 18 months, until it was safe to conduct the research. This required further ethics application and negotiation with the local services, given staffing changes within the organisations. The main person collecting the data had previously worked in needle exchanges for 20 years. She was familiar with the client group and competent at interviewing whilst ensuring participants were able to receive the service they came for. Interviews were conducted in both (treatment) service-based needle exchanges and a pharmacy-based exchange to ensure those who were not accessing treatment services were given the opportunity to engage in the research. One person also took part who was accessing a sex worker project and agreed to meet the researcher within that project. Inclusion criteria included anyone who was injecting heroin and willing to take part; many chose not to due to needing their equipment for use or having appointments to attend in treatment.

The identity (gender and ethnicity) of the participants was not asked specifically and further research on the needs of individual groups would be beneficial if the city were to go ahead with such a facility (Askew et al., 2022). Seven of the participants did present as male and two presented as female, all appeared to be white British background. All were aged over 18.

Results

After careful analysis of the interviews, the researchers identified three main themes repeating from the data: yes, to safer injecting facilities, the chaos in the injecting community and more than just a clinic. These themes have been identified previously by other authors, but the fact this has come directly from the service users themselves, in individual interviews, gives strength of discussion to anyone working in the field who advocates for such facilities.

Yes, to safer injecting facilities

There was overwhelming support for a safer injecting facility expressed by the service users, with many reporting that this was a pragmatic and 'common sense' approach to addressing the needs of injecting drug users. The service users reported that harm reduction information was scattered and inconsistent and that access to reliable equipment was fragmented. This position chimes with the historical fragmentation of drug services and the reduction of spending within harm reduction services (Page, 2022). We are in a position now where drugs are more diverse, complex and more widely available; and a pragmatic harm reduction approach is needed in the scaffolding of a good recovery, treatment and rehabilitation system.

Service users highlighted the need for education, training and support in relation to reducing overdoses, with all discourse pointing towards a deepening of naloxone provision and more access points for naloxone for service users with trained professionals to assist, educate and advise a unique and vulnerable community.

> Twice naloxone has saved my life… I'm grateful to him [my friend] … because if it wasn't for him giving me that naloxone, I wouldn't be here today.

The service users also disclosed that they would like to see access to anonymous and confidential drug testing support and advice so that those who continue to take drugs can do so in a safer and better-informed manner. They reported that the consistency and safety of street drugs remain an ongoing concern within the community.

The service users also reported communities of malpractice in relation to safer injecting; by malpractice, we refer to the range of activities including self-initiation in isolation to injecting, poor peer advice and misinformation around an overdose. At the centre of this is a lack of good evidence-based interventions available from low-threshold open-access support services. This community of malpractice has led to service users reporting complications such as abscesses, deep vein thrombosis and overdoses. Whilst we recognise that opiate use by young people is reducing, those who do take up opiates or injecting practices are at higher risk due to the lack of good information surrounding them. One injecting drug user reported that:

> A lot of people that I've been in contact with have been a mess… I've seen people who I look at their bodies and I think you must have been using as long as I have, they've been using two years and it's like how do you look like that? How have you lost all your veins?

In terms of safer injecting advice and harm reduction intervention, there were many discussions about not having enough access to the basic harm reduction messages such as rotating injection sites. One service user commented on there being: 'some very strange ideas about injecting'. Although many of the participants stated they had 'good teachers' when they started injecting, and many were initiated by peers or simply watched and learnt how to do it. There was concern shared by older participants about the lack of information younger/newer users were getting.

The service users wanted access to harm reduction and safer injecting facilities that could reduce risk, poor practice and deaths. They also raised questions about the access to and provision of drug-using paraphernalia. Access to good quality and sterile equipment were also a central theme of the discussion, along with longer and more consistent opening hours and knowledgeable, approachable staff.

> If someone … had taught me … my veins might be alright now.

The issue of location and space for SIF and harm reduction facilities was central with participants reporting that it needs to be accessible and open to all; the idea of a city centre was posited. The city centre site, while a popular choice, was also recognised to be controversial given the direction and gentrification of the city centre. However, they all felt the city site was the best, but that it needed to be discreet and sensitive to the needs of the wider non-drug-using community.

> Somewhere in the city centre would be good… But then again … a lot of [the] public would have something to say about that so, [it should be situated] in a quieter area so, accessible to most

The chaos in the injecting community

Part of the resounding yes to safer injecting facilities by participants is rooted in the chaos of misinformation and poor injecting practices located within the injecting community. Whilst these narratives are individualised in our data, they can be located in wider social policy and the reduction and retrenchment of harm reduction services on a national

scale. The worst horror stories of poor injecting practice are always related by participants in an allegorical manner, that it is 'someone they know'. The truth is often more complex, and more often, rooted in personal experience or close social networks.

The enclosed and hidden peer social networks are at the heart of the chaos in the injecting community; the nature of injecting drug use and the deviancy and stigmatisation that are experienced have created a socially invisible subterranean network of misinformation.

There has always been a long-established form of peer education among drug users, and most injectors are introduced to injecting by other injectors. Our data suggests that this culture is embedded within the injecting community. Historically in the UK, harm reduction services have acted as a point of contact, with outreach, community hubs, addiction units and street-based services providing contact points for exchange, education group work and information.

Harm reduction services have historically been able to plug the chaos gap, trying to ensure effective messages get out to the wider community of injecting drug users. The cuts to harm reduction services have taken its toll on an effective form of service delivery. This has happened primarily because the emphasis from the last drug strategy has been on engaging people in treatment and promoting recovery, rather than focusing on the fundamental principle of harm reduction. A systematic campaign by previous governments to present harm reduction as a strategy that promotes drug use and parks people on methadone has, in part, contributed to the rise in drug-related deaths in the UK. Participants in our data collection highlighted that they could not get good, or consistent, access to harm reduction information or equipment.

> The needle exchange here [project based] is brilliant … but you find there doesn't seem to be a lot of needle exchanges in the city

Participants commented that the city-based needle exchange was good, but access to this was limited due to opening times and the offer by pharmacies was not as consistent.

> A lot of them get thrown out of places like [pharmacy] … because they'll be nicking … I've been thrown out… I've never nicked … so their needle exchanges and stuff aren't exactly brilliant, and the attitudes of their staff are quite abysmal.

Participants also reported the poor quality of the equipment available and how the product is inconsistent with varying standards offered. A reduced harm reduction service provision in the city with scattered services delivered from non-specialist agencies, such as community pharmacies has had mixed and often unpopular results.

Chaos in the injecting community was also reflected in the range of health concerns reported; the stigma, shame and marginalisation of injecting drug users lead to challenges when accessing health services (Rhodes et al., 2012). Participants have reported a range of complex health issues including deep vein thrombosis, swollen limbs, scar tissue and cardiovascular complexities leading to the loss of injecting veins. Participants also reported using a chaotic and hardy mix of psychoactive substances, often combining stimulants and depressants as a routine behaviour. It is time to recognise that polysubstance misuse is a persistent and normalised behaviour within the injecting community that can enhance injecting complications.

> I used to snowball as well. And the crack, is not even crack cocaine now, I don't know what it is … in the 90's and 80's crack was good you know what I mean.

The use of stimulants and depressants raised a concern, as injecting stimulants (in particular crack) on a regular basis produces an anaesthetic area effect, leading to a higher risk of injury and long-term health implications. The participants seemed to feel that this behaviour was routine and normal. It is one aspect of the chaos that could be addressed by a structured safer injecting facility. With this in mind, we move on to the next section where service users describe and articulate what a safer injecting facility would look like.

More than just a clinic

The injecting drug users interviewed recognised that a safer injecting facility would be useful and beneficial. They also had a well-developed and nuanced understanding of the complexity of providing this service, as they knew the issue was both contentious and divisive. One of the participants suggested a safer injecting facility should be more than a clinic. They thought it should be a hub and place where they could receive support, advice and information to make positive choices to not only reduce individual health-based risk and harm but also address wider social and personal issues, in building recovery and promoting social well-being. These findings very much reflect the work of Belackova et al. (2019) who highlighted several of the same factors in their paper.

> I think counselling would be helpful, that would help people move on … [also] helping people relocate [to move away from the drugs]

Participants viewed the development of a safer injecting facility as of benefit to the community. The need for

good quality paraphernalia, overdose prevention provision and a safe, hygienic and secure space was much identified to reduce the isolation and risk of lone injectors in the community. It was also felt that the facility should be a site for the collection and disposal of injecting paraphernalia.

> There's a lot of people what don't do it in a safe place or in a safe environment, they leave all their dirty stuff lying about

Participants further reported that the safer injecting facility should be more than a clinic space but also a location where health promotion advice and information on 'safer injecting' and 'safer smoking' could be passed on to individuals and groups, creating a community of positive practice to mitigate and change some of the chaotic practices that have become embedded.

One area of concern was how behaviour would be managed. Both drug workers and injectors wanted the clinic to be safe; for them, this would involve the clinic being more than a clinical medical space to manage. The staff should be drawn from a diverse range of social and health professions and be able to provide social support, as well as monitor and supervise behaviour alongside practical harm reduction advice. The marginalisation of injecting drug users is a long-standing issue within the UK and one that is not unique to this city. The creation of a safer injecting facility, or hub, offers a chance to provide a safe space where some of the most vulnerable members of your community can be supported to build better injecting practice and overdose prevention. But such facilities can also be used as a platform to address wider social harms and build deeper links into positive well-being practices.

> Personally, I wouldn't like to see anyone taking drugs, because I've lived that life myself and it's not a nice way to live, but if it's going to keep people … in a safe environment to take it in front of professional people then I'm all for it really.

Discussion

Multiple conversations are taking place in different areas of the UK regarding safer injecting facilities and are engaging with service users as part of this process (Trayner et al., 2020). Many of these discussions are pragmatic in the face of rising drug-related deaths, and collectively we are looking for solutions to reduce these numbers. This small piece of research aimed to ensure that the voices of those who are injecting drugs locally are included. There should be no conversations about harm reduction without service user voices placed at the centre of that discussion (Askew et al., 2022; Greer and Ritter, 2019). It is also worth acknowledging here that although this group of people have been marginalised and stigmatised, at the centre of many of the respondents' replies was the welfare and view of the wider public. This group demonstrated their compassion for the wider community and recognised throughout how controversial this project would be. All participants were informed this research does not mean the city would be getting a safer injecting facility.

The voice of the participant, which has been captured within this work, mirrors the increasing evidence from around the globe in terms of harm reduction and engagement in treatment and wider social welfare services. Increasing vulnerabilities, such as age and polysubstance use, are no doubt having an impact and increasing risks for injectors. A pragmatic and harm reduction-based solution is needed to address these issues, but this should not be done in silos. Working with wider health and social care services would ensure injecting drug users receive the support they need in order to address some of the challenges they are facing.

Recommendations

> A resounding yes to a Safer Injecting Facility. Whilst many participants said they would not use it, they recognised the need for one, and would recommend, or knew people who would use a SIF.

> The Safer Injecting Facility needed to be more than a clinical space. The new provision, if developed, should be more than a clinic; participants desired an exchange that offered social support, advice, information, and a community space where they felt safe.

This paper has highlighted that there is a gap at the heart of harm reduction within the UK and particularly in England. Years of austerity have frustrated service providers and have created a scattered and fragmented service provision that can operate in silos. Whilst this research offers only a small sample of service user voices, the themes that we have identified can be extended. We need policy and practice that promotes life, human dignity and safety and also services at the heart of our cities, where the most disenfranchised and vulnerable are located. This should be a space that offers support, guidance and education in a format that is beyond a medical clinic, it needs to be a social space where hope, support, advice and recovery can be built.

Footnote

Humankind supports radical change to systems of care and how people experience support so that people impacted by drugs, alcohol and related issues have a fairer chance to thrive. There is growing international evidence to suggest

that creating a safer environment for people to use drugs in can reduce harm and promote well-being by offering a supply of sterile equipment, harm reduction advice and overdose prevention services, alongside information about pathways into treatment and wider health and well-being services. As part of a fully funded and evidence-based local system, drug consumption rooms could help reduce the shocking numbers of preventable drug-related deaths. Humankind would welcome the chance to discuss with any of our partners any evidence-based public health intervention which could preserve the lives of the people we serve.

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Supplemental material

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