

Evidence-based interventions for managing illicit drug dependence

Medical professionals have a key role to play in managing the harms (see **Box 1**) associated with illicit drug dependence. This can be in a clinical setting (ie directly managing withdrawal and relapse and in maintenance prescribing) or in advocating for the provision of evidence-based interventions in local areas with a high level of need.

There are, however, a limited number of treatment options available for individuals dependent on illicit drugs. Within drug and alcohol treatment services, opiate dependence (including heroin) has the lowest rate of successful treatment, around 28% of those who access services.¹ Despite this, there is strong and consistent evidence to support the approach of OST (opioid substitution treatment), which is routinely used in addiction services throughout the UK.^{2,3,4}

Other substance use treatment options – including supervised consumption rooms and HAT (heroin assisted treatment) – are not routinely used, despite being associated with reduced levels of harm for users. This short briefing aims to raise awareness about these treatments that are being underused, by explaining what they are, what evidence exists for their effectiveness, and what their role is in a UK context.

Harms associated with illicit drug use dependence^{3,4,5,6,7}

The use of illicit drugs – particularly strong addictive drugs like heroin, cocaine and methadone – is associated with a range of physical, psychological and social harms.

Not all illicit drugs are equally harmful and the extent of harm varies between individuals and depends on the level and pattern of drug use, as well as the pharmacological properties of each drug. For example, heroin and crack cocaine have been scored by an expert group as the most harmful drugs to individuals.⁸ Cannabis and heroin, in particular, have been shown to have the highest rates of dependence.⁹

As well as a range of short and long term harms associated with illicit drug use – for example cardiovascular disorders; pulmonary disorders and gastrointestinal complications – dependence on illicit drugs is also associated with a number of specific harms. Dependent individuals are more likely to use illicit drugs in an unsupervised environment, where support services are not readily available. There is a greater likelihood that individuals will share injecting needles. There is also less supervision over the regularity of their drug intake.



Supervised consumption rooms

What are supervised consumption rooms?

Supervised consumption rooms provide a space where illicit drugs can be used under the provision of trained staff. Their primary aim is to reduce the acute risks of disease transmission through unhygienic injecting, preventing overdose and connecting users with treatment.

Their format and the range of services that they offer differs on a case-by-case basis. Typically they provide users with sterile injecting equipment; counselling services before, during and after drug consumption; emergency care in the event of overdose; and referral to appropriate social healthcare and addiction treatment services.

There are 3 primary models of drug consumption rooms: integrated, specialised and mobile.

1. **Integrated or low threshold facilities** offer a range of services as well as supervision of drug use. Other services include food, showers, clothing for the homeless, contraception, counselling and drug treatment.
2. **Specialised facilities** offer a narrower range of services directly related to consumption, for example injecting materials, advice on health and safer drug use, intervention in emergencies and a space where drug users can remain under observation after drug consumption.
3. **Mobile facilities** provide a geographically flexible and more accessible deployment of the service, but typically catering for a more limited number of clients than fixed premises.

There are around 80 supervised consumption rooms across Europe. The first facility was opened in Berne, Switzerland in June 1986, and around 80 facilities operate across other countries (including the Netherlands, Germany, Spain, Switzerland, Denmark, Norway and Luxembourg).¹⁰

Evidence of the effectiveness of supervised consumption rooms

The degree of benefit of a supervised consumption room is largely dependent on the nature of the injecting episodes that would otherwise have taken place. The health impacts are higher if, in the absence of supervised facilities, use is more likely to take place in an unhygienic, unsupervised and ultimately unsafe environment.

There is good evidence to support the effectiveness of supervised facilities to attract and maintain contact with highly marginalised populations.^{11,12,13} This delivers a range of health improvements through more hygienic and safer use of illicit drugs, as well as public order benefits. For example, there is evidence of self-reported reductions in injecting behaviour such as syringe sharing¹⁴ and public injecting.¹⁵

A reduction in syringe sharing decreases the risk of HIV transmission and death by overdose,¹⁶ although the ability of supervised facilities to reduce HIV or hepatitis-C among the wider population remains unclear.¹² There is some limited evidence consumption rooms may contribute to reducing drug-related deaths,¹⁷ and across Europe there has only been one reported death in a facility since the first was opened in 1986.¹⁸ It is difficult to measure the impact that the advice and signposting to withdrawal support offered at consumption facilities has, although this is likely to be positive as this supports dependent individuals to access services. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or the frequency of injecting.¹⁴

The legality of supervised consumption facilities

Proposals to introduce supervised consumption facilities are often complicated by the legal context surrounding illicit drug use. The UK is a signatory to the three UN (United Nations) conventions governing drug trafficking and other aspects of international drug policy (see **Box 2**). In domestic legislation, the Misuse of Drugs Act 1971 was designed to meet the treaty obligations and to set out an analogous scheme of drug scheduling, with drugs deemed to be the most harmful (such as heroin and cocaine) classified as Class A drugs.

International drug control conventions

- **1961 Single Convention on Narcotic Drugs** prohibits the production and supply of specific drugs, except those under licence for specific purposes, such as medical treatment and research.
- **1971 Convention on Psychotropic Substances** is designed to control psychoactive drugs such as amphetamines, barbiturates, benzodiazepines and psychedelics.
- **1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances** provides additional legal mechanisms for enforcing the 1961 and 1971 convention.

Source: www.unodc.org/unodc/en/commissions/CND/conventions.html (last accessed 16.12.2016)

There are two legal aspects of supervised consumption rooms which are often contested. First, whether they breach the three UN conventions; and secondly, whether operating a controlled facility would put individuals at risk of prosecution under domestic law. A 2006 review by the Joseph Rowntree Foundation concluded that well-run supervised consumption rooms would not act contrary to the primary objectives of the UN Conventions.¹⁹ In December 2016, the ACMD (Advisory Council on the Misuse of Drugs) recommended that consideration should be given to the provision of medically-supervised drug consumption clinics in localities with a high concentration of injecting drug use.²⁰ The UK Government has not responded to the ACMD recommendation, and its position on the legality of supervised consumption rooms is therefore unclear.

Supervised consumption rooms in the UK

There are currently no supervised consumption rooms operating in the UK. An independent drugs commission in Brighton rejected plans to pilot supervised consumption rooms in the city in 2014, on the grounds that they would not meet the needs of the overall community.²¹ More recently, in 2016, NHS Greater Glasgow and Clyde have commissioned the development of a full business case for a safer drug consumption facility and heroin assisted service pilot in Glasgow city centre (see **Box 3**).

Greater Glasgow and Clyde

Following a large and rapid rise in new HIV cases among people who inject drugs in Glasgow in 2015, a health needs assessment of people who inject drugs in public places in the city centre was undertaken. This concluded that there is a population of city centre public injectors, estimated to be 400-500 individuals, with complex health and social care needs which are not being met by current service provision.¹⁰ The report recommended development of existing services and a pilot of novel evidence-based services, including safer injecting facilities and heroin assisted treatment, targeted at this population.

In October 2016, the Glasgow City Integration Joint Board approved the development of a full business case for a co-located safer drug consumption facility and heroin assisted treatment service pilot in Glasgow city centre. Since October 2016, work has taken place to scope the key actions needed to facilitate delivery of the service, develop a financial framework and engage with key stakeholders, among other actions. This will form ongoing work developing the business plan.²²

Heroin assisted treatment

Heroin assisted treatment allows for the provision of pharmacological heroin to dependant individuals who have not previously responded to other forms of treatment. Typically patients receive injectable or inhalable heroin 2-3 times per day from a doctor in a clinic setting under strict controls.

More than half a dozen countries in Europe and North America have implemented HAT, including Switzerland, the Netherlands, Spain, Germany and Luxembourg. It has been prescribed as a treatment for heroin dependence in the UK since the 1950s. The Dangerous Drug Act 1967, restricted the prescribing of heroin, in addiction treatment, to doctors licensed by the Home Office. In practice, since the early 1970s, very few doctors have prescribed it.²³

In 2002, the Home Affairs Select Committee recommended that a pilot study of structured heroin prescribing to addicts should be conducted in the UK, along the lines of the highly structured model^a adopted in Switzerland and the Netherlands.²⁴ If proven to have a positive effect, the committee recommended such a system should be introduced in the UK. While stating their commitment to ensuring access to prescribed heroin for those who could benefit from it, the UK Government did not commit to piloting the structured model of heroin prescribing.²⁵ In 2009, the National Treatment Agency considered the available evidence on the effectiveness and cost-effectiveness of HAT. It recommended that treatment be expanded to cover a large proportion of the minority of opioid-dependent persons who need this treatment.²⁶ Despite this advice, central funding for HAT in England was ended in 2015, and the three clinics running randomised injectable opioid treatments trials in the UK, that were providing HAT, closed down.²⁷

More recently, in 2016, the ACMD recommended that, across the UK, central government funding should be provided to support HAT for patients for whom other forms of opioid substitution therapy have not been effective.²⁴

Key messages

- Medical professionals have a key role to play in treating the harms associated with illicit drug dependence, including advocating for the provision of evidence-based treatments in local areas with a high level of need.
- Current treatment options are limited in the UK. While opioid substitution treatment is routinely available (including for those with heroin use problems), other treatments associated with reduced levels of harm – notably supervised consumption rooms and heroin assisted treatment – are not widely used.
- Supervised consumption rooms are a space where illicit drugs can be taken under provision of trained staff. They aim to reduce the acute risks of disease transmission through unhygienic injecting, preventing overdose and connecting users with treatment services. There is good evidence to support their effectiveness in attracting and maintaining contact with highly marginalised populations.
- There are currently around 80 supervised consumption facilities across Europe. In the UK, questions over their legality are often cited as a barrier to their introduction. In 2016, the Advisory Council on the Misuse of Drugs recommended consideration should be given to the provision of medically-supervised drug consumption clinics. While there has been limited action on this recommendation, Greater Glasgow and Clyde have commissioned a business case for a safer drug consumption facility in the city centre.
- Heroin assisted treatment supports the management of heroin dependence. It allows for the provision of pharmacological grade heroin to dependent individuals who have not previously responded to other forms of treatment.
- It is used in some parts of Europe, but has only been used to a limited extent in the UK. In 2016, the Advisory Council on the Misuse of Drugs recommended that, across the UK, central government funding should be provided to support heroin assisted treatment for patients for whom other forms of opioid substitution therapy have not been effective.

a The structured model of heroin prescribing is specifically designed for patients who have not responded to standard treatments such as oral methadone. All injectable doses are taken under medical or nursing supervision, therefore providing monitoring, safety and prevention of passing on drugs to the illicit market. This involves screening and appropriate treatment selection and structured monitoring with highly trained individuals.

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