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Responding to Drug Related LITTER Public Drug Use and the Changing Profile of Injecting Drug Users: Developing the response

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Abbreviations

BBV	*Blood Borne Virus*
CGL	*Change, Grow, Live*
DCR	*Drug Consumption Room*
DEFRA	*Department for Environment, Food and Rural Affairs*
DRL	*Drug Related Litter*
MSIC	*Medically Supervised Injection Centre*
NICE	*National Institute for Health and Care Excellence*
NSP	*Needle and Syringe Programme*
NX	*Needle Exchange*
IPED	*Image and Performance Enhancing Drug*
PWID	*People Who Inject Drugs*
RCT	*Rational Choice Theory*
SCP	*Situational Crime Prevention*

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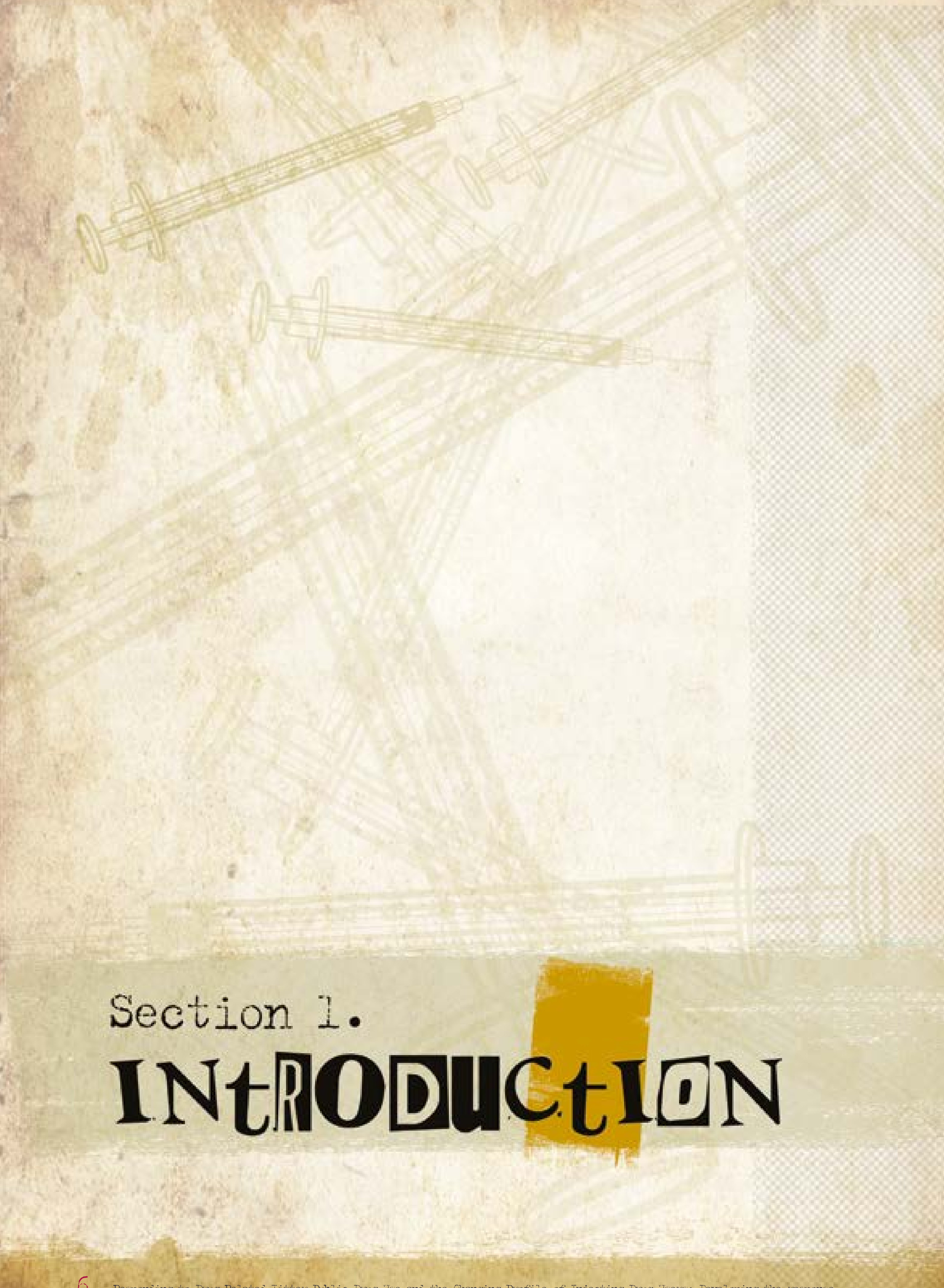


Section 1.

Introduction

1. Introduction

1.1 Aims and objectives

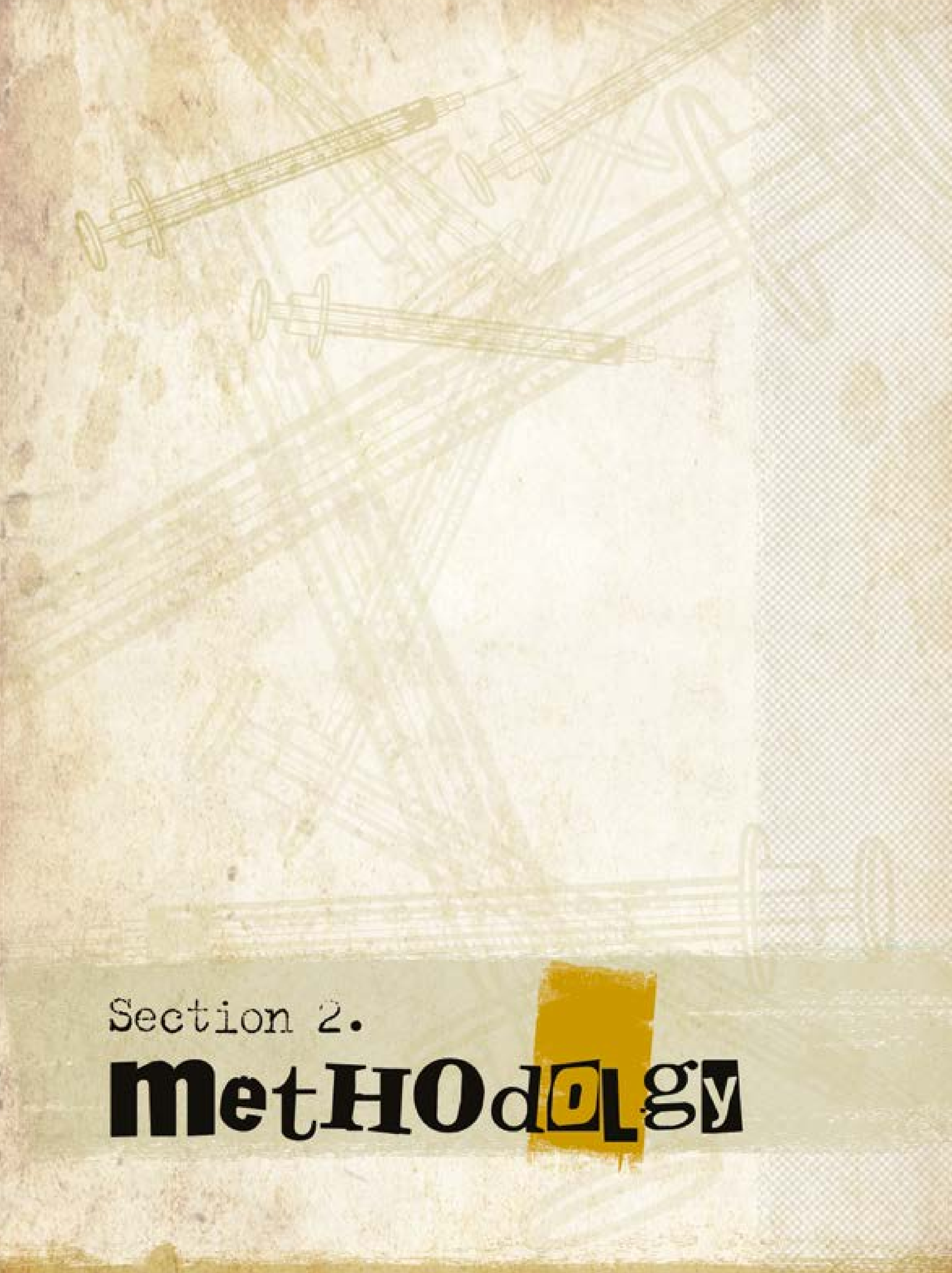
Manchester City Council's Community Safety Partnership Board commissioned this research project in 2017. The overarching aim of the project was to ascertain the extent and nature of *drug related litter* (e.g. discarded needles & syringes, hereafter referred to as **DRL**) in Manchester, including the identification of 'hot spots' for DRL.

There was a perception by some members of the public and business community that DRL is on the increase in Manchester. Therefore, the research was commissioned in order to provide the Community Safety Partnership Board with a clearer, independent, research-informed understanding of the prevalence of DRL in Manchester. This included the research team being directed to focus on establishing the scale and nature of DRL in the city, as well as the identification of any 'hot spots' for DRL. Following on from establishing the scale of DRL and hotspots, the research team set out to produce a report that would provide evidence-based recommendations to Manchester's Community Safety Partnership Board on how to reduce or stop incidents of DRL in the city.

In summary, the key objectives of the research project were to:

- Provide a review of current guidance and good practice on needle and syringe provision (including disposing of used needles and syringes) and identify how this is implemented locally;
- Gain a clearer understanding of occurrence/hotspots/rate of recurrence across the city;
- Ascertain the views of injecting drug users, practitioners and local communities and gain insight/views on why the problem occurs and what can be done to reduce incidents;
- Identify gaps in service provision and staff training/knowledge needs/strengths; and,
- Provide options or recommendations on how to reduce or stop incidents of DRL.

The following research findings and report recommendations should be used to guide future service development, in compliance with national guidance and in light of international developments around needle and syringe provision and harm reduction good practice.



Section 2.
Methodology

2.Methodology

2.1 Introduction

The research was conducted over a nine-month period between October 2017 and June 2018. The research team utilised a mixed-methods approach incorporating a combination of: qualitative interviews; outreach work; secondary data analysis; and a short survey with people who inject drugs (PWID).

2.2 Qualitative research methods

We sought to canvass the opinion and experiences of a wide range of stakeholders on the extent and nature of DRL in the city; their views on its causes and suggestions on how to address it. A total of 80 interviews were conducted. This comprised 24 interviews with PWIDs and a further 56 with stakeholders. The 24 interviews with PWID focused on obtaining their insight into hotspots and views on needle and syringe provision, the causes of DRL and potential solutions. Interviews with stakeholders also addressed these topics alongside gathering their experiences and views on the current response to DRL including recording systems, response time and the impact on residents and businesses.

The breakdown of the 56 stakeholder interviews is as follows: 12 members of the city centre business community; 10 residents, including four who represented either resident groups or canal and riverside trust volunteers; four councillors; four staff members from Manchester's commissioned alcohol and drugs service (CGL); a further five professionals working with PWIDs; five pharmacists; six staff involved in the city's waste disposal operations; four neighbourhood police officers; and, an additional six members of the city centre neighbourhood team, including three members of the homelessness outreach team.

All 56 interviews with non-drug users were digitally recorded. These interviews ranged from 40 minutes to 1 hour 55 minutes in length. Of the 24 Interviews with PWID, 14 were digitally recorded, the others, conducted in street settings, relied on interviewers taking hand written notes. The interviews ranged from between 10 to 25 minutes for street-based interviews with users, through to 50 minutes for user interviews in needle exchange and health centre settings. The digitally recorded interviews were fully transcribed and thematically analysed using NVivo, a qualitative data analysis software package.

2.3 Outreach and fieldwork

The formal interviews detailed above, and the surveys outlined in the following section, were supplemented by observations and numerous short conversations with users and non-users during outreach work. In total, the research team conducted outreach on 28 separate occasions during the research period. This initially consisted of accompanying dedicated outreach professionals - including members of neighbourhood teams, the homelessness outreach team and multi-agency teams - on their regular outreach in the city centre, and on patrols of DRL hotspots with neighbourhood officers, neighbourhood police officers and needle exchange harm reduction staff. These initial outreach sessions were invaluable. They provided knowledge on areas to avoid as well as key DRL hotspot areas. They also acted as a way of being introduced to rough sleepers and people with street-based lifestyles who inject drugs who were often well known to the different professionals we accompanied. These introductions, coupled with our previous experience of conducting similar city centre outreach over the past two years as part of our research into new psychoactive substances such as 'Spice' within this population, provided the platform for our independent city centre outreach. The outreach sessions typically involved spending between two and four hours walking around the city centre, engaging with street-based populations. During the outreach work, the research team spoke to users and non-users in an informal, ad hoc manner, leading to several impromptu conversations with people with street-based lifestyles and rough sleepers. We would also speak to residents and staff working in businesses that we encountered as we searched for evidence of DRL.

In the main, this involved short, informal, and unrecorded conversations. However, sometimes we would engage in longer conversations ranging from 15 minutes to 40 minutes. Where possible, hand written notes were taken and subsequently typed-up as field notes. When the opportunity arose, we were also able to conduct the occasional survey during outreach work. However, as outlined in the section 2.4 below, the majority (three-quarters) of surveys were completed in needle exchanges.

In addition to attempting to engage with PWIDs in the city centre, the outreach sessions set out to witness at first hand the nature and scale of DRL in the city centre. This incorporated the routine photographing of DRL. During the course of the research, we were also invited to accompany resident group members, and city centre canal and riverside trust volunteers on 'walking tours' of city centre DRL hotspots. It was also common for residents and businesses to show the research team their own photographic and video evidence of both DRL and injecting drug use that they had recorded.

It is important to note that all outreach sessions were conducted in pairs and the research team were experienced in engaging with the target population. All those involved in conducting street-based outreach sessions had a minimum of 15 years' experience of working with PWIDs, including street-based and rough sleeping populations. Our research team had received appropriate health and safety and risk assessment training, including a bespoke two-day 'street awareness and conflict management' training programme delivered by MMU security services that included self-defence and breakaway techniques.

2.4 Quantitative research methods

Between January and June 2018, a short survey was administered to 110 PWID. The analysis of the survey was undertaken using IBM-SPSS Statistics, a quantitative data analysis software package. Here, we provide a brief overview of the survey respondents.

2.4.1 Overview of survey respondents

The survey respondents were predominantly male (75 per cent) and aged between 20 and 65 years of age, with an average age of 42. A third (34 per cent) lived in rented accommodation, with over a quarter (28 per cent) sleeping rough on the streets or in a park, 14 per cent were sofa surfing and 17 per cent lived in a hostel or supported accommodation. Two-thirds (66 per cent) of survey respondents reported daily injecting drug use. The most commonly reported substances injected were heroin (72 per cent) and crack cocaine (62 per cent), with amphetamines (10 per cent), anabolic steroids (eight per cent), mephedrone (six per cent) and crystal methamphetamine (five per cent) also reportedly injected.

2.4.2 Secondary data analysis

The project also incorporated analysis of needle exchange data and refuge collection logs of DRL reports and needle collections. The analysis of DRL reports, combined with the accompanied walking tours and independent outreach outlined above enabled the research team to identify DRL hotspots and popular hangouts for PWID. For example, the first 17 months of recorded data we obtained from the contracted waste collection company on reported discarded needles contained 789 separately logged cases, of which over half (54 per cent) occurred in the city centre (254) and Ancoats and Clayton wards (170). This was consistent with the wider research findings. That is, the research was dominated with concerns expressed by residents, councillors and businesses in relation to reported incidents of open injecting drug use and DRL in the Ancoats, New Islington, Angel Meadows and Northern Quarter areas of the city centre. Speaking to neighbourhood policing teams, the waste disposal needle collection data clearly mapped onto the same areas from which they received complaints about DRL and open injecting drug use.

> *'We decided we'd sort of map the locations where users tend to congregate, the idea being it gave us an intelligence map of the area. ... So when we get complaints in ... from members of the public, we can show them that we're already aware of the issue, and that we're already dealing with it'.*
> (City Centre Neighbourhood Police Officer)

Therefore, although the research had a citywide remit, it soon became clear that the main areas of concern were located in the city centre and surrounding areas. In particular, the Angel Meadows, Ancoats, New Islington and the Northern Quarter districts dominated our research. Within these areas, the canals, car parks and green spaces were consistently highlighted as hot spot areas.

In addition to reviewing reported needle and needle collection data, the analysis of needle and syringe programme (NSP) data enabled the research team to identify the most appropriate needle exchanges and pharmacies to target.

Section 3.
The Nature & Scale of the Problem

3: The nature and scale of the problem

3.1 Introduction

'It [DRL] is far more evident in the last couple of years than it's ever been I think'.
(City Centre Management & Partnership Consultancy)

The above quote illustrates the common perception that was consistently highlighted by respondents in relation to the apparent increase in DRL in the city in the last few years. Local councillors, the business community and residents consistently supported this view.

'It's got more prevalent. I've been here for five years [and] I've noticed a dramatic increase'.
(City Centre Resident)

'It's got worse in the last two years'.
(Local Councillor)

For some, the reported increase in DRL appeared to be linked to the closure of the needle exchange provision in the city.

'There used to be a needle exchange ... in central Manchester. We thought we noticed the increase in it [DRL] when that service was removed'.
(9 Locks Rochdale Canal Volunteer)

Indeed, the relationship between needle exchange provision and DRL is something that will be discussed in more detail later in the report (see Section 5).

We begin our findings sections with an overview of the nature of DRL that was both reported and observed during the research process. In this section, we also document the impact of DRL and profile those who cause DRL. In addition to the perceived rise in DRL in the city centre, respondents routinely commented on the perceived increase in visible injecting drug use. We therefore document the nature and prevalence of intravenous drug use that was reported to us throughout the data collection process.

3.2 The nature of DRL

'There are different types of drug litter obviously, but the most extreme is needles'.
(City Centre Management & Partnership Consultancy)

This section documents the wide-ranging nature of DRL in the city. This ranges from discarded plastic snap bags and nitrous oxide canisters at one extreme through to discarded used needles and bloodstained tissues at the other.

As illustrated in the table below, over 600,000 syringes and needles were given out during the financial year April 2017 to March 2018 by needle exchanges and pharmacies across the city.

Needle exchanges	Numbers
Syringe - Insulin 0.5ml	**139,665**
Syringe - Insulin 1ml	**190,785**
Needle Ends - Long Blue	**89,297**
Needle Ends - Long Green	**77,297**
Needle Ends - Long Orange	**65,064**
Needle Ends - Short Blue	**33,319**
Needle Ends - Short Grey	**4,672**
Needle Ends - Short Orange	**50,068**
Needle Ends - Short Yellow	**12,694**
Total from needle exchanges	***662,861***
Pharmacies	***12,401***
Total from needle exchanges & pharmacies	***675,262***

DEFRA recommends that fair procedures are implemented to monitor return rates, including disposals in public sharp bins, to measure how much DRL is being safely disposed of and the effectiveness of action plans which aim to reduce DRL (*DEFRA 2005*). Figures were provided by commissioned needle and syringe providers for the financial year 2017-2018. These figures report that 675,262 needle and syringes were provided between April 2017 and March 2018, of which, 250,619 were returned. This leaves a total of 424,643 potentially used needles and syringes unaccountable. We note that not all of these unaccounted for needles and syringes will find their way into public places, and many will be safely disposed through other methods (see section 5.4.3). Nevertheless, with this figure in mind, it is perhaps unsurprising that several respondents highlighted the sheer volume of discarded needles that are being found across the city on a regular basis.

'In the last few months we have got tens of thousands of needles ... that we have collected from ... 36 car parks within the city centre'.
(City Centre Car Park Manager)

'We can go to somewhere and pick 200 needles up'.
(Waste Collection General Manager)

'It varies but I would estimate easily 150 to 200 minimum, perhaps 300 [needles we would collect] in one weekend half-day session'.
(Canal & Riverside Trust Volunteer)

As will be touched on in more detail later in the report (section 3.4), research (*Bourgois, 2009; Fountain & Howe, 2002; Fountain et al., 2009; Homeless Link, 2014; Klee & Reis, 1998; 2009; Wall, 2017*) has demonstrated a link between homelessness and dependent drug use that often includes injecting drug use. As such, DRL is often associated with those who are homeless and rough sleeping or those who have a street-based lifestyle. Therefore, it was no surprise that those respondents from the city's waste collection and street cleansing teams reported finding discarded needles and other paraphernalia (see below) in abandoned tents used by Manchester's homeless and street-based community.

'Tents … literally full of needles'.
(Waste Collection General Manager)

'Tents full of all sorts of horrific drug-related litter'.
(Contract Manager, Waste Recycling & Street Cleansing Team)

As noted above, while discarded needles are at the extreme end of the DRL spectrum, the wider injecting 'paraphernalia' associated with intravenous drug use was also identified as a concern. This paraphernalia included antiseptic swabs, metal spoons, phials of water, citric acid and filters.

'It's all the paraphernalia that goes with injecting. It might not be visible needles, but you'll see cooking pots, you'll see citric as well, the wrappers off that'.
(Homelessness Outreach Team)

'You go to some sites [that] residents will complain about … [and] it's just a load of wrappers and spoons and paraphernalia. There's probably about three pins [needles] but it looks bad'.
(Needle Exchange Harm Reduction Worker)

'I'm finding a lot of the packaging, the small, metal spoons, and a lot of the small, little phials [of water]'.
(City Centre Police Officer)

'Spoons and wipes and … the packets that the syringes have come from'.
(Ancoats Resident and Canal Trust Volunteer)

In addition to the paraphernalia listed above is the issue of the blood that can result from femoral injecting - be that bloodstained tissues or blood-splattered property - and the human waste that can result from street-based drug users congregating in various locations around the city.

'Bloody tissues. … You see quite a lot of them around'. (City Centre Business)

'Human waste is a massive thing. Blood. When they inject, a lot of the time they will be spraying the blood up the walls. … That is the biggest complaint we get'. (City Centre Car Park Manager)

As noted in *Ralphs et al.'s (2017)* study into the nature and prevalence of New Psychoactive Substances in Manchester, the use of synthetic cannabinoids (more commonly known by the generic term 'Spice') was identified as being particularly prevalent within the homeless community in the city. As such, in addition to the litter associated with intravenous class A drug use discussed above, the litter associated with synthetic cannabinoid use was also commonly identified by respondents as a pressing concern.

'Ends of joints and Rizla packets'. (NQ Forum)

'Spice wrappers and bags, like thousands'.
(City Centre Business)

There is a longstanding established link between dependent and injecting drug use and sex work to fund use *(Cusick et al., 2003; May et al., 1999; McKeganey et al., 1990)*. Hence, it was unsurprising that sex litter (i.e. used condoms) was sometimes present alongside DRL.

'I was out there [in the city] early morning … and saw drug litter mixed in with sex litter'.
(Homelessness Outreach Team)

'There was used condoms and stuff down there'.
(Treatment Service Outreach Team)

As we highlight in section 4.7, it was common for waste disposal teams to focus solely on removing needles, leaving the wider DRL we outline above on the streets and pathways. During our outreach and walking tours of DRL hotspots supported the interview data. It was common to witness discarded packaging from syringes and citric together with water bottles and spoons. To a lesser extent, we also witnessed discarded condoms, clothing and human faeces.

In addition to the DRL described above, discarded silver Nitrous Oxide (aka 'Laughing Gas') canisters were routinely spotted during our outreach. This type of DRL was also discussed during interviews.

'Empty gas canisters'.
(Manchester City Council Community Safety Manager)

'Used [gas] cylinders'. (Pharmacist 2)

'Quite a lot of the laughing gas bottles'.
(City Centre Business)

However, although the above quotes highlight how nitrous oxide canisters were occasionally discussed as a problematic form of DRL within the city, in contrast to discarded needles and related paraphernalia, these canisters rarely received a mention.

3.3 The impact of DRL

'It [DRL] looks bad for everyone. It's not just the people who are leaving it, it's everybody'.
(Needle Exchange Harm Reduction Worker)

This section documents the wide-ranging impact of DRL in the city. This includes the negative impact of the litter on local residents, communities, and businesses, as well as the wider impact on how the city itself is perceived.

A number of respondents highlighted the negative psychological impact that DRL can have, particularly on residents and those who are exposed to it. As highlighted in the quotes below, this can relate to people feeling threatened or becoming distressed.

'Drug related litter is a sign that you've got drug users in the area and that in itself can make people feel quite threatened because ... a lot of people have this image of this drug addict who will resort to any violence to get what they need'.
(City Centre Councillor)

'It's not pleasant to see used needles on the street, especially when they've got blood in them. ... It's distressing for people'.
(Local Councillor)

A further negative impact of DRL is on local communities; in particular, the health risks and dangers that discarded needles pose to residents - especially children - and those using public spaces in and around the city.

'At Angel Meadow, although there isn't a playground, young kids go to play football. It isn't a great situation especially in the autumn when things are covered up with leaves and children are running through the leaves'. (NQ Forum)

'They just need to do something because, otherwise, sadly it will be a kid who will just go running and will get caught up with a needle sticking out of them'. (New Islington Resident)

'It [DRL] is not acceptable in a public park when there's a local school that use it [the park] as a playground, when people are having barbecues, people are kicking footballs around in bare feet sometimes. This is a public park!'
(Angel Meadows Resident)

'There are certain areas you wouldn't want to go to, like on the canal path which should be a beautiful walk. ... Once we were down there, ... I looked across [the canal] and there was a guy with his pants down with a needle in him. It was like something from an awful future. It was horrendous'. (NQ Forum)

During several visits to Angel Meadows, we documented numerous incidents of needles left lying around park benches, often stuck into the bench, left on walls or hidden under fallen leaves. We also regularly observed open drug dealing and (injecting) drug use in this space. As the only green space in the 'Green Quarter' of the city, this is particularly problematic.

Sadly, the issues raised above undermine the efforts made by active local residents to improve the areas they live in. The end result is that disenchanted residents then choose to leave an area rather than tolerate DRL.

'You have established residential communities that are trying to build something positive, and that's being undermined by the drug taking'.
(Angel Meadows Resident)

'The families ultimately move out [of the area]'.
(Angel Meadows Resident)

While the above quotes highlight the negative impact that DRL has on residents and local communities, a wider negative impact is the effect that visible DRL has on how Manchester itself is perceived by those who choose to visit the city. This appeared to be particularly apparent when it came to people choosing whether or not to bring children and young people into the city.

'It's not a good advert for the city'.
(Waste Collection General Manager)

'There's nothing [that] makes you feel like ... more in a scene of Trainspotting [than] when you're coming across syringes on the floor. It puts me off bringing my three children here [into the city] because I don't want them to see it'.
(City Centre Business)

'If people have got children, or if they have relatives who are children, it [DRL] impacts on where they will go and where they will take them'.
(Councillor)

The issue of DRL not being a 'good advert for the city' is particularly relevant to the business community in Manchester. Not only as a result of less people coming into the city, but also in terms of the costs that

businesses incur when responding to the problem. A clear example of the multiple issues that DRL cause businesses can be seen in the quotes below from city centre car park managers.

> *'Our frontline staff and customer service assistants, their role is to provide customer service, but a lot of the time, probably 80 per cent of their time, they are spending dealing with drug users ... or cleaning up needles or human faeces or urine'.*
> (City Centre Car Park Manager)

> *'It [the impact of DRL] is massive. We have season ticket customers. We could lose a full business. They could have 100 tickets worth hundreds of thousands of pounds [and] they could cancel'.*
> (City Centre Car Park Manager)

> *'Well, on staff wellbeing there is a massive impact. ... We have had many members of staff leave'.*
> (City Centre Car Park Manager)

Having outlined the nature of DRL, we now turn attention to profiling those who are responsible for DRL.

3.4 The profile of those who cause DRL

This section profiles those individuals and/or groups of individuals that are currently associated with DRL in the city. As briefly discussed earlier (see section 3.2), there are well-established links between homelessness and dependent substance use that includes injecting drug use. As such, DRL (in particular, discarded needles) is often associated with those who are homeless. Indeed, as evidenced in the quotes below, a range of respondents allied DRL with those who are homeless and sleeping rough on the streets of Manchester. However, as will be seen later in the section, DRL has also been linked to students and sex workers.

> *'People are linking it [DRL] to the homeless issue'.*
> (City Centre Police Officer)

> *'This [DRL] is very much allied to people who are rough sleeping'.*
> (Ancoats Resident & Canal Trust Volunteer)

> *'Based on evidence when we're doing the clean-ups, we are frequently finding tents ... literally full of needles'.* (Waste Collection General Manager)

> *'I can only assume they are homeless from their appearance, when you see them using they always have a bag or two of belongings with them including sleeping bags so you can only make that assumption'.* (Ancoats Resident)

A range of respondents highlighted the fact that homeless intravenous drug users injected in small groups rather than individually.

> *'You might get the odd individual on their own but they're often within a group'.*
> (City Centre Councillor)

> *'It'll never be one person. There will always be a minimum of two. Normally three or four'.*
> (City Centre Business)

> *'We're not talking about twenty people doing it, but two or three people. Or if it's one group, about four or five people'.* (Canal & Riverside Trust Volunteer)

This was supported through photographic and video footage of small groups of users taken by both residents and businesses. Furthermore, we often witnessed small groups of users around Angel Meadows, Ancoats and the Northern Quarter areas. As noted previously, seeing users in groups was intimidating for residents and business staff. Moreover, as we outline in section 4, groups of injecting users presented challenges to moving on users and clearing up DRL.

It is important to note, however, that despite the links made between those who are rough sleeping in Manchester and DRL, many of those who use drugs intravenously in the city are not strictly homeless. As highlighted below, much of the DRL in the city can be attributed to those with a 'street-based lifestyle'. In other words, those who have accommodation outside of the city centre, but who choose to come into the city to score, and then use drugs. For some, this may extend to obtaining funds for drugs through begging or other forms of acquisitive crime such as shoplifting, or to obtaining needles and other drugs paraphernalia to use drugs.

> *'They are not all rough sleepers, you know. You are attracting all sorts of people into the city, or people who are just in the city, and just hang around and use'.* (Homelessness Outreach Team 1)

> *'I think people who've got a street-based lifestyle. So people who may not necessarily be sleeping rough but are going to score and they're going to use near to where they've scored, rather than they go home and use'.* (Homelessness Outreach Team 2)

As we discuss further in the recommendations in section 7, working with this community is key to reducing reported levels of DRL and open (injecting) drug use in the city centre.

Furthermore, it is worth emphasising that contrary to the common public perception, those who are

homeless and those who have a street-based lifestyle are not solely responsible for all DRL in the city. For example, as highlighted earlier in the report (see section 3.2), sex litter is commonly found among discarded needles, and discarded nitrous oxide canisters are particularly prevalent around student accommodation and night-time economy venues.

'Where you have little pockets of student accommodation, you do see nitrous oxide capsules'. (Council's Neighbourhood Compliance Team Lead)

'It makes people more likely to feel negatively towards the people who are rough sleeping and [people] attribute all of the [drug-related] litter to them, which is not always the case'. (City Centre Councillor)

'A lot more of our women are quite entrenched [intravenous drug users] now'. (City Centre Street Health Manager)

Of course, the homeless and sex workers are not mutually exclusive groups and several of Manchester's third sector organisations and statutory teams provide support for homeless substance users who engage in a variety of sex work.

Having outlined the nature and prevalence of DRL, we now turn our attention to city centre intravenous drug use.

3.5 The nature and prevalence of intravenous drug use

'I've worked here for nearly nine years, [and] it's way worse than it ever was. Way worse!' (City Centre Business)

This section discusses the nature and prevalence of intravenous drug use in the city. It focusses on where in the city people are injecting drugs, what particular times of day people are choosing to inject, and crucially, whether there have been any changes in the nature and prevalence of use over the last few years.

Public injecting was widely reported and often evidenced by respondents via photographs and video footage. Not only was this evident in our own outreach observations around the city centre, but also in residential areas, often visible from apartment windows.

'The first case that I know of that was reported to me was photographs taken and it was on some derelict land that had been fenced off and the fence had broken down and a resident could see into that land and people were using it for rough sleeping and then injecting'. (City Centre Councillor)

During the course of the research, we were often presented with images and video footage that residents had taken of injecting drug use that was visible from their apartment windows and balconies.

'If I come out to stand on my balcony for a drink or a smoke I will often see people over there in the bushes with their pants down, injecting.' (New Islington Resident)

'You see them there on the ramp at the side of the building. Sometimes you hear them screaming. I've had to call for ambulances when I've seen people overdose from the balcony'. (Ancoats Resident)

The city centre business community recounted similar experiences of witnessing open drug use.

'I've seen people shooting up in the streets'. (City Centre Management & Partnership Consultancy)

'People are just sat around, jacking up'. (Northern Quarter Bar Owner)

The issue of public injecting was exacerbated by the fact that many of those seen injecting were injecting into the femoral artery in the groin. Hence, users would have their pants down, exposing themselves.

'Injecting into their groins … in a residential street'. (NQ Forum)

'Femoral injecting is very common'. (Homelessness Outreach Team 1)

'It's not nice, it's not what you expect is it? Looking out of your window to see a guy sticking a needle in his arse!' (Ancoats Resident)

As highlighted in the above quotes, intravenous drug use is now prevalent across the city. During fieldwork, the research team witnessed this in Angel Meadows and in backstreets and alleyways in the Northern Quarter. Although these incidents were rare, the evidence of injecting drug use across the city centre was commonplace (as outlined above). As evidenced in the following quotes, public injecting was most commonly reported on the canals in the city; in city centre car parks; on the streets in and around the Northern Quarter and Piccadilly; at the New Islington Marina in Ancoats; and around the Manchester cathedral. Again, the issue of femoral injecting was highlighted as aggravating an already pressing issue.

'You can just walk up the towpath [and] under the [canal] bridges … you will see somebody sitting there shooting drugs up'. (Canal & Riverside Trust Volunteer)

'You sometimes get out of your car and somebody is crouched behind the car ... shooting into their groin'. (City Centre Street Health Manager)

'[In] Tib Street car park ... people are just sat around, jacking up'. (Northern Quarter Bar Owner)

'The Oak Street car park and Dorsey Street in the Northern Quarter'.
(City Centre Neighbourhood Team)

'I've seen it in Piccadilly, people shooting up in Piccadilly'.
(City Centre Management & Partnership Consultancy)

'At Jackson Canter, the solicitors at 111 Piccadilly, there was about four of them and they were all actively injecting. ... So of course it's not very nice because they're pulling their trousers down and this is a busy walkway'. (City Centre Business)

'Walking down Portland Street, you'll see a blanket raised up in a doorway. Look over it and somebody's injecting'.
(Treatment Homeless Outreach Worker)

'[At the marina] some of them have been lifting the canopies on the boats and getting under the canopies and injecting'.
(Treatment Service Outreach Team)

'They were doing it around the cathedral. The people inside the cathedral gift shop ... could see them injecting through the window. They were just dropping their pants, knocking it in'.
(Needle Exchange Harm Reduction Worker)

As touched on previously (see section 3.4), while respondents did report seeing individuals injecting on their own, it was much more common to see small groups of individuals injecting together.

'At Jackson Canter when they were there, there was about four of them and they were all actively injecting'. (City Centre Business)

'[I: When you see people injecting will it typically be people on their own or in small or large groups?] I have seen people on their own but I would say there are [usually] two or three in a group'.
(NQ Forum)

'There was a group of three in behind the bushes shooting up'. (Canal & Riverside Trust Volunteer)

As the above quotes illustrate, two to four users was typical, although occasionally larger groups were discussed.

'So there would be a group of thirteen [users], with their pants down'. (City Centre Car Park Security)

These reports of groups of users has implications for the risk of users sharing needles. We discuss this further in section 5.4 on needle provision.

While the above quotes highlight the nature and prevalence of intravenous drug use in the city, they do not shed light on the times in the day when the issue is more or less prevalent. As evident in the quotes below, it would appear that there is/are no particular time/s of day when public injecting is more common. Rather, it appears to take place 'all day', '24/7'.

'[I: Is there any particular time of the day where you are seeing people injecting in public more?] It's all times, all the time, 24/7'.
(City Centre Car Park Manager)

'Virtually every day, during the day'.
(New Islington Resident)

'Injecting all day, every day'. (NQ Forum)

'I see people with their trousers down injecting into their groins in the middle of the day'. (NQ Forum)

As we discuss further in sections 5.4.5 and 6.2.9, service provision needs to ensure it caters for the 24/7 nature of injecting drug use in the city centre.

In summary, the research process revealed a commonly expressed perception that open injecting drug use has significantly increased in the city centre. This perception was often supported by images and corroborated in our own observations. Furthermore, it was noted by a number of respondents that intravenous drug users seemed to be less concerned with injecting in public than they may have been in the past.

'I have only seen that [public injecting] over the last couple of years, where it has been more visible and they aren't so bothered'.
(City Centre Street Health Manager)

'I've seen people injecting ... in a more open way. In a way that I didn't notice even two years ago'.
(Ancoats Resident & Canal Trust Volunteer)

'A few years ago, they used to go to the corners of the car park, or to the roof, or the top of a stairwell. Now, they don't care. They will do it on level one; they do it in the entrance to the car park'.
(City Centre Car Park Manager)

As highlighted in the quotes below, it was often suggested that this increase in visible injecting is related to the rise in recent years of synthetic cannabinoid ('Spice') use among the homeless community in the city *(see Ralphs et al., 2017)*. Prior to the introduction of the Psychoactive Substances Act in May 2016, and the subsequent classification of third generation synthetic cannabinoids as a class B substance in December 2016, synthetic cannabinoids were openly consumed in public places; indeed this was one of (and arguably still is) the particular appeals of synthetic cannabinoids to those with a street-based lifestyle. It has been argued that this has led to a shift in drug use in general from more 'hidden' spaces to more public spaces; hence, the apparent shift in injecting alluded to in the final quote above.

> *'I personally think that it [DRL] has increased massively since the epidemic of legal highs in the last five or six years'.* (City Centre Business)

> *'I blame it on the Spice me. Before Spice, people wouldn't use drugs in public. They were smoking in the tents, on the high street so now the next step is they've moved on to openly smoking crack pipes and injecting gear'.* (City Centre Rough Sleeper)

> *'It's the Spice effect isn't it? They blaze the Spice in public so that got them used to doing drugs on the streets so injecting in public is progression – the Spice started it off'.* (IV Heroin User)

Other explanations offered for this apparent increase centred on the redevelopment and redevelopment of previously derelict and underused areas of the city centre. Thereby making the once hidden spaces where users could inject away from the public gaze now part of the expanding night-time economy, city centre living and business spaces. This in turn, has made what were once scarcely used back streets and canal paths into busy walkways and cycle routes. Hence, there remains some uncertainly as to whether injecting drug use and DRL has categorically increased, or whether it has (at least in part) simply become more visible due to recent city centre redevelopment. Whatever the reason, there is no doubt that the current levels of DRL and open injecting drug use reported in this chapter require a review of the current response.

Section 4.

Reporting, Recording and Removing DRL

4. Reporting, recording and removing DRL

4.1 Introduction

This chapter commences with an overview of the problems that were associated with both the reporting and the recording of incidents of DRL. In particular: the issues related to reporting and recording; the issue of both under and over-reporting and recording; and, how the process of reporting and recording incidents could be improved in the future.

'[I: When a resident reports drug related litter via the council website, what typical experiences do they have?] It's not an experience, generally. Nothing comes back. ... They [just] get an automated confirmation email'. (Councillor)

4.2 Reporting and recording problems: under-reporting/recording

'I suspect that there will be thousands of cases we just don't get to know about'.
(Manchester City Council Community Safety Manager)

Before addressing the question of how/why incidents of DRL may be under-reported, it is important to highlight the crucial first stage in the process; recognising the whole range of DRL (i.e. not just syringes but the associated drugs paraphernalia). As noted below, it was felt that the general public would be more likely to 'recognise' a discarded needle or syringe as DRL, and hence report it, as compared to discarded swabs, spoons, phials of water, discarded citric acid packets, filters and so forth.

'I honestly think that most people wouldn't even know what it [DRL] was if they saw it'.
(City Centre Resident)

'It needs people to be professional or people to be ex-users to know what they [the various bits of DRL] are'. (Homeless Outreach Team)

'If it's needles, it's more likely to be reported because obviously there's more concern'.
(Councillor)

'The general public, if they see a needle, it's instantly drug related, but if they see any of the other items it's not as easily identifiable. If they see a water bottle, well it's water but it could be for anything, they wouldn't necessarily link that to drug related litter'. (Homeless Outreach Team)

As highlighted below, in addition to a general lack of public awareness of wider drug using paraphernalia, one of the main issues when it comes to the under-reporting and/or under-recording of DRL is the fact that members of the general public clear up the litter themselves, instead of reporting it.

'They [the public] might take the view to clean it up themselves'.
(City Centre Management & Partnership Consultancy)

'There's lots of clear ups going on around the canal or residents' groups where you'll just be picking up your own litter and that won't be being reported'.
(Angel Meadows Resident)

However, this issue was not restricted to solely members of the public clearing up DRL themselves. As evidenced below, the same applies to both businesses and even the waste disposal contractors themselves.

'We just don't get to know about sharps that have been picked up on a daily basis by people if it's their own business'.
(Manchester City Council Community Safety Manager)

'Sometimes our cleaners aren't even recording them now because there's that many on a Saturday morning or Sunday morning'. (City Centre Business)

'If my staff just come across needles, that's not recorded [I: So it's only in relation to the direct reports?] Yes, it's only to the direct reports'.
(Waste Collection General Manager)

We also found that no attempt to record the volume of needles collected. That is, the existing systems only record the number of occasions waste disposal teams go out and recover needles. As highlighted below, this makes estimates on the actual number of discarded needles reported almost impossible to calculate as this can range from single needles to several hundred.

'We can go to somewhere and pick one needle up. We can go to somewhere and pick 200 needles up'.
(Waste Collection General Manager)

Before moving on to look at the issue of over-reporting and/or over-recording of DRL, it is worthwhile to remember that litter can only be reported and/or recorded when someone comes across it. As demonstrated below, while DRL in areas of high footfall may be reported and/or recorded multiple times, DRL in remote and/or unfrequented areas may never be reported/recorded.

'You may get 20, 30, 40 reports because people are really, really concerned. You know, there are going to be people around. You leave a needle in a piece of land when no one really passes, no one really cares, [and] that needle could sit there forever'. (Contract Manager, Waste Recycling & Street Cleansing Team)

Indeed, during outreach sessions, we often came across large numbers of needles hidden away under bushes or hidden away in corners that were sheltered from the public gaze.

4.3 Reporting and recording problems: over-reporting/recording

As touched on above, reasons for the over-reporting of DRL can include how concerned those reporting the litter are, as well as how many people come across the litter. In relation to the former, is also the notion of how 'tolerant' people are of DRL and the impact this can have on reporting behaviour.

'A hotspot for us could be it's just been reported lots of times. Rather than it's actually a hotspot, it's just a high footfall area'. (Contract Manager, Waste Recycling & Street Cleansing Team)

'Obviously the closer it is to someone's home, or an area that they relax in or an area that they know there are children in, the more likely they are to report it'. (Councillor)

'There's a fear isn't there [that in] more aspirational areas people will report more so these things get skewed'. (Contract Manager, Waste Recycling & Street Cleansing Team)

As alluded to in the above quotes, arguably the most problematic issue when it comes to recording the prevalence of DRL is the fact that a single instance of DRL (i.e. a single discarded syringe) can be reported, and thus recorded, multiple times. Thereby making any analysis of quantitative records of instances of DRL (e.g. to identify hotspots etc.) rather meaningless.

'There's like 245 reports in the last six months. [I: But that could be for potentially, you know, 50 sharps and multiple reports] Yeah'. (Contract Manager, Waste Recycling & Street Cleansing Team)

'If you've got three reports for needles on or around 68 Ancoats Street on the same day or within a day or two, within 24, 48 hours, you could probably say that's the same needle that's been reported two or three times'. (Waste Collection General Manager)

Other respondents noted a significant amount of under-reporting of DRL through official channels that adds further questions to the reliability of the existing official figures of DRL.

'There is a point where they've stopped reporting it but they will tell us [about it] in the meeting. Do you know what I mean? ... You walk into a certain part of the city and there's just a morass of people who are out of their heads, and [say] you're a business that's nearby, what do you do? Do you phone up everybody and see if somebody is going to come and get it sorted? This is the thing that you see all day every day'. (City Centre Management & Partnership Consultancy)

Taken together then, we put little faith in the official figures on DRL. On the one hand, the existing data on hotspots may include 'double counting' of the same DRL, whilst on the other hand, we found many people who did not report through these channels, choosing to use residents, local councillors, or business groups. In many cases, this extended to removing and disposing of DRL themselves (see section 4.7).

Leaving aside the significant potential for the current system to produce skewed and inaccurate DRL data, we came across a number of other glitches in the local reporting systems for DRL. These are outlined in the following section.

4.4 Reporting and recording improvements

The official channels of reporting DRL were often criticised. This spanned the lack of awareness of how to report discarded DRL, through to the limitations of using the police 101 line and the council website.

An issue that was highlighted a number of times during the research was the need to make the public more aware of both the need to report DRL, and the process of how one would actually go about reporting litter. For example, it was felt that the current situation is over-reliant on members of the public searching the council website to find out how to go about reporting DRL.

'People need to know how important it is to report things. People think it is not their problem or that they don't live round here so why should they bother'. (NQ Forum)

'I can't even remember any kind of public message or anything like that, that says, "Here's what you do". ... If I contrast that from other places where I've lived, I would say it's very, very low levels of communication. It's almost like a one-way thing, "Oh, you've got to go the website and you've got

to go check it out on the website". Well, that's like saying, "Why don't you know that, because it's on the website?" Well, I don't spend all day reading the Council website!' (City Centre Resident)

This section highlights the key frustrations that were commonly expressed by city centre businesses and residents. These include the current recording processes, the speed of the response and the failure to locate and remove needles and other drug paraphernalia. We begin this section with a focus on the limitations of the existing recording system.

Reporting DRL on the council website was frequently highlighted as being ineffective. As this city centre resident discusses below, in its current format, it is difficult to provide an accurate location. For example, when we spoke to respondents who had managed to navigate their way through to reporting DRL, one of the recurring issues that was raised by interviewees was the difficulty in accurately describing the location of DRL on the website. This related not only to those locations that did not have an obvious postcode assigned to them (e.g. areas of wasteland, or paths by canals), but also to the issue of pinpointing exactly where, in a particular location/postcode, the litter is.

'Some of the problem is to do with how to pinpoint exactly where it [DRL] is and sometimes postcodes can be a bit confusing'. (Councillor)

'There's been a problem in terms of describing some of the areas, which aren't associated to an obvious address, because postcodes relate to buildings, not say a patch of land by a canal'.
(Ancoats Resident & Canal Trust Volunteer)

'Filling in the form that's on the website, one of the difficulties that has been associated with that is ... describing locations, because obviously it's difficult to pinpoint things and, you know, it's almost literally the needle in the haystack, isn't it?'
(Ancoats Resident & Canal Trust Volunteer)

One potential solution that was repeatedly suggested to address the reporting and recording issues highlighted at the start of this section was adding the option to upload photographs. It was felt that the ability to upload/attach a photo to any reported incident would make the reporting of any litter more accurate, and as a result, increase the likelihood that the reported litter would be found and cleared away.

'I know with the council system you can literally go in and put X marks the spot. But if you put X wrong [and] we go to X, we won't walk the length of the canal looking for something. ... We will look probably 20 yards the other side of that [X]'.
(Waste Collection General Manager)

'I don't think you can do photos on the website which slightly annoys me because I just think that is a very obvious thing to do these days'.
(9 Locks Rochdale Canal Volunteer)

'It would be better, wouldn't it, if you could use photos'. (Homeless Outreach Team)

'[Currently] you're reliant on dropping a pin on a map and then describing something. I think that's fine when you're doing rubbish or waste or ... bigger more obvious things. But things like needles, are much more intricate ... and also are in much more unobvious places'.
(9 Locks Rochdale Canal Volunteer)

'You have to move that little pin to show exactly where it is that you have seen it and that is not as accurate as it could be. There is nowhere to upload a photograph of where it is. They might think it is on a certain street but they won't know whereabouts'.
(City Centre Resident)

In relation to photos, some respondents even felt that, rather than simply receiving an automated email to say that the reported case was resolved/closed, it would be preferable to receive a photograph that clearly shows that the reported DRL had been cleared away.

'They should have to send a photograph showing that they've actually done it [cleared up the litter]'.
(City Centre Business)

A point that was raised by a number of interviewees was the sheer time it takes to report incidents of DRL (often multiple times for multiple incidents) on the council website. As a result, there were calls for the process to become more streamlined and straightforward. The idea of a drug related mobile App was also raised as another way of improving the current reporting procedure.

'I've been regularly reporting needles via the council website when I've been seeing them and sometimes that feels like quite an occupation in itself'.
(Ancoats Resident & Canal Trust Volunteer)

'People reporting something online want to be able to do it very, very quickly. The more clicks they've got to do, to get through the information and report, the less likely they are to do it. Often people see this on their way to work or on their way to a social engagement and if they can do it quickly, they'll do it. If there are too many steps [and] too much to read before you get to filling in the location, [then] they won't do it'.
(Councillor)

'People like to use Apps now, so I think that might be a good idea. A needle report or a drug litter reporting App, maybe. If there was a simple App where you just press a button and it records where you were and sends a report to BIFFA, say, that would be good'.
(Homeless Outreach Team)

'If it was easier to get through on 101 that would be better. The police know it's a problem but rather than getting on the phone and waiting and waiting if there was an App that people could use which said, "There is something happening there now" which went straight to someone to deal with, that would be good'. (City Centre Resident)

Timing issues were also raised in relation to the response to reported DRL incidents. The following section highlights the repeated calls for a more immediate response.

4.5 Response time

'[I: So what's the expectation then when the public report DRL? Is there a timescale?] Yes, the next working day is our service level agreement'
(Contract Manager, Waste Recycling & Street Cleansing Team)

As outlined above, the existing service level agreement is for a 24-hour response. However, we came across many complaints that the 24-hour response was not always adhered too.

'[I: How do you or they think that the response could be improved?] I think they would like it dealt with immediately, they would like it dealt with within 24 hours. They'd like, quite reasonably, I think, the syringes to be picked up outside their front doors or parks that they walk their dogs within 24 hours. I think that would be seen as reasonable by them'. (City Centre Councillor)

'We've had issues with Biffa where even the Police have said that they'd reported some hot spots and it's not been cleaned up. ... Yeah, we've had complaints, like, "it's been here, and we've told the Council it's been here for a week and it's supposed to be within 24 hours"'.
(Needle Exchange Harm Reduction Worker)

This often leads to complaints and additional pressure on needle exchange staff to go out and collect discarded needles.

'As a drugs service, we're struggling [to address the complaints]. What do you want us to do? We can go out and pick up the odd one, but we can't be going out all the time'.
(Needle Exchange Outreach Worker)

The problems with the existing recording mechanisms we identified in section 4.4 went beyond the frustrations of residents. The limitations of the recording system coupled with the non-specific reporting of DRL often led to the failure of the waste disposal team to locate DRL.

'This is one of Biffa's frustrations. Someone goes to the park and reports they've seen a needle, in amongst grass and shrubs. You know, they [Biffa] haven't got hours to go, looking for it'.
(Contract Manager, Waste Recycling & Street Cleansing Team)

Indeed, during the course of the research, the research team were taken on several 'walking tours' of DRL hotspots by city centre residents and it was clear how easily DRL could be missed or hard to locate by waste disposal teams. Fallen leaves and bushes often covered DRL, or DRL was located in areas with no identifiable street names or landmarks to guide waste disposal teams.

It was also noted that the presence of large groups of often aggressive users presented problems for waste disposal teams and their ability to immediately clear up DRL. Indeed aggressive users is one of the many stated reasons why needles are not always removed within 24 hours.

'I've had staff threatened, I've had staff assaulted when they were trying to do clean ups in certain parts of the city centre because they [users] were slumped and there's lots of bins and they're trying to empty them and clean around them and they've been threatened, they've been assaulted, racially abused, the whole lot'. (Waste Disposal Manager)

'If they [waste disposal staff] go down to pick up a needle and there are people [users] down there, they will leave without picking up the needle, but tick that job off as a job done. I've had them admit that before'. (Councillor)

This sometimes led to DRL not always been removed at the first attempt, leading to frustration with the response, in particular, the length of time it takes for DRL to be removed.

4.6 Responsibility for removing drug related litter

The research uncovered clear tensions between what the council's waste disposal team remit was and what fell outside of the contract. There was tangible frustration amongst city centre residents and businesses around the responsibility for DRL. This issue was most frequently raised in relation to city centre car parks, residential blocks and the canal pathways.

'There's an argument between the city council and the business. The business think that the city council should clean it and the city council think the business should clean it'.
(City Centre Management & Partnership Consultancy)

'Where it's on private land, then it comes down to the landowner. ... Where it is clearly the responsibility of a business - you're talking larger businesses really - then we will say so. We will say there is a solution, however you need to spend money to reduce the impact that it [DRL] is having on your residents. There is an obligation and a duty of care for your residents and the businesses within your building. ... If it's their building, then they have to spend money'.
(Manchester City Council Community Safety Manager)

Manchester's vast canal ways present particular issues for waste disposal operations. It was noted that only parts of the canal network were contracted for waste removal. Providing the exact location on the canal paths where DRL was located was difficult and the waste disposal team would not always collect all the DRL along a stretch of the canal pathway.

'I think that's what you've got to potentially consider on the canals especially. My team, they go on there, find some needles. It's like, "Right, okay, I've got it". There might be some more ten yards further down, but because they are busy, it's like, "Right, you haven't told us needles here. I've got the needles that are there". Again, they won't walk 100 yards down the canal to find even more of them because they haven't got the time'. (Waste Disposal Manager)

In addition to frustrations that all needles in the vicinity are not always removed, there was often frustration that wider drug paraphernalia was not cleaned up.

4.7 Removal of drug paraphernalia

'They [waste disposal contractors] should be moving the needles and everything around them that's related to the drug activity. They should be doing the whole thing'. (Local Councillor)

The above statement by a local councillor represents a commonly expressed view we encountered that waste disposal operatives attending DRL hotspots should be removing all drug paraphernalia rather than a sole focus on discarded needles and syringes. As this city centre resident states, residents and businesses expect the whole area to be cleared up.

'I would hope that if they come out that they will clean the area. That they wouldn't just come out and pick up the sharps, put them in the sharps bin and move on. I would hope that they come out and do the whole thing'. (City Centre Resident)

However, during our outreach observations we came across numerous incidences of hotspots where it was clear that only discarded needles had been collected from a DRL hotspot. It was common to see areas littered with other drug paraphernalia such as citric and needle packaging, spoons, cans, bottles and snap bags. In some cases, we witnessed human excrement, condoms and discarded clothing.

I met up with one of the Ancoats residents today who is also a volunteer for the Ancoats Canal Trust. He took me on a 'walking tour' of the area. This included the ironically named 'Paradise Walk'. I was amazed at the amount of drug paraphernalia in this short stretch of space. There were literally hundreds of discarded needle and syringe wrappers, empty citric packs, bottles, spoons and lighters etc.. There was the odd needle mixed in but it was clear that needles and syringes had recently been collected as the amount of other DRL was consistent with much higher levels of use than the needles I could see. Why don't they clean up the whole area? I must check this out.
(Fieldwork notes, Tuesday 21st November 2017)

Dissatisfaction with this practice of waste disposal operatives only removing needles was expressed during several interviews.

'If you report needles then you have to put in another report to do the wrappers, they won't do both because they're on a contract, so you have to put another job lot in for them to pick up the wrappers'.
(Needle Exchange Harm Reduction Worker)

'When they've had a job raised, they will go down there and remove the needles, but they won't remove the spoons, the citrics, the cans and stuff. They will just leave the rest of the detritus just there. That's something else that I've raised with them'. (Councillor)

On further investigation, we were informed that the waste disposal contract for attending reported DRL only included the removal of 'hazardous waste' (i.e. needles) and hence this appears to be a contractual issue rather than any culpability of the contracted waste disposal company.

As we have outlined above, there are numerous legitimate reasons why reported DRL is not always removed within the 24-hour timeframe of the service level agreement. However, the business community were particularly critical of the current 24-hour service level agreement for DRL removal. For many businesses, a 24-hour turnaround to remove reported DRL is simply not fast enough. It was common for businesses to state that an immediate response is required.

'I've got customers 24/7, so if there is rubbish and waste outside my doorway, it needs moving'.
(City Centre Car Park Manager)

'We will try and get it sorted [cleared up] as quickly as possible because the business can't lose any trade that day'.
(City Centre Management & Partnership Consultancy)

Therefore, many larger businesses have taken it upon themselves to train up staff to clear up DRL. This responsibility was typically assigned to security staff and/or facilities teams.

'We have somebody who … [will] come in at six o'clock [in the morning] … to make sure the area's clean and there's no alcohol bottles and needles and stuff like that lying about. … We don't want the customer to see any of that really. We want it to be nice and tidy, so that there's nothing there that shouldn't be'.
(City Centre Business)

'The environmental services, they are not available 24 hours a day. So, my staff, at three in the morning, at weekends, they can't leave this drug stuff there so, we've had to train them in how to deal with the drugs paraphernalia'.
(City Centre Business)

'A lot of big companies have got a facilities management team and one of their things will be to be trained in sharps disposal'.
(City Centre Management & Partnership Consultancy)

'The security staff have all been trained recently in how to deal with sharps and stuff. They have the tweezers, they have the sharps boxes and they have the bags as well. If it's a small quantity of drugs related litter, they'll sort it themselves. If it's a larger quantity, we ask our environmental services, within the [organisation], of dealing with waste.'
(City Centre Organisation)

However, beyond the large businesses, we identified that there is a clear need for training and guidance on how to handle, store and dispose of needles amongst SMEs, independent retailers and city centre residents. As this city centre management and partnership consultant asserts:

'From a practical point of view, people don't really know what to do with it'.
(City Centre Management & Partnership Consultancy)

This assertion was evident throughout the research in our conversations and interviews with business owners and residents.

'When you see needles and syringes, it's like, "Well I should sweep it up and do something with it", but I'm never sure what that something should be. I'm not sure that putting them in general waste bins on the street is an appropriate way, if you know what I mean? Whether that puts the bin men at risk. So, generally, I'll leave it'. (NQ Bar Owner)

'I can't remember any kind of public message or anything like that, that says, 'Here's what you do".
(City Centre Resident)

This lack of clear guidance combined with the frustration we have documented earlier in this section with the existing response has led city centre businesses and residents to take matters in to their own hands.

'People just use their own initiatives [to clear up DRL]. I mean they're not supposed to'.
(Local Councillor)

Furthermore, the collection of DRL was often undertaken with a lack of appropriate safety equipment (e.g. litter pickers, sharp bins), training and knowledge of where to safely dispose of DRL. During the research, we identified a number of unsafe practices such as not using litter pickers or sharp bins. We illustrate some of these health and safety issues below.

'We constantly ask residents to do litter picks, and we provide them with the equipment to do so, [but] we don't provide them with equipment to pick up drug related litter and if you're picking up litter in the city centre, you're going to pick up drug related litter'. (City Centre Councillor)

In the absence of sharp bins, residents reported using plastic bottles to store needles.

'What we do when we find them is get an empty bottle because there are lots of those around with a screw top and put them in that. We had one in our car for about two weeks waiting for someone to collect it.' (NQ Forum)

'We put them in a bottle and the street sweeper came round. I asked him if he had a sharps box. You would think they would but, no, he didn't. He said, "Give it to me" and before I could say anything he threw it in his trolley. They will take them but that isn't very safe either'. (NQ Forum)

On a positive note, it appears that some training already exists and is available to city centre businesses through the Business Crime Reduction Partnership which provides training and sharps bins.

'What we do have as well is we have a Business Crime Reduction Partnership. ... It's got a membership of retailers, hoteliers, property owners. ... They've all got sharps boxes. They're all trained to pick them up. If they're not, we will send someone who is. One of our businesses has offered to give free sharps disposal training amongst the partners'.
(City Centre Management & Partnership Consultancy)

However, there is a need for comparable training, including guidance on how and where to safely dispose of needles that incorporates the wider business community and city centre residents.

'I don't think everybody knows. I don't think people really know what to do. A few people have said, "I moved it" and I say "You shouldn't do that"'.
(City Centre Councillor)

'It's education, it's making people aware of it. ... Some more guidance and advice to individuals of what do you do if you find a needle'.
(Canal & Riverside Trust Volunteer)

'Concerned residents, and there are quite a lot of them, could literally ... be trained if needs be and dispose of these things themselves'.
(Local Councillor)

'Certainly there are different types of drug litter obviously but the most extreme being needles. People aren't necessarily au fait with how to dispose of things like that'.
(City Centre Management & Partnership Consultancy)

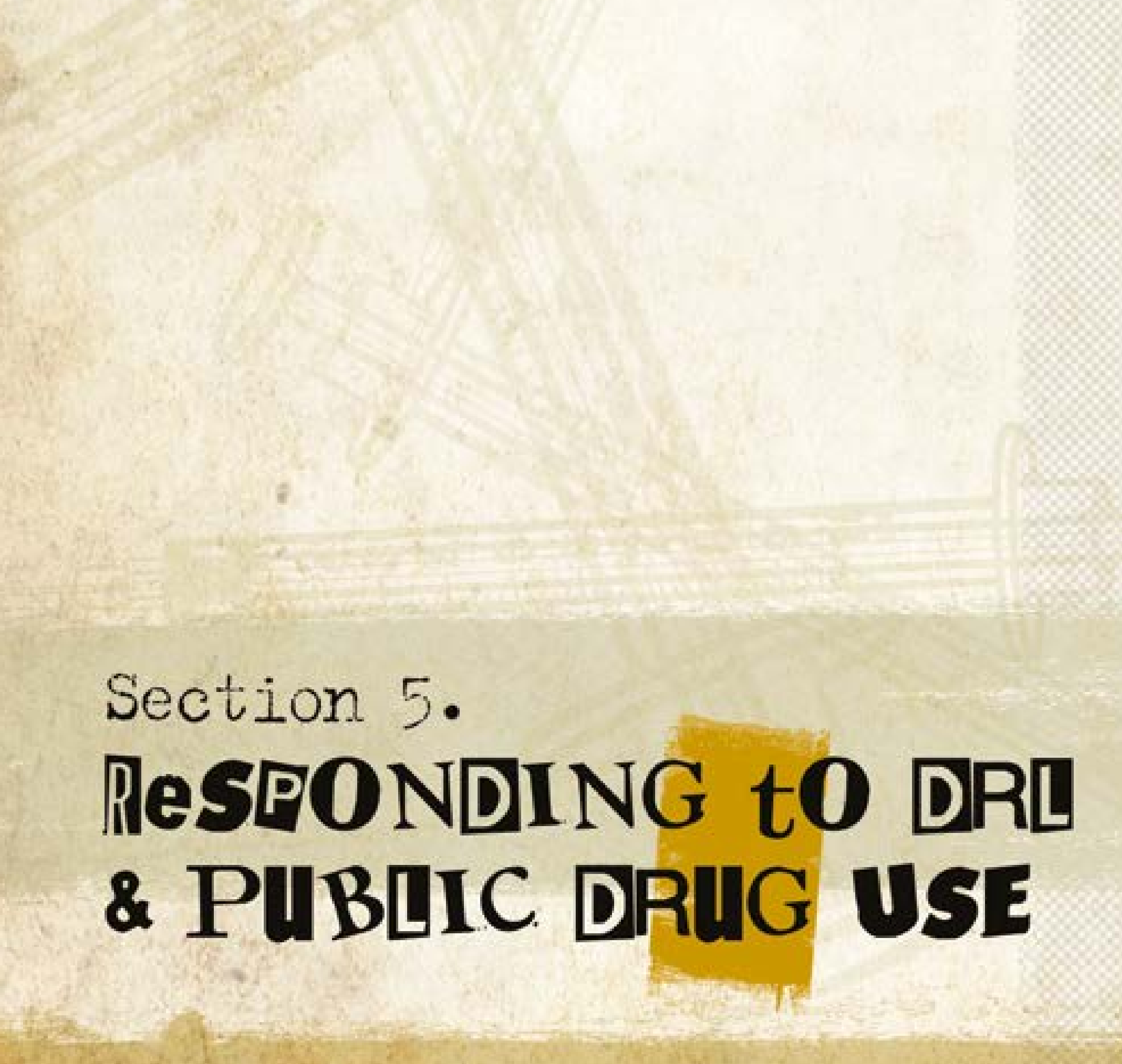
This lack of awareness of where to safely dispose led some residents reporting they stored them up for lengthy periods.

'I just keep them in the boot of my car'.
(Angel Meadows Resident)

'To be honest with you I've just been keeping them in my garage. I've got a big bin I've kept them in for what, ... probably two years or more now'.
(Angel Meadows Resident)

To summarise, the research process identified a number of concerns regarding the current processes in place to record, respond, remove and dispose of DRL in the city centre that need to be addressed. Recommendations on how to address these concerns are provided in Section 7.

In specific relation to sightings and recording, as this section has highlighted, the current official data is at best unreliable, and at worst, not fit for purpose. While we acknowledge that some duplication of the same DRL happens, we are much more inclined to view current figures on DRL as under-estimate. A recorded sighting of DRL could range from a single needle to multiple needles running into the hundreds. Our understanding of the current recording and removal processes in place is that the number of needles is not logged. When added to the finding that many residents, businesses, canal trust volunteers and even waste disposal operatives are routinely collecting DRL but not recording it, then we can only conclude that existing data on the scale of DRL in the city unreliable and on balance, does not reflect the true volume of DRL that is present in the city. Leaving the accuracy of existing data on DRL aside, we can assert with some certainty that sightings of DRL, along with sightings of drug users injecting in public places and spaces, has increased in recent years. With this in mind, in the next section we now turn our attention to the city's response to this visible increase.



Section 5.

Responding to DRL & Public Drug Use

5. Responding to DRL and public drug use

'What is the council's policy? Is it about deterring, is it about facilitating, or is it something in the middle? So is the policy 'this isn't acceptable and the last thing in the world we're going to do is put things in place to facilitate it', or is it 'these are vulnerable people and whilst we don't want it here we do want to make sure that they're safe".
(Waste Recycling and Street Cleansing Team)

5.1 Limitations of the existing response

In Section 4, we highlighted the frustrations of Manchester's city centre business and residential communities. Here we highlight the views expressed by professionals employed in the city centre neighbourhood team who voiced similar frustrations on the limited impact of the current response to DRL.

Many residents and members of the business community saw clearing up needles and other DRL as having limited impact. This view was acknowledged and endorsed by a range of professionals working in the city centre neighbourhood team. It was noted for example, that when needles had been removed, they quickly reappeared.

'It'll get cleaned and after a week there'd be about 100 needles, at least'.
(City Centre Neighbourhood Police)

As this police officer illustrates, neighbourhood teams were already aware of reported open injecting drug use or discarded needles.

'A lot of the times we'll get a complaint saying, "Oh, this and that" and it's like, "Right, well, we know that's a location, we know there's an issue there. We already patrol there". And that's your reply to the complainant. "Don't worry, we're aware of it, we've always been aware of it, we know what's going on there. It's part of the patrol plan"'.
(Neighbourhood Police Officer)

This response includes some proactive enforcement. Where hotspots were identified and the gathering of users was reported, banning orders have been issued.

'At the minute, in the pagodas [in Chinatown], we've got some ongoing actions with regard to the Community Impact Statement from some of the residents and businesses in terms of getting banning orders for people who are street drinking, using drugs in the pagoda'.
(City Centre Neighbourhood Team)

However, it was also common for police and city centre neighbourhood teams to acknowledge that they were often simply displacing the issue rather than addressing the root cause.

'We are just pushing around the problem from place to place. We get complaints about a group, a tent or something where people are using. We'll do the paperwork, go in, move them on and clear up the DRL, tents and other rubbish they leave behind. Then a few weeks later we get similar complaints they've set up under a bridge or back of a building somewhere and it's 'here we go again'! We're not solving anything and that's our main frustration'.
(City Centre Neighbourhood Team)

The existing response has clearly led to what could be described as 'a game of cat and mouse' of constantly moving the problem around the city rather than resolving it.

The policing response appears limited with police officers, city businesses and residents all expressing their frustrations with the current situation.

'One of the things that we found was, you get your callout, go there, you have to park on one of the ends to get into the park and walk to that corner. By the time you've got there, they've finished. If they see you coming, they can shoot up quickly or get rid or hide it, or whatever. So by the time you'd got to them they'd either finished or they'd covered up, or something'.
(North Manchester Police Officer)

It is clear from our research findings that alternatives to the current response are needed to address the current situation that research participants ubiquitously perceived as escalating. In the following sections in this section and in Section 6, we discuss a range of alternative responses that participants suggested during the course of the research.

5.2 Strategies to reduce DRL

'It seems to be a counter reaction. There's no proactive policy across the city. It's just a reaction to what comes next'.
(Green Quarter Resident Group Member)

As the above statement illustrates, there were frequent calls for a more proactive and innovative

response during interviews spanning residents, local councillors, businesses, treatment service and neighbourhood teams. In this section, we focus on the most frequently raised suggestions for improving the current response to tackling DRL in the city centre.

As documented in the previous section, there are limitations to the local authority remit regarding tackling DRL and drug use on private property. We commence this section with a focus on the main suggestions that respondents made for what the business sector and private property management companies can do to address DRL on private property before moving on to discuss proposals to improve the local authority response.

5.2.1 Designing out DRL

> *'I've worked with businesses in the city centre to try and design out the problem'.*
> (Manchester City Council Community Safety Manager)

The concept of designing out crime and situational crime prevention has gained popularity since its inception in the mid-1980s (*Clarke, 1983*). The basis of this approach is to make places less attractive to deviant individuals or groups to carry out their criminality or deviant activity in that area. Situational crime prevention (SCP) sets out to: *"Reduce crime via the management, design, or manipulation of the immediate environment in as systematic and permanent way as possible so as to reduce the opportunities for crime and increase its risks as perceived by a wide range of offender" (Clarke, 1983: 225*). Typical solutions involve the installation of alarms, bright lighting, and cutting back overgrown hedges and bushes. The absence of a guardian or form of control is also highlighted as a contributing factor and to this end, increased surveillance - either in the form of CCTV or physical security - is commonly championed.

SCP is underpinned by Rational Choice Perspectives e.g. Rational Choice Theory *(Cornish & Clarke, 1986)* or Routine Activities Theory (*Cohen & Felson, 1979)* and assumes people make informed and calculated decisions whether to commit an offence based on perceived risks/harms weighed against potential gains/pleasure. However, it is noted that an individual's ability to make a 'rational choice' can be undermined by things like drugs and alcohol (people may not have full cognition needed to perceive the risks) or IQ. Also, deviant behaviour can at times be spur-of-the-minute or ill-considered, and can be motivated by strong feelings or urges (e.g. punching someone, or injecting a drug that you've just picked up from a dealer) and so again rational decision making is likely to be undermined. Hence, there is a general criticism of assumed rationality. The ongoing debate is the degree to which a) crime is 'displaced', or b) benefits of SCP are 'diffused', known as the bonus effect *(see Guerette & Bowers, 2009).* In summary, displacement may be: temporal (simply doing the behaviour but at a different time); spatial (simply doing the behaviour in another place or part of the city centre); tactical (simply changing the mode of the behaviour, e.g. smoking heroin rather than injecting) or functional (change the 'crime type', so maybe using another drug such as spice). Despite these criticisms, SCP remains popular and in keeping with SCP techniques, all of the main interventions associated with SCP were routinely discussed during the fieldwork process.

In specific relation to tackling open drug use, a study by *Wood et al. (2004)* that focused on attempts to use SCP to control illicit drug use in Canada concluded:

> *'The effort to control illicit drug use did not alter the price of drugs or the frequency of use, nor did it encourage enrolment in methadone treatment programs. Several measures indicated displacement of injection drug use from the area of the crackdown into adjacent areas of the city, which has implications for both recruitment of new initiates into injection drug use and HIV prevention efforts'.* (Wood et al., 2004).

These findings echo the views expressed in section 5.1 by numerous members of the neighbourhood team around current practices and powers that are simply displacing the problem around the city centre. As outlined in the previous section, people who inject drugs in public places will simply be displaced and will relocate to a nearby building or open space. Furthermore, as discussed below, the use of security staff is limited in its utility.

> *'They're looking at maybe alarms, bright lights and if nothing works they're going to send a security guard. But even they have said that at times it is very difficult for them because there'll be four or five of them [users] and they're very aggressive. What good's one security man at three o'clock in the morning?'* (City Centre Business)

> *'They [the NCP car parks] are large buildings with many entrances and exits, so it's very difficult to police'.* (City Centre Car Park Manager)

> *'[I: And will there be instances where there will be one member of staff and then there will be a few of them?] Yes. Well, 90% of the time it will be one member of staff. [I: Does that create a problem?] Yes. Well, in the last two years we have had more staff assaults than we have ever had'.*
> (City Centre Car Park Manager)

In addition to SCP techniques, there was a call for an improved council response.

5.3 Improving the council response

So far, we have focused on crime prevention and neighbourhood policing interventions to address city centre street-based drug use and the DRL that ensues. As we noted in the previous sections, these policing methods are limited. In this section, we focus on a more public health orientated approach to how Manchester City Council could enhance the current offer for people who inject drugs. We begin this section with a focus on suggestions for improving existing needle exchange provision.

5.3.1 Needle and syringe provision

During the research process, participants – including those who inject drugs, treatment staff, police, residents, businesses, councillors and neighbourhood and waste disposal teams – all expressed their views in relation to existing needle and syringe programmes (NSPs) in the city centre. This section attempts to capture the discourse around needle exchange services and their perceived role in the DRL problem before documenting suggestions presented by research participants in relation to how the provision of needle exchange services in the city centre could be improved.

Best practice for NSPs in England is informed by NICE *(NICE Pathways, 2017), DEFRA (2005)* and UK guidelines on clinical management for drug misuse and drug dependence *(Department of Health, 2017*). Public Health England do not provide guidance on NSPs; the body defers to NICE guidance. Whereas NICE and UK guidelines on clinical management are recommended for all services, DEFRA guidance is applicable to local communities that face DRL problems[1], apart from when it is specifically referred to in NICE guidance. The current NICE guidance was first published in 2014, and then republished in 2017 as a NICE Pathway, which brought together all NICE guidance, quality standards and other NICE information on NSPs. Models of service delivery that NICE guidance refers to includes pharmacies, specialist programmes, other community settings, outreach settings, vending machines and secondary distribution. NICE do not recommend formal peer distribution schemes as there is a lack of evidence on the effectiveness in preventing risky injecting practices and encouraging people to use NSPs *(2014, p.59).*

In this section, we highlight the key debates that emerged during the research regarding local NSPs. We begin with a focus on the distribution of needles.

[1] DEFRA states that 'Where local communities face drug litter problems, local agencies should respond by following this advice wherever possible (p.2)'.

5.4 Needle exchange

NSPs were first officially piloted in 1987, in the wake of rising reports of HIV diagnosis across the UK. NSPs are now a widely offered and accepted intervention for reducing injecting-related harms. The service can be offered in a range of settings including pharmacies, fixed sites, outreach teams, sexual health services, hospitals, prisons, in detached settings or via secondary distribution and peer led distribution. The people who are likely to use an NSP are people who inject psychoactive drugs and image and performance enhancing drugs (IPEDs).

The 2017 Drug Strategy *(HM Government, 2017)* and UK guidelines on clinical management for drug misuse and drug dependence *(Department of Health, 2017)* both advise that the availability of injecting equipment through NSPs should be maintained. However, as the quote below illustrates, the consensus view of all the users and various stakeholders who took part in this research, is that the service offer for injecting users in the city centre has declined significantly in recent years.

While the nature of the research focus – DRL and open injecting drug use – has led to a focus on traditional injecting drug use populations, during the course of the research we were made aware of the loss of the dedicated 'Pump Clinic' sessions aimed at users of IPEDs. In light of current national evidence that we outline below on the rise in IPED use, we suggest close monitoring of IPED users engaging with current service provision and consideration of whether a more targeted response is necessary to meet the needs of this apparently increasing user group.

While the 'traditional' widely held view of those who utilise NSPs is intravenous opiate users, recent research has highlighted that a significant proportion of those who access needle exchanges are intravenous steroid users. Since the late 1980s, the use of IPEDs has increased significantly in the UK *(Antonopoulos & Hall, 2016; Bates & McVeigh, 2016; Begley et al., 2017; McVeigh & Begley, 2017)*. Once largely confined to professional athletes, IPED use has transcended the elite sporting arena and is now predominantly found among non-elite, recreational gym users *(Coomber et al., 2015; Hanley Santos & Coomber, 2017; McVeigh, Bates, & Chandler, 2015, p. 2; Van Hout & Kean, 2015)*. Estimates from the Crime Survey for England and Wales (CSEW) show that use of anabolic-androgenic steroids (AAS) – the most commonly used IPED – has increased from 170,000 in 2001/02 to 356,000 in 2016/17 *(Home Office, 2017). Further, as Begley et al. (2017)* note, the CSEW is likely to underestimate the actual number of users, with data from NSPs – which suggests that IPED use has grown at a more significant rate (see, for example, *McVeigh & Begley, 2017)* – being a more accurate predictor.

During the research, high levels of IPED users were reported.

> *'When I first worked in the needle exchange, that was the most shocking thing. I couldn't believe it was like say round about 50% heroin user and about 50% steroid use. I didn't realise it was actually that popular. I didn't realise that many people used steroids'.*
> (Treatment Service Outreach Team)

These individuals now frequently use a diverse range of substances concurrently *(Dodge & Hoagland, 2011; Sagoe et al., 2015)*. This includes: the 'stacking' of various AAS, with Testosterone Enanthate, Deca-Durabolin and Sustanon among the most popular varieties of AAS *(Antonopoulos & Hall, 2016; Bates & McVeigh, 2016; Kraska et al., 2010)*; the use of substances to enhance the muscle-building properties of AAS, such as human growth hormone (HGH) and insulin *(Kanayama & Pope, 2012; Kraska et al., 2010; Sagoe et al., 2015)*; and the use of substances to combat the negative side effects of AAS use, such as sildenafil (e.g. Viagra) to treat erectile dysfunction, benzodiazepines to improve sleep, and antioestrogens for conditions such as gynecomastia *(Hope et al., 2013; Jennings et al., 2014)*.

In addition to the above ancillary substance use, numerous studies have reported IPED users' concomitant use of illicit psychoactive substances (e.g. *Antonopoulos & Hall, 2016; Begley et al., 2017; McVeigh & Begley, 2017; Sagoe et al., 2015; Van de Ven et al., 2018)*. Since 2013, annual surveys into IPED use carried out by researchers at Liverpool John Moores University *(Bates & McVeigh, 2016; Begley et al., 2017; Chandler & McVeigh, 2014; McVeigh et al., 2015)* have continually demonstrated concomitant psychoactive substance use among their sample of IPED users. Findings from their most recent survey *(Begley et al., 2017, p. 20)* show that a third (33 per cent) of their sample had used cannabis within the past 12 months, a quarter (25 per cent) had used cocaine, with one in six (14 per cent) using ecstasy and one in 12 (seven per cent) had used amphetamine. Importantly, whilst rates of concomitant psychoactive substance use differ markedly between studies (e.g. *Hope et al., 2013; Jennings et al., 2014; Kanayama, Pope, Cohane, & Hudson, 2003; Sagoe et al., 2015)*, IPED users consistently appear to consume illicit recreational drugs at rates far in excess of general populations (e.g. *Broadfield, 2017; Substance Abuse and Mental Health Services Administration, 2017)*. Such diverse polydrug-using repertoires pose a number of risks to users (see *Begley et al., 2017)*, in particular potential adverse psychophysical effects from the chemical interactions from AAS-related polypharmacy *(Sagoe et al., 2015)*.

As touched on above, the stereotypical view that needle exchange services are primarily for intravenous opiate users has resulted in non-opiate using intravenous drug users feeling stigmatised. As evidenced in the first quote below, this tends to lead to steroid users picking up large numbers of needles for other users as well as themselves.

> *'[I: So [you are saying] a lot of the steroid users get massive amounts because the guys who they're supplying won't come?]. Yeah, they're too scared. They think they're going to get interrogated. They're massive blokes and they'll typically say, "Oh, do I look like a gearhead now, walking out of here?" It's like, "No, no, you don't. No-one would mistake you for a heroin user." But that's what's in their heads if they come to the needle exchange'.*
> (Needle Exchange Harm Reduction Worker)

> *'[I: So they imagine that they're going to be sat in a waiting room with a load of heroin users?] Yeah, and they feel weird about it. … If you go into a drugs service, you go to the reception and you're waiting to be seen and you might have a load of heroin users sat next to you. They can sometimes be a bit lairy and you're sat there, on your own, feeling a bit weird. So, it can put people at unease'.*
> (Needle Exchange Harm Reduction Worker)

As already highlighted above, having a single person picking needles for other intravenous users reduces the opportunity for staff to give out harm reduction advice and safe injecting information. This issue is exacerbated by the fact that steroid users have often been given poor or incorrect injecting information and advice.

> *'You give them [steroid users] stuff to make it sterile and all of a sudden, they're doing practices that are just a waste of time, it counter-acts what you've done for them'.* (Homeless Outreach Team)

> *'Some of the steroid injectors, especially the new ones, they'd have so much poor advice [about injecting], they could do themselves lifetime damage. … [But] they are the worst ones for taking the advice personally, "We know how to do it and we can do it", sort of thing'.*
> (Homeless Outreach Team)

> *'I'm worried about that. … Over the years, you hear more and more and more about insulin use because it's easy to get hold of and you can get fast results but it's dangerous in terms of how you use it. It's highly dangerous and if you get that wrong, you get it really wrong'.*
> (Needle Exchange Harm Reduction Worker)

In summary, UK evidence presents a picture of an increasing number of IPED users, coupled with high reported rates of polysubstance use. They often have poor injecting practices and receive inadequate advice. Although they do engage with services for needles, they often collect needles in bulk due to the stereotypes and stigma attached to treatment services. Taken together, this evidence points to the need for a targeted service that aims to increase engagement with this growing cohort of typically injecting IPED users. With this in mind, as we discuss in Section 7, we recommend a review of the existing service offer.

Returning to the traditional user group, the view that the service offer has declined was widespread.

> *'I think we had a lot better needle exchange facilities here a few years ago. So, I think the Lifeline needle exchange was very good and a treatment room in the back and a nursing staff there, very well managed and very little anti-social behaviour involved in a well-managed needle exchange'.* (Homeless Outreach Team)

Hence, there was a consistent call for the return of a city centre needle exchange to replace the previous Oldham Street location that closed in 2016.

> *'City centre needle provision, invest in it with a holistic care package. So, not just, "Here's some needles", but very much on the model which they used to have when Lifeline ran it'.*
> (Treatment Homeless Outreach Worker)

This notion that needle exchange provision is simply about handing out needles was a common misconception. As we note throughout section 5.4, PWID cited a number of benefits to using needle exchanges over pharmacies. Beyond this ill-informed understanding of what these services provide, we found a perception that needle exchange services give out too many needles.

> *'Just giving out needles like it's candy for Christmas or whatever it is, I can see why that provokes people and they think, "Are we facilitating this?"'*
> (City Centre Neighbourhood Team)

When discussing the volume of discarded needles, there was criticism of needle exchange provision for giving out what was perceived by some to be too many needles.

> *'If you give somebody 50 or 100 pins and they're homeless, what do you think they're gonna do with them? They won't carry them around'.*
> (City Centre Police Officer)

> *'We find them collapsed in here [car park] with a carrier bag full of needles all over the floor. What a waste that is'.* (Car Park Manager)

> *'I think they give out too many pins myself. I mean, I see it when I walk out of here me. You go down the canals, they've come in here [Ancoats NX], got their pins, gone to the nearest spot – under the canal bridge at the back there. They use then leave a box of needles they've just picked up'.* (IV Heroin User)

It is not advisable for there to be specific figures on how many needles and syringes should be provided as these figures will inevitably be somewhat arbitrary and would not make any allowance for individual differences in need *(Public Health England, 2017, p.25)* that affect amount of injecting equipment required at each visit. NICE guidance advises that dissemination should be tailored to the individual and should meet their needs *(NICE Pathways, 2017)*. No UK or international guidance indicates that access to injecting equipment should be limited to encourage regular NSP attendance. However, as the following quotes demonstrate, the research revealed concerns around the apparent disparity around the high volume of needles issued and the apparent low rates of returns.

5.4.1 Low rates of needle returns

> *'We had a meeting, a few years ago, with a needle exchange on Oldham Street. ... They told us their stats about how many needles that they get back. We were quite shocked at how little they get back, considering the amount they give out'.*
> (City Centre Car Park Manager)

> *'[drugs service] don't work hard enough to get the needles back. They [CGL] should lay down the ground rules and say, "You're not bringing your needles back, so you're not getting anymore"'.*
> (Manchester City Council Community Safety Manager)

This view of the need for a stricter model of needle exchange (NX) was also called for by many of the PWID that we surveyed. As we illustrate below, it was frequently suggested that NX services should offer a 'one-for-one' NX service.

> *'It should be noted down how many needles they have, and if they don't bring them back they should not get any'.* (IV Heroin and Crack User)

> *'They should make a rule where you can't have any [needles] without old pins'.* (IV Heroin User)

> *'Don't give needles out if they're not returning any'.*
> (ID 72)

Despite these assertions from both users and other stakeholders, it should be noted that UK and international guidance does not recommend that the receipt of sterile needles should be conditional on the return of used injecting equipment *(Strike et al., 2006; Scottish Government, 2010; Welsh Government, 2011; NICE Pathways, 2017; Public Health Agency and Health and Social Care Board, 2017)*. The rationale behind this guidance is that there is a greater risk of BBV transmission through shared needles, rather than through needle stick injuries, as a larger quantity of blood passes through the needle, with estimations showing that the amount of blood passed on through a needle stick injury is 1/7 of that passed on through syringe sharing *(Gaughwin et al., 1991*). Therefore, priority is given to coverage of sterile injecting equipment, rather than return of used equipment. Nevertheless, whilst it is poor practice to limit the provision of sterile injecting equipment if injectors are not returning used equipment, it is good practice to encourage returns *(DEFRA, 2005)*. That being said, although international and UK returns rates have been monitored *(Ksobiech, 2004)*, there is no clear guidance on what a desirable level of return would be, or what would be a minimum acceptable level of return.

Nonetheless, there were a number of practical suggestions put forward in the research that could be considered in order to encourage higher return rates. These recommendations focused on actions such as, better communication between NX workers and service users, but primarily, on NX location and opening times. The following section highlights existing good practice alongside our research findings in relation to ways to improve returns and reduce DRL.

5.4.2 Improving return rates

There are a number of examples of actions implemented in other UK regions, which have been successful in encouraging higher return rates. A project summary published by the 'Scottish Community Safety Network', details the response to an increase in reports of DRL being found in public places in close proximity to NSPs. A consultation with service users of NSPs identified that education/prevention were the most ideal and sustainable solutions. Actions taken were to attach stickers designed by service users to the outside of injecting equipment packs with key messages regarding the safe disposal of injecting equipment. Posters with safe disposal messaging, designed by service users, were displayed prominently in identified hotspots, such as public toilets. The project was advertised through poster campaigns in specified venues, peer networks and through the dissemination of information at the Scottish Borders Needle Exchange Network *(Scottish Community Safety Network, 2012).* The project saw a 57 per cent reduction in discarded sharps across the Scottish Borders.

Similar calls for better advertising around NX and service provision were made during surveys and interviews with PWID in Manchester.

> *'They need to be advertising services more and providing more accessible sin bins'.* (ID 29)

> *'Do you know what, I think with some of them it's ignorance, they don't know where to return and they are not told about where they can take them'.* (ID 54)

> *'They should have a big sign in pharmacies, so you know where you can return your pins'.* (ID 12)

The need for making better use of city centre pharmacies for returns was often noted in surveys and interviews with PWID.

> *'Chemists should provide sharp bins and NX services'.* (ID 27)

> *'Chemists should take returns'.* (ID 45)

> *'I wish all pharmacies did NX'.* (ID 22)

> *'I think what could be improved is more chemists taking bins and providing and changing it because sometimes people need it'.*
> (IV Heroin and Crack User)

However, we were often informed that many pharmacies did provide a facility to accept discarded needles.

> *'Most pharmacists will accept them'.*
> (Waste Collection General Manager)

> *'You can take it into the local chemist and they will dispose of needles. People probably aren't aware of that'.* (Canal and Riverside Trust Volunteer)

> *[I: So even if a pharmacy doesn't give out needles, it will dispose of used needles?] As I understand it, yes'.* (Canal and Riverside Trust Volunteer)

> *'A lot of pharmacies do have needles exchanges anyway now'.* (Homelessness Outreach Team)

Nevertheless, as we illustrate above, this was not always common knowledge amongst residents or PWID with needles to dispose.

> *'Chemists should have a recognisable sign saying they do NX. Pharmacies should take used needles - at the moment they're not doing an exchange'.*
> (ID 67)

As this injecting drug user notes, even though pharmacies will often display a sign indicating they provide a NX service, users are unaware of this or, as we outline in section 5.4.7, are put off by concerns that they will be looked down upon for doing so.

> *'They [users] would need to know what the sign means and know the chemist does supply needle exchange, it does take bins and doesn't discriminate'.* (IV Heroin User)

We also came across many experienced staff who work closely with PWID and people with street-based lifestyles who also appeared unclear on the current set-up for pharmacies that accept used needles.

> *'We used to have quite a few pharmacies that would give out needles, and you could take them back. I don't know how many of those do that these days'.* (Homelessness Outreach Team)

As we note throughout this section (see for example, 5.4.5 & 5.4.6), ensuring awareness of existing services where users can access and safely dispose of needles is imperative. The transient nature of this user group – who include rough sleepers from other areas – means that many will be unfamiliar with the local service offer. We discuss the need for more awareness raising in the recommendations section (Section 7) of this report.

Section 1.1 of the DEFRA guidance provides suggestions on how NSPs can encourage returns. DEFRA advise that commissioners could introduce incentives schemes to encourage returns rates. They cite a survey of pharmacists in the South of England identified that highlights 'returns rates are significantly higher where returns are actively pursued by pharmacists, who should therefore be encouraged to remind clients to bring back their used equipment' *(Sheridan et al., 2002:1558)*. It was clear during our time spent in needle exchanges that PWID were actively encouraged to return needles. This included verbal encouragement alongside signs and posters encouraging returns.

The survey responses from PWID in relation to their current needle disposal practices are outlined below.

5.4.3 Disposal of needles

Of the 110 PWID that completed our survey, 70 per cent reported using the needle exchange provision to dispose of used needles. Only 10 per cent stated they used pharmacies and worryingly, 10 per cent stated they disposed of used needles in public rubbish bins. This was almost double the number who stated they used public sharps bins (e.g. in hostels) (six per cent). Others reported using large street waste bins, kitchen bins in their home, hostel or supported accommodation. Other methods of disposal included burning them, putting them down drains or giving them directly to their GP, hostel staff or street cleaners. As we note in section 5.4.2 above, the underuse of pharmacies appears partly explained by users being unaware that many pharmacies accept used needles. Furthermore, those who used public or household bins often reported that they did not like to have a sharps bin in their hostel or that they did not like carrying sharps bins and used needles around on their person. These findings regarding a reluctance to use their own sharps bin offers further support for the potential benefits of installing sharps bins in the city centre that we discuss in section 5.5.

5.4.4 Improvements to the existing service offer

Over a quarter (26 per cent) of PWID who completed our survey stated the need for a more convenient location. Suggestions provided included a more central city centre location and specifically, Oldham Street, Piccadilly and the 'gay village' were mentioned. A fifth (20 per cent) called for better opening times. One in 10 called for a safe injecting space. A better choice of drug paraphernalia was requested by just under 10 per cent (nine per cent) of respondents. We discuss the views of PWID and other stakeholders in more detail in the following sections.

5.4.5 Opening times

> *'My take on service users is that you need to be at a convenient place and open a lot'.*
> (Needle Exchange Harm Reduction Worker)

DEFRA advise that longer, more flexible NSP opening times can provide more opportunities for safe disposal. In addition, information can be given out about NSP opening times, including a map of facilities to aid those with poor literacy skills. Information of available faculties can be posted outside premises, so users can be re directed when they are shut. Fixed sharp bins can also be provided outside the service, along with a notice of available facilities to facilitate safe disposal when the service is closed. In line with DEFRA guidance, we were informed of extended provision beyond Monday 9 to 5 in the city centre.

> *'We are open five days a week. It's five afternoons a week. Monday is now 3:00 pm to 6:00 pm. On Tuesday, Wednesday, Thursday and Friday we are open from 12:30 pm to 3:30 pm. We then open two evenings a week on every Wednesday and Thursday evening until 11 o'clock at night. That vehicle goes out four nights a week from 8:00 pm until midnight. That's also quite unique. If you look around the country most outreaches finish at about 10:00 pm'.*
> (City Centre Street Health Manager)

'We open late nights in the week and at the weekend'.
(Needle Exchange Harm Reduction Worker)

However, despite this extended service offer we found clear evidence of users being unaware of service provision beyond Monday to Friday 9 to 5.

'[I: So you think there needs to be more places open at the weekend?] Yes, for the weekends. Centres like this [Ancoats NX], like the Zion, they're open every day of the week but not Saturday and Sunday'.
(IV Heroin and Crack User)

'If they could open on a Sunday for, like, two hours or something or an hour?' (IV Heroin and Crack User)

The above statements were taken from two PWID interviewed at the Ancoats needle exchange. This service does offer extended opening times, including evenings and weekends. As we discuss further in this section and in section 5.4.6, it was striking how many PWID that we spoke to during the course of the research were unaware of the service offer across the city. In addition to the lack of knowledge of extended evening and weekend opening times, many people we spoke to during outreach or at services were only aware of the Ancoats provision.

'It's the only place I know'. (ID 3)

'I don't know anywhere else to be honest.' (ID 42)

A couple called for needle exchanges services where they already exist.

'We need one in Hulme'. (ID 59)

'They're not happy that we're not open on Saturday, we don't open at the weekends. ... I mean that's one of the things I think that they're saying you know, some of them don't know where the needle exchanges are'. (Pharmacist 2)

Others called for more late night or early morning opening times.

'You need an exchange in the city centre ... that is accessible for quite long hours. ... People sleep all day and beg at night. If that's what they do, they are missing all services. If they're out at night, where do they get their stuff?'
(Homelessness Outreach Team)

'You need them open 24/7 ideally. You can't turn your rattle off!' (IV Heroin User)

'Not enough NX open, there's times when they're all closed'. (ID 76)

Calls for a 24/7 needle exchange service were also made by practitioners with the chemsex cohort.

'That's one thing that come up with the chemsex, ... people saying there needs to be extended hours and it needs to be 24/7'.
(Treatment Service Outreach Team)

As we highlight below, there is a need to ensure users are aware of existing provision. This is particularly important when working with the homeless community who are likely to be a transient population, often coming from other areas into the city centre and therefore less likely to be aware of existing service provision. During our outreach, the lack of knowledge around needle exchange provision was evident.

'Communication is definitely a development area, I think. Some people don't even know that the [chemsex] services exist'.
(LGBT Substance Use Worker)

This ranged from a lack of knowledge of Ancoats or Carnarvon Street NX services through to a lack of knowledge of where needles could be returned.

These fieldnotes, taken after a Monday morning outreach session, illustrate the consequences of this lack of awareness of weekend opening times and NSP.

We went checking on the small side street at the back of Smithfield Market Buildings off High Street where we had found DRL before. As we took some pictures and moved some large waste bins to look for the extent of the DRL, a chef came out of the cafe to smoke a cig. She talked about how they constantly find needles and report them. She said it is a daily occurrence, some days are worse than others. I asked if it was at night and she said it was 'all day long'. I asked if the needles were cleaned up within 24 hours as per the BIFFA contract and she said sometimes it can take three or four days. She said she would like to see a regular daily clean-up of the area as it is such a regular occurrence and they report it so often it should be part of the city centre clean up routine. She also discussed regularly seeing open drug dealing there. As I was talking to her and taking another picture, a male in his mid-30s walked over and picked up one of the used needles discarded on the floor and a spoon. I told him what I was doing there and he said, 'let me get myself sorted out and I'll talk to you'. He walked over to a step and started to sort his drugs out. Two minutes later he came back over, this time looking for some citric. He picked up a used wrapper and walked back to the steps calling back that it was Monday, so he had run out of needles, filters and other paraphernalia and

that he was going to go over to Ancoats to get some more needles and filters later. He said again that he would speak to us when he had sorted himself out. A few minutes later, I went over and spoke to him. He said he was using discarded needles because the needle exchange wasn't open at the weekends, so he had run out (It actually is!) and because there isn't a convenient city centre needle exchange. He said NX's should be open until 'at least 10pm' every day.
(Fieldwork notes, Monday 26th February 2018)

This example demonstrates how a lack of knowledge regarding opening times can lead to risky, unhygienic injecting practices. The lack of a city centre location to obtain needles and other drug using paraphernalia was also stated as a contributing factor in his reuse of equipment. The call he makes for the return of a city centre NX, was one of the most frequently expressed ways of improving NSP in the city during our research. We highlight the repeated calls for a more centrally located needle exchange service below.

5.4.6 Location

'I think it's crazy that here we are in Manchester and we've only got one official needle exchange point and it's not actually in the city centre.'
(Canal and Riverside Trust Volunteer)

In order to encourage safe disposal of needles and to reduce DRL, upholding DEFRA *(2005)* recommendations and to meet government recommendations concerning availability of injecting equipment, as set out in the 2017 Drug Strategy *(HM Government, 2017)* and UK guidelines on clinical management for drug misuse and drug dependence *(Department of Health, 2017)*, the location of needle exchanges is an important consideration. As the statements below from a range of stakeholders illustrates, a central city centre NX was frequently called for.

'There used to be a lot of places in Manchester, needle exchanges. So, you had one on Oldham Street, about 200 yards away. You had this one [Ancoats], so you had two right in the city centre'.
(IV Heroin User)

'I'd like to see a clean needle exchange open back up in the city centre'. (City Centre Councillor)

'You need an exchange in the city centre that is accessible for quite long hours'.
(Homelessness Outreach Team)

'Having a needle exchange in the City Centre is an obvious thing to have'.
(Treatment Homeless Outreach Worker)

'One on Oldham Street again is easier [to get to]'.
(ID 62)

During interviews with PWID, it was noted that the practice of sharing needles was common.

'A lot of people do use dirty needles and it's not good. I've met people with Hep C and Hep B and sadly, HIV. I do know people around me that use dirty works and do share dirty works'.
(IV Heroin and Crack User)

The loss of a more central needle exchange provision was viewed as contributing to this sharing practice. Therefore, the re-establishment of a city centre NX was viewed as one way of reducing this practice by PWIDs.

'There should be a city centre needle exchange again. I mean people only come here [to Ancoats Clinic] if they are around this area. A city centre needle exchange would stop people using used needles'. (IV Heroin and Crack User)

The relocation of the needle exchange (from the more central Oldham Street site to Carnarvon Street) was attributed by some as a reason why DRL had seemingly increased in recent years. Even though the current Carnarvon Street and Ancoats needle exchange services are close to the city centre and accessible by public transport (train stations and metro stops), they were far enough away to be viewed as having a negative impact on levels of returns.

'[In] the needle exchange on Oldham Street, … the staff were actually very good at telling people to bring back the returns. I think it's got worse since [the Oldham Street NX has closed]'. (Local Councillor)

Indeed, even residents suggested that a more central NX provision would encourage them to return discarded needles.

'I would be more inclined to pick up a needle with my litter picker and gloves and put it in a receptacle if I knew I could go round the corner and hand it in somewhere'. (NQ Forum)

Furthermore, as the quotes below highlight, a commonly expressed feeling was that the relocation of the Oldham Street NX to Carnarvon Street on the outskirts of the city centre, had led to less contact with users, which resulted in less opportunity for NX staff to deliver harm reduction advice and to monitor the health of users.

'I think ours, it's a bit out the city centre, I think people are coming in and getting [needles in] bulk and getting it for other people as well. So, it doesn't seem as busy as it did on Oldham Street'.
(Treatment Service Outreach and Needle Exchange and Harm Reduction Worker)

'Really, we're just slightly too far out for easy access, and Oldham Street was an ideal sort of place'. (Needle Exchange Harm Reduction Worker)

'The beauty of having it on Oldham Street was you didn't have to carry a lot of pins with you. You could get ten and then come back later and get another ten and sometimes you'd see the same person three times a day, every day'. (Needle Exchange Harm Reduction Worker)

'Just having to walk up here or you know, make a journey. It's like a lad who come in the other day, he's like, "Oh I've got to make an effort to get up here, so I'll get what I need", but I won't see him again for a week or two. Whereas when I worked at Oldham Street he's in three times a day'. (Needle Exchange Harm Reduction Worker)

According to *NICE (2014)*, the primary purpose of NSPs is to reduce the transmission of BBVs and other infections by providing sterile injecting equipment. However, the secondary purpose is to provide advice targeted towards minimising the harms caused by drugs, helping individuals to stop using drugs, providing access to drug treatment (for example, opioid substitution therapy) and facilitating access to other health and welfare services. The documented loss of regular contact with injecting users described above by several NX staff as a direct consequence of users having to travel to the outskirts of the city centre is a concern in terms of the reduction in opportunities to deliver harm reduction advice and to engage users into treatment.

'They used to come in [to Oldham Street] and it was the same faces and it's also better because you can do welfare checks on people. So, they're coming in, multiple times in a day, rather than you haven't seen that gentleman now, because for the last two weeks because he only comes down when he gets a taxi on payday'. (Homelessness Outreach Team)

'The needle exchange they did have in the city centre was, it was a holistic needle exchange centre, as well. Because it had consulting rooms, they had clinics there. They had nurses there giving proper advice about, you know, safer injecting practice. So it was not just run [in] and get your needles. [Instead it was] let's get you involved with other services'. (Treatment Homeless Outreach Worker)

The impact this has on both user engagement and needle returns is further outlined below.

'If you are getting one person who's going to go and get a few hundred from Urban Village, then that's taking [away] a load of people who would have come in for advice. ... And, they won't get hundreds returned'. (Treatment Homeless Outreach Worker)

PWID obtaining needles from other users was also cited as contributing to discarded needles and low return rates.

'Not getting their needles from an NX, instead pharmacy and friends so they won't return them'. (ID 19)

Indeed, obtaining needles for others appears common practice with just over half (51 per cent) of those surveyed stating that they obtained needles for other people. This was most commonly for one or two other users. Three respondents we spoke to during outreach stated that they did not engage with any pharmacies or NX services, preferring instead to access needles from other users, stating: '*I get my needles from other users*' or *'I use whatever others can spare really*'.

The lack of a central city centre NX was viewed as encouraging users to collect more needles than they would previously have obtained and indeed, more than they could feasibly carry on their person. As noted above, this was often viewed as leading to a reduced level of engagement with services and also a cause of large amounts of discarded needles. The below quotes from interviews with injecting drug users further highlights this issue.

'You see it here under the canal bridges, people will come here and pick up a box or two and then go straight away and use under the canal bridges. They just leave the rest of them all over the place. It's a waste it really is. If they could access a city centre service, they wouldn't have to pick up so many'. (IV Heroin User)

'[I: Do you think that's made a difference, then, shutting that down [Oldham Street NX]?] The one in the City Centre, yes because they've all got to come here [Ancoats Needle Exchange] and they think coming here's too far. So, they've got to get more, here, so that they don't have to keep coming out of town, here, backwards and forwards. So, they get a big box and a big box is going to go all over the floor. So, then they come for another big box, the next day, and so on and so on. So, in a week, you've lost 7,000 needles and they only need eight'. (IV Heroin and Crack User)

'We need more city centre needle exchanges'. (ID 29)

Despite the frequently expressed need for more city centre provision, many stakeholders were pessimistic at the prospects of this happening. A local councillor provided support for these pessimistic stakeholder views.

'People didn't like the drug and alcohol support services being in the city centre, even though they were here first before many residents were'. (City Centre Councillor)

This highlights the tension that exists around the need for PWID to have accessible service in the heart of the city centre and its redevelopment and increasing desirable real estate. We discuss this further in Section 6.

In light of this perceived resistance, the use of city centre pharmacies to provide additional NX facilities was mentioned as an alternative to any new treatment provider-managed city centre NX provision.

'Yes, that's on Oxford Street, so they could probably set that [free NX] up fairly straightforwardly if they were funded to do that, I would have thought. That's where most of our, that and Boots, most of the people we work with, will get their methadone from [Yes, so they go in there anyway] Yes, they'll all be going there anyway'. (Homelessness Outreach Team)

However, as we highlight in section 5.4.8, PWID have a strong preference for a more discreet, supportive and non-judgemental needle and syringe provision setting.

5.4.7 Views on NX and pharmacy provision

'The other ones need to be like Ancoats - full range of services, opening times, equipment'. (ID 88)

The research uncovered a clear preference amongst PWID for NX provision over pharmacies. The most commonly used needle provision was the Ancoats NX with over three quarters (77 per cent) of survey respondents accessing this service. The next most commonly used NX service was Carnarvon Street with just under a third (30 per cent) of respondents accessing this service. Less than one in six (15 per cent) reported obtaining needles from pharmacies. There were a range of reasons provided by users for why they preferred the dedicated NXs to pharmacies. The following sections provide more detail on these survey responses in relation to the reasons for using particular needle and syringe provision.

During the research, we were made aware of complaints from a local school and kinder garden regarding discarded needles close to the respective premises. As we note in this section, it was common for the emotive example of the risk of a child picking up a used needle and the inherent risk of BBVs to be raised as a key public health concern.

'You shouldn't be locating a needle exchange in a residential area, next to a nursery or next to or near a primary school'. (New Islington Resident)

The high volume of DRL around the Ancoats and New Islington area, and in particular the reported DRL and open injecting drug use on the canals and around residential land that we documented in sections 3.2 and 3.5, led some to suggest that the Ancoats needle and syringe provision was part of the problem rather than a solution.

'Please don't put a needle exchange in a growing residential area which is 100% residential'. (New Islington Resident)

With this objection to this service in mind, it is imperative to highlight the overwhelmingly positive reports that we received throughout the research on the service provided by CGL at Ancoats by PWID. The Ancoats clinic was reported by over two thirds (66 per cent) of the respondents as the main place where they obtained needles and other drug paraphernalia. Over two-thirds (67 per cent) of PWID who reported Ancoats as their primary site for needles and other drug paraphernalia stated its convenient location as the reason they used this NX. In terms of other reasons, over a third (34 per cent) cited the opening times, just under a quarter (22 per cent) cited the choice of needles, 15 per cent cited the available injecting advice, and around one in 10 (nine per cent) the range of wider paraphernalia available.

5.4.8 One Stop Shop

The survey respondents and PWID that we interviewed often noted the convenience of having all services co-located in the same premises.

'I know Gary and Eddie, [they] are very approachable, and it [the location] is private, my doctor is here, and I come here anyway for my leg ulcer so it's easy to just pop upstairs [to the needle exchange service]'. (IV Heroin User)

'My GP is here so it's just really handy'. (ID 61)

'I'm always here anyway to see my GP or have my leg ulcer and dressing checked over so I just pop-up, it's dead handy'. (IV Heroin and Crack User)

In addition to clear benefits of having a range of medical services under one roof, the PWID that we surveyed consistently praised the quality of the service they received. The following free text survey comments represent only a fraction of the positive feedback on this service. In contrast to user's views on their experiences of local pharmacies, they reported a much more positive experience of their engagement with staff at the Ancoats needle exchange provision.

'I come here because the staff are friendly'. (ID 32)

'You can have a chat with the staff, excellent customer service'. (ID 81)

'I get on with the staff'. (ID 87)

'I like the staff - Gary and Eddie'. (ID 102)

'I like the service, staff are good, engaging, talkative'. (ID 25)

'I have a good relationship with advisors Ed and Gaz'. (ID 27)

'It's a good service, I feel secure coming here and they are friendly'. (ID 92)

While we received a wide range of very positive comments in relation to the NX staff and service, a recurring theme centred on the non-judgemental attitude of the staff.

'The staff are non-judgemental'. (ID 6)

'I'm not judged going to Ancoats'. (ID 13)

'The staff here don't judge you and they know their stuff'. (ID 77)

'I am treated like a person here - good staff'. (ID 89)

'We need more staff like at Ancoats - they don't judge'. (ID 16)

This was often contrasted with the user perception of how they are viewed by pharmacy staff.

'Good attitude of staff – they don't judge or look down on you like scum. That's what you feel like in the chemists'. (ID 73)

'Chemists aren't very open minded or compassionate'. (ID 70)

'Chemists are discriminatory and stereotyping'. (ID 58)

'The staff can be a stuck-up. They leave you waiting a lot longer than is necessary. We are society's punch bags so if they are having a bad day they take it out on us'. (IV Heroin and Crack User)

NX staff also noted the lack of compassion and understanding that PWID receive from pharmacy staff.

'[In pharmacies] you get staff that don't understand'.
(Needle Exchange Harm Reduction Worker)

In addition to contrasting staff attitudes and knowledge, favourable comparisons were also drawn in relation to the more discreet and private experience of the NX compared with the pharmacy environment.

'It's private, not like a chemist where you've got a shop full of people knowing your business. A lot of people won't use a chemist because of that'. (ID 11)

'I don't like pharmacies, ... it isn't discreet. You don't want people knowing your business, do you?'
(IV Heroin and Crack User)

'It's discreet, supportive, more than anywhere else'. (ID 19)

It is evident that users need an environment where they feel secure where they will not be judged or looked down upon – whether this is by staff or the general public. Concerns about being stigmatised were evident in many ways, for example, PWID also commented on not liking the fact that needles were given out in black plastic carrier bags.

'I don't like the black bags everywhere - everyone knows what it is'. (ID 54)

Several pharmacists noted the shame and stigma felt by PWID as a barrier for PWID accessing needles through pharmacies.

'I mean sometimes I do say to them, "Are you sure you only want the one?" And they're like, sometimes they're embarrassed to ask for more. Sometimes I go, "Do you know what, there's an extra packet"'.
(Pharmacist 4)

'I've spoken to a couple of the people that come in and they've said basically what it is, they're ashamed to come in, so they send the same person, the same one person would come in on Monday, get five packets, they'll come in on Wednesday and get three, they'll come in on Friday and get two because there are people that are ashamed of what they do'. (Pharmacist 1)

'If you've got a shop full of people, they don't like to come in, and some of them do actually wait outside or they just come and sit quietly in the corner'.
(Pharmacist 5)

In addition to the positive experiences regarding the non-judgemental service, the knowledge of the staff at the Ancoats NX was frequently commented upon.

'The staff know what they're doing and they don't judge'. (ID 98)

'Friendly staff, not judgemental and they give you good advice.' (ID 74)

'Staff knowledge, they know what they are talking about'. (ID 85)

In contrast, pharmacists acknowledged their lack of up-to-date injecting advice.

'Updates, training, that's so important. Which we never get'. (Pharmacist 4)

Other stakeholders raised the lack of safe injecting advice provided by pharmacy staff as an issue.

'These pharmacies, if they are going to be on board in terms of dishing out methadone, dishing out clean works, they should be able to give advice on that, and they should be taking them [needles] back'.
(Homelessness Outreach Team)

5.4.9 Range of needles and other drug paraphernalia

Rather than just provide needles and syringes, NICE guidance recommends that services provide 'injecting equipment', which can include swabs; utensils for the preparation of a controlled drug (that would include articles such as spoons, bowls, cups, dishes; acidifiers; filters; ampoules of water for injection *(Home Office, 2003)* and foil *(Home Office, 2013)*.

PWID also preferred the choice of needles and wider drug paraphernalia on offer at the NXs compared to pharmacies.

'Better quality service at Ancoats - chemists try and get rid of you quickly and they don't give you water and swabs, just pins and bins'. (ID 30)

It was frequently noted during surveys with PWID that chemists have a limited range of needles.

'Choice of needles here [Ancoats NX] is better than a chemist'. (ID 13)

'Pharmacies should have the full range'. (ID 37)

'A better range of equipment in pharmacy locations'.
(ID 88)

It was often stated during the research that pharmacies only provide the one size.

'Chemists just do Insulin needles - I like the longer ones'. (ID 22)

'[I: So, what do they get from a pharmacy then?] They only get one mls, no citric. ... And it's no good for steroid use'.
(Needle Exchange Harm Reduction Worker)

These shorter needles are inappropriate for groin injection and present the risk to users, as this experienced treatment service homeless outreach worker explains.

'So, basically, you need to have a needle which is long enough to get into your groin vein, but which, so your barrel's not touching your skin. As soon as the barrel starts touching your skin, it's like, you get more prone to infection, because the barrel bits not as sterile as the needle. So, they should be using either 1ml, 2ml barrels. Then it's a choice but they should either be using long orange or blue needles, which are longer. I mean, one of the arguments is the long orange are thinner, so they could snap. Whereas the other argument is the blues are too thick and can cause... I mean, groin injecting is not great. But it's things like that. You know, which I don't think are openly discussed with a lot of people. It will be at the Ancoats one because it's a day to day needle exchange and it's away from the main building. But I don't believe that will be happening all the time at the other needle exchanges. And, I don't think those conversations will be had at all in chemists. That's the problem with them. It's a bolt on [service] for a pharmacist'.
(Treatment Homeless Outreach Worker)

The pharmacy provision was also criticised by NX staff.

'Our pharmacy coverage is rubbish. They don't give out the right amount of stuff'.
(Needle Exchange Harm Reduction Worker)

The number of needles that users could access from the NXs in comparison to what was obtainable from pharmacies, was a further reason why users chose not to engage with pharmacies.

'Chemists only give you five packs at a time whereas there is no limit on packs here [Ancoats NX]'.
(IV Heroin User)

The limitations of needle choice and wider drug paraphernalia was acknowledged by pharmacy staff we interviewed.

'We do get asked a lot for the bags, you know for the main things [paraphernalia], which we don't do'.
(Pharmacist 2)

There was also disproval of the fact that some (unspecified) pharmacies charge what were considered inflated prices that are prohibitive for PWID with limited finances.

'They [pharmacies] will sell you it but at extortionate prices, you know like 50p for a syringe or something that's ridiculous like that. But because it's a late-night chemist, the people go there in desperation'.
(Needle Exchange Harm Reduction Worker)

'They do give out pins, but you have to pay for them. Paying, it's just pointless, you shouldn't have to pay for them'. (Homelessness Outreach Team)

While the user satisfaction with the NX services was certainly noteworthy and important to document, there were a number of suggestions made to improve the current offer by PWID and other stakeholders.

5.4.10 Needle provision

This section looks at a range of issues related to needle provision raised during the research. In particular: the size of needles that are being issued by NXs and pharmacies in the city; the availability of coloured needles; the quality of the needles being issued; the number of needles being issued; and, the contentious question of whether or not the number of needles given out should be limited.

5.4.11 Size of needles

As we noted in section 5.4.9, NXs were able to provide a wide range of needles and syringe options, whilst most, if not all pharmacies only supplied a single size (1.0 inch).

'[I: Do you get a good range of different sizes?] Half amps [inches] and one amps [inches]'.
(Needle Exchange User)

'[I: Users are telling us that pharmacies only offer one size needles?] Yes 1 mil'. (Pharmacist 3)

'[I: Do you get asked for smaller or larger needles for things like steroids use?] We do. But obviously, we don't supply them'. (Pharmacist 5)

The evident lack of choice available at some pharmacies raises health implications of using needles that are not appropriate for their purpose. For example, guidance advocates not using 1.0-inch needles for groin injecting.

'[I: All of the needles I have seen are these 1.0-inch ones] . . . we wouldn't advise someone to use the one-inch needles if they were groin injecting'.
(City Centre Street Health Manager)

Typically, a 1.5 or 2 inch needle would be preferred. The reason for this is clearly outlined below.

'You need to have a needle which is long enough to get into your groin vein, but so your barrel's not touching your skin. As soon as the barrel starts touching your skin, ... you get more prone to infection, because the barrel bits are not as sterile as the needle'. (Treatment Homeless Outreach Worker)

In addition to a lack of choice leading to the potential for injecting complications, the research uncovered concerns regarding the increased potential for unintentional sharing of needles.

5.4.12 Coloured needles

A number of interviewees expressed a preference for coloured, or 'Nevershare', needles. Primarily because they enabled users who injected with other users to differentiate whose needles were whose.

'The coloured ones, I prefer them [because] then you know whose is whose and what's what'.
(IV Heroin and Crack User)

Indeed, the provision of coloured needles for those men involved in chemsex has been identified as effective harm reduction practice in terms of reducing the risk of exposure to BBVs.

'The slamming packs that I've got at the moment, ... have things like the syringes, needles, fittings and they're colour coordinated for two people, red and blue. So, one person uses red, the other uses blue, and it just avoids cross contamination'.
(LGBT Substance Use Worker)

'Would like the coloured pins again [Nevershare]'.
(ID 36)

Notwithstanding the obvious benefits of coloured needles, it was evident at the onset of the research that a number of needle and syringe provisions in the city, including all of the pharmacies, were not providing coloured needles. This was raised as a concern to commissioners who moved swiftly to resolve our concerns with service providers and the coloured needle provision was promptly reinstated.

5.4.13 Quality of needle provision

During stakeholder interviews, city centre outreach and the administration of the survey with PWID, it was suggested that the quality of needles had recently gone down.

'We are hearing back from some of our clients that they are not really getting on with the new needles. They complain that the heads come off or they are blunt'. (Street Homeless Outreach Worker)

'Some [users] don't like these needles we are getting from a different supplier. They say they can't make friends with them so they prefer [to use] the 0.5 [inch needles] because they are finer and work better for them'. (City Centre Street Health Manager)

Indeed, we came across similar views from PWID on the quality of needles.

'The needles are getting blunter quicker. ...The quality's gone down'. (Needle Exchange User)

'They are often blunt, bent. ... New pins should be straight and sharp'. (IV Heroin and Crack User)

'Some needles are coming back blunt, they're not sharp enough. Or the heads fall off and you lose your gear. Some of the citric you open it and there is no citric in them'. (IV Heroin User)

The poor quality of needles prompted one injecting heroin user we met on outreach to purchase his needles from a pharmacy, as he believed that the quality was better.

> *I spoke to an IV heroin user today in Piccadilly Gardens. He said he always buys his needles from pharmacies now because he was getting a lot of tissue damage due to the poor quality of needles he was receiving from the needle exchange. He said they were blunt and reckoned he could tell the difference between them and the one's he purchased from pharmacies with his eyes shut - which he said 'were like the olds one's you used to get back in the day. Sharper and stronger – they don't break'.*
> (Fieldwork notes, Thursday 14th December 2017)

As was the case with the access to coloured Nevershare needles discussed above, we relayed this user feedback to commissioners and the commissioned service providers who once again took swift action in addressing our concerns regarding needle quality.

5.4.14 Numbers of needles

'We probably give out about 10,000 needles per week'. (Needle Exchange Harm Reduction Worker)

As we noted in section 5.4.6, the relocation of the more central Oldham Street needle exchange to the outskirts of the city centre was viewed as resulting in PWID attending NX service less often and obtaining more needles and other drug paraphernalia when they do so. In addition to this, many of those interviewed talked of PWID collecting in bulk for others.

'People are coming in and getting bulk and getting it for other people as well'. (Treatment Service Outreach Team)

Indeed, this appeared to be common practice for the growing number of non-traditional PWID such as IPED and chemsex users.

'We had quite a lot of old users who come in, doing the chems and they come in and probably get about 600'. (Treatment Service Outreach Team)

'They'd get at least 500, lowest amount, really. There was one guy, he always gets a ridiculous amount, he comes in monthly, and I've asked him how many people he's sorting out and he said at least fifteen'. (Needle Exchange Harm Reduction Worker)

'Steroid users, it's no good for them, just the odd needle here and there, they need a huge amount. Some people come in for multiple other people as well, so they get it for the group they're in. So, they'll send one person and they're getting it for five or six people'. (Homelessness Outreach Team)

One of the more contentious issues when it came to needles was the question of whether or not the number of needles handed out should be limited. Some of the interviewees advocated a 'one-in-one-out' model and/or limiting the maximum number of needles that can be collected by individuals at any one time.

'It should be one-for-one, shouldn't it?' (City Centre Car Park Manager)

'Whether it's ethical or not, if someone came in for 200 pins, I'd go "No, you can have 100"'. (Treatment Service Outreach Team)

'It's like "Why has this person got 40 needles and is now unconscious in our car park?" Obviously, businesses look at that and think, "What the hell is going on? Why has this person got so much?"' (City Centre Management & Partnership Consultancy)

However, due to the common practice we identified of PWID frequently obtaining needles for other users, and as we note in section 5.4, users disposing in sharps bins in supported housing or at pharmacies etc. it makes it difficult to accurately measure what proportion of their used needles an individual is bringing back or safely disposing off in other ways. This monitoring process would be complicated further if the public sharps bins are introduced (see sections 5.5 and 7.4.5 for further discussion of sharps bins).

'If they're actually doing that [getting needles for other people], then the other people aren't going to bring the returns back, are they'. (Treatment Service Outreach Team)

'Someone might take ten ... but someone else might bring them back for them. [Because of this] it's very difficult to then, kind of, match that up'. (Homelessness Outreach Team)

Furthermore, a number of treatment staff highlighted that national guidelines clearly state that needle providers should not limit the number of needles handed out. In fact, some of the needle exchange staff talked of issuing more than the requested amount.

> *'When the [NTA] guidance came out, which was years and years ago, ... they were saying, "Don't limit, give more". Then, the secondary guidance, it was updated for steroid users, said basically, the same thing again, "Don't limit in any way"'.*
> (Needle Exchange Harm Reduction Worker)

> *'The guidance says you should give out more than what people need, which is what we always do, and we always add a bit extra. ... You shouldn't run out and think, "Oh, I only got 100, I should have got 120", [so] we will always put a bit extra in, just to make sure'.* (Needle Exchange Harm Reduction Worker)

Interviews with needle exchange staff also highlighted what appeared to be a cultural clash between drugs workers and the public health approach of needle exchanges.

> *'Every time I do training with a drugs worker, they're really surprised that I give out a lot of equipment, "Oh, how come you give out that many?" And I say, "That's normal". But in their world, it's not normal, so drug workers have a different take on reduction to what our needle exchange workers do'.*
> (Needle Exchange Harm Reduction Worker)

> *'Some [drugs] workers just can't get their heads round it. It's probably because their mind-set is, "I want you to use fewer drugs". They can't get that public health aspect because it's about drugs, [but] we're saying, "It's not really about drug use, it's about public health." It's a different take on it'.*
> (Needle Exchange Harm Reduction Worker)

Indeed, a number of interviewees felt that a public health approach was the raison d'etre of needle provision and challenged the views of those calling for a stringent needle exchange model.

> *'You can't make them [needles] scarce because otherwise there's no point in having a [needle exchange] service'.*
> (Needle Exchange Harm Reduction Worker)

> *'If you're doing it on a one-for-one basis, and if you're not getting one back then you don't give one out, if this person has got quite a serious habit, is that going to create issues for that person?'*
> (City Centre Police Officer)

> *'You want people to be using clean works and have easy access to clean works every time. I would say that should be the overriding priority. You shouldn't have to have one-in-one-out or anything like that'.*
> (Homelessness Outreach Team)

In summary, there was widespread concerns spanning PWID, residents through to neighbourhood teams and even some treatment staff that NXs are too lax on the number of needles they currently give out to PWID and that stricter measures should be put in place to ensure higher return rates. However, as NX harm reduction staff pointed out, existing guidance around good practice clearly states that needles should not be limited. Therefore, despite the view that some form of capping of needles would reduce DRL and increase engagement, it is difficult to advocate such policy in light of existing national and international guidance and the practicalities of doing so.

Nevertheless, the practice of providing needles and other drug using paraphernalia for third parties that was particularly evident amongst 'chemsex' and IPED users accessing the needle exchange provision has implications for other elements of NICE good practice guidance around quality standards for the commissioning of needle and syringe provision. For example, but not exclusive of:

- Increasing the number and percentage of people who inject drugs and who are in regular contact with a needle and syringe programme
- Increasing the proportion of each group of people who inject drugs who are in contact with a needle and syringe programme
- Encouraging people to ask for advice and help from staff providing the services (as well as providing them with needles, syringes and injecting equipment)
- Increasing the proportion of people who have been tested for hepatitis B and C and other blood-borne viruses (including HIV) in the past 12 months
- Encouraging people to stop using drugs or to switch to a safer approach if one is available (for example, opioid substitution therapy); and address their other health needs

In short, if users are not directly engaging with NX provision and harm reduction staff due to secondary distribution practices, this will impact on the ability of the local service to deliver on these good practice quality standards as outlined by *NICE (2017)*.

5.4.15 Conflicting co-located service provision

The co-location of NSP and treatment services at the Carnarvon Street premises and the provision of methadone at pharmacies where PWID may also be asking for needles and other drug using paraphernalia was highlighted as having the potential to discourage PWID from accessing NX services.

> *'I don't think it is good practice to be honest having a needle exchange service co-located with a treatment service. I'm sure it makes people reluctant to pop next door after a meeting with their drug worker and pick up a load of needles!'*
> (Homelessness Outreach Team)

> *'Compared to where we used to be, I think in the past, we had a much better NX set-up. It's almost an add on now not core business. The Carnarvon set-up, [where the needle exchange is] in with a treatment service is not good practice'.*
> (City Centre Outreach Worker)

> *'I think a lot of drug users, if they are in drug treatment, so if they are going to a chemist and getting methadone, for example, they don't want to be saying, "Oh, can I have some needles, as well?" Because, they think, well, the contradiction in terms is obvious'.* (Treatment Homeless Outreach Worker)

Likewise, it was noted that PWID would be less likely to return used needles to a pharmacy where they were obtaining methadone, or a NX located at the same site as their treatment service provider. This was just one of the reasons that PWID provided as potential explanations for the current levels of discarded needles that we report in section 5.4.16 below. We discuss these explanations further in the following section.

5.4.16 PWID views on the reasons why needles are not always returned

> *'Off it, don't like carrying, not near sharp bins'.* (ID 13)

It was common for PWID to be highly critical of those who leave needles and other DRL in public places. With statements such as 'Can't be arsed', 'lazy', often accompanied by a range of expletives, common in free text survey comments. However, others noted that the nature of injecting drugs in public was always going to result in a certain level of DRL. The fact that some users are chaotic or were under the influence of drugs and therefore incapable of thinking straight and clearing up their DRL was often noted.

> *'They're smashed'.* (ID 27)

> *'Off their heads'.* (ID 80)

> *'Desperate and chaotic individuals'.* (ID 22)

> *'[They are] off it so they don't realise what they're doing'.* (ID 89)

> *'Fucked, don't know what they're doing'.* (ID 9)

> *'No excuse for it but I've known people to be so wasted they haven't been able to pick everything up'.* (ID 101)

> *'Too smashed. Drugs take sensibilities away'.* (ID 29)

It is clear from these explanations from PWID that discarded needles and DRL will remain an issue for as long as public injecting is the only option for this cohort. However, there are ways that DRL can be reduced.

As we highlighted in section 5.4.2, several PWID cited a lack of general awareness of where to safely dispose as a contributing factor for DRL. As the following quotes illustrate, this spanned statements regarding their own personal lack of knowledge of where they could safely dispose or in some cases, it was provided as an explanation for why DRL occurred more widely.

> *'Don't know where to put them – it doesn't say in NX that you can dispose of them'.* (ID 11)

> *'There is nowhere for people to take them back to'.* (ID 78)

As we note in section 7.4.1, it is imperative that PWID are regularly provided with information on where to obtain and dispose of needles and other drug paraphernalia.

It was also stated that PWID do not want to carry around used needles. A point noted by one of the survey respondents when explaining why he sometimes failed to safely dispose of his needles.

> *'Too much hassle to lug needles around'.* (ID 61)

This reluctance of street-based users to carry used needles was accompanied by statements regarding a lack of public sharps bins as a contributing factor for existing levels of DRL in the city centre.

> *'Convenient [to use street bins] and no public needle bins'.* (ID 70)

> *'Lazy, they won't travel far and there is a lack of sharps bins in public places'.* (ID 66)

> *'Not enough about [sharps bins] and easier to throw away'.* (ID 49)

'Not enough bins - should be a couple of yellow bins in the canal basins and where dealers are'. (ID 42)

'Lack of needle bins outside'. (ID 7)

This constant highlighting of a lack of accessible public sharps bins by PWID is particularly noteworthy as the interviews and informal conversations with other stakeholders highlighted conflicting views regarding the use of sharps bins as a method of reducing DRL in the city centre. The following section provides a more detailed overview of sharps bins, drawing on our research findings, previous research and good practice guidance.

5.5 Public sharps bins

'Sharps bins, I think you're on a hiding to nothing there. You'll have people who'll agree with it and you will generally have people who'll say, "Right, so we're paying for drug users now to come and stand in my park"'. (Neighbourhood Police Officer)

As the previous section has highlighted, a lack of facilities can be a barrier to safe disposal and the introduction of public sharp bins as an intervention for increasing safe disposal opportunities was frequently discussed during the research. In the UK, NICE *(NICE Pathways, 2017), DEFRA (2005)*, Scottish *(Scottish Government, 2010)* and Welsh guidance *(Welsh Government, 2011)* all advise that public sharp bins should be considered as a means for promoting safer disposal of injecting equipment, particularly in areas where DRL is prevalent. Emphasis is given in these guidance notes to working in partnerships with other stakeholders to maximise the effectiveness and acceptability of the bins.

Nevertheless, despite the promotion of sharps bins in national guidance, the evidence on the effectiveness of public sharp bins is both limited and mixed. A pilot study conducted in the late 1990s failed to find a significant change in needle discard compared to control areas. However, in contrast to the high level of DRL reported in this study, a low number of needles were sighted before and after the placement of the drop boxes *(Riley et al., 1998)*. There is some evidence to suggest that public sharp bins would be an effective intervention for increasing safe disposal of needles and syringes. A controlled before and after study found that the installation of public sharps bins was associated with a significant reduction in discarded needles. The reduction was highest within 25 metres of the bins (98 per cent reduction) reducing to 92 per cent within 50 metres, 73 per cent within 100 metres and 71 per cent within 200 meters of the bins. This very positive effect persisted throughout the study period, indicating that public sharps bins could have a lasting impact *(de Montigny et al., 2010)*.

DEFRA advise that all partners should be included. They suggest that a public consultation would be invaluable when 'communities do call for and support bins in their area', which would 'bring ownership of the problem, and its solution' *(2005:37)*. The call for sharp bins tended to be made by injecting users and stakeholders working with PWID, the homeless and people with street-based lifestyles. In contrast, residents and the local business community tended to see limited utility in sharp bins and questioned the message it was sending out. Sharp bins were seen as a sign of giving up on stopping the open drug use we reported in section 3.5.

However, there is the possibility that any initial community resistance to public sharp bins will decrease when community members are presented with evidence or when sharps bins are introduced and fear and concerns are unfounded (Smith et al., 1998). DEFRA provide an example of residents in Oxford being initially resistant to the idea of public sharp bins but changing their mind when they saw the reduction in needles in neighbouring areas that did have public sharp bins *(2005:37)*.

5.5.1 Previous resistance

'Our culture is we don't want needles on the floor, but we don't want a sharps bin either. We just want them to go away'.
(Needle Exchange Harm Reduction Worker)

During the research process, we spoke to many participants who highlighted the fact that sharp bins have a long history of being discussed in Manchester. It was noted how there had been significant resistance from a range of stakeholders that ultimately resulted in sharps bins not being implemented in the city.

'I don't really understand it, and I was really surprised by the amount of resistance we've got about it [sharps bins]. Even [contracted waste disposal company] were resistant to it, they mentioned something about the safety of their staff'.
(City Centre Neighbourhood Team)

'We nearly got one. We were so close. The cops were going to pay for it and they were going to screw it on the side of the pharmacy wall, but the local residents said, "We don't want to draw people into this area to use this sharps bin"'.
(Needle Exchange Harm Reduction Worker)

The notion that providing sharps bins would attract more users to an area is one of many reservations discussed below.

5.5.2 Reservations

Studies that have examined perceptions of public sharp bins have identified that non-drug using community members felt the bins would be under used, with police officers suggesting that people who inject drugs (PWID) would still discard needles even if safe disposal options were available *(Smith, 1998)*. However, focus groups with PWID have reported that they are concerned about unsafe disposal of needles and syringes *(Smith, 1998; Miller, 2001)*.

The research uncovered similar reservations regarding the extent that sharp bins would make a difference to DRL. A range of stakeholders expressed reservations regarding whether PWID would use sharps bins. As we highlighted in the previous section, PWID stated that in some cases, users would be too intoxicated and in no fit state to think about safely disposing of their used needles. However, they also advocated the need for public sharp bins to help reduce current levels of DRL. The following section highlights concerns about the underuse of sharps bins.

5.5.3 Underuse

> *'I suppose it's a question more to the people that are going to be injecting initially. Whether or not, they say, "Right. Okay. I know there's a bin for me to put this needle into". Whether or not they would. I suppose, some would and some wouldn't'.*
> (New Islington Resident).

> *'You're also not 100 per cent thinking straight after you've used, so I'm not sure you think about putting something in a bin afterwards. ... When people drink a bottle of beer or a bottle of cider or a bottle of wine on the street, there could be a bin next to them, they still leave it there because they're intoxicated. So, they're not bothered. The whole point of being intoxicated is so you're not bothered about your environment, so why would they [PWID] care?'*
> (City Centre Councillor)

> *'If you're desperate enough to have to shoot up on the city centre streets, are you really that concerned about where your needle's gone? And if a sharps box was there, would you actually use it?'*
> (Waste Collection General Manager)

> *'Well, you saw the sharp box that's down there and they've not used it. ... Well you saw the hundreds of needles lying round the side of it'.*
> (City Centre Business)

> *'Our research show that people don't use litterbins, they don't want to use litterbins. Forget people that are in a state because they're just injecting themselves with a strong drug'.*
> (Contract Manager Waste Recycling and Cleansing Team)

> *'You could put a bin right in front of someone and it doesn't mean they're going to use it'.*
> (Homelessness Outreach Team)

Others expressed concerns that members of the public might be more inclined to pick up needles unsafely to dispose in sharp bins.

> *'It might encourage people [the public] to pick things up [and put them in a sharps bin] when they shouldn't'.*
> (City Centre Management & Partnership Consultancy)

As we noted in Section 4, there is a need for clearer guidance and public awareness raising on how to clean up and dispose of DRL.

5.5.4 Key community concerns

Reviewing the literature on sharps bins, the key concerns about public sharp bins among non-drug using community members include: the bins would send the message that the community 'condoned' drug use, convey a negative message about the community *(Smith, 1998)* and that children would access the bins *(Springer, 1999)*. However, participants in Springer's focus group felt that public sharps bins would be a convenient and discrete method for disposing of syringes.

Our research found similar reservation regarding the message they would send out together with the impact it would have on the area.

> *'But by doing that, are we then saying that it's okay for people to use drugs there?'* (City Centre Police Officer)

This notion that the introduction of sharps bins to an area would serve to increase open injecting drug use was frequently discussed.

> *'I'm not sure that they [sharp bins] would make a difference. You'd have to put them in the hotspots. So if they do their data map, they'd have to put them in those spots where use was prolific and then that would just perpetuate the use in that area because people would use next to or somewhere where they could dispose of them'.* (City Centre Councillor)

However, as one sexual health and homeless outreach worker noted:

> *'People see it as something that will attract drug users to the area, but they are already there. That's why you want the bin!'*
> (Sexual Health and Homeless Worker)

5.5.5 Support for sharps bins

Despite the reservations outlined above, there was widespread support and optimism that they would be utilised by both PWID and stakeholders we interviewed.

> *'I told them, "If you're going to use round here, put them in the bin" and people will comply and put them in the bin, but some people don't'.* (Needle Exchange Outreach and Harm Reduction Worker)

> *'A lot of people will use it. Responsible people will use it'.* (Manchester City Council Community Safety Manager)

> *'I would be more inclined to pick up a needle with my litter picker and gloves and put it in a receptacle if I knew I could go round the corner and hand it in somewhere'.* (City Centre Resident)

Our findings from both face-to-face interviews and surveys with PWID found strong user support for the introduction of sharps bins. For example, 43 out of 110 (39 per cent) advocated the use of sharp bins to reduce DRL. Many other stakeholders echoed this support.

> *'It would be an improvement. It's got to be better than what they're doing now'.* (City Centre Neighbourhood Police Officer)

It would reduce the risk to the public.

> *'It's not cleaned up what the actual issue is, but it's taking away the hazard ... to other people, isn't it? From picking up a needle or stepping on a needle or whatever else it is'.* (City Centre Business)

It was common for respondents to use emotive examples of the risk of a child picking up a discarded needle when advocating the use of sharp bins.

> *'What would you rather have, a bin that is child-proof and at a level where they can't get in, or pins strewn all over the floor that a kid could just pick up?'* (Homelessness Outreach Team)

> *'Okay, I probably wouldn't like it where I live if there were drug users using in the green space near me. [But] if the Council suggested putting a sharps [bin] in because they had found drug litter I would just think, "Yes. A kid could get hold of it". You think, "Is it not better in a safe, secure bin which is going to be taken away and another one slotted on rather than have it strewn around and putting somebody at risk of a needle-stick injury?"'* (Street Health Service Manager)

Others noted the harm reduction benefits to injecting users who would have reduced opportunity to pick up and reuse needles off the floor if sharp bins were used (see fieldwork notes in section 5.4.5).

> *'It's not different to giving out pins. ... People would say we are encouraging them by giving the pins and the paraphernalia, but they are going to use anyhow. They are going to pick up a dirty syringe that somebody else has used and use that. It's harm reduction'.* (Street Health Service Manager)

It was also viewed as a cost-effective measure for both the local authority and business sector.

> *'I'm sure the private landlords would probably appreciate that as well. Imagine the clean-up costs for them, when they finally get round to cleaning up the land that somebody's occupied'.* (City Centre Neighbourhood Team)

> *'It'll cost money but how much will it cost in the long run? It'll cost less money than treating a young kid picking a needle up and getting HIV, wouldn't it?'* (IV Heroin User)

> *'In certain hotspots where it happens that people know they can use and they can deposit their waste. It makes it easier, because obviously, we're facing cuts and it would make it easier for the contractors to go and collect it'.* (Local Councillor)

As alluded to above, placing sharps bins in DRL hotspots would seem the logical solution. Yet as we outline in the following section, the appropriate location of sharps bins was much debated.

5.5.6 Location

> *'It would have to be very, very carefully thought out as to where in that area, the box was placed. Who removes it? Who cleans up on a regular basis? Who pays for it? Is it going to be monitored?'* (Manchester City Council Community Safety Manager)

Decisions on the location of sharp bins needs careful consideration. In previous studies, PWID expressed support for public sharp bins *(Smith et al., 1998; Springer et al, 1999; Parkin & Coomber, 2011*) but raised concerns that: they would not be placed in areas that were 'environmentally or geographically relevant' *(Parker & Comber, 2011)*, the bins would identify them as a person who uses drugs *(Smith, 1998; Springer, 1999)* and the bins would put a person at risk of arrest for possession of injection paraphernalia, particularly if the box was being targeted by police *(Smith et al., 1998; Springer et al., 1999; Miller, 2000; Parkin & Coomber, 2011)*.

On the one hand, it is important to ensure that public sharps bins are located in places where they will be used by PWID. On the other, many residents and businesses did not want them to be visible. It was common for both PWID and stakeholders to offer suggestions for where they thought sharps bins should be located. We outline some of the most common suggestions made by PWID for the location of sharps bins below.

Several survey responses suggested locating sharps bins in public toilets and on walls around the city centre. More specifically, some of the parks such as Angel Meadows where injecting drug use was documented (see section 3.5) were stated. As we observed on several occasions during fieldwork, the Angel Meadows area was a site of open drug dealing and drug use with discarded needles regularly cited around park benches.

Placing sharp bins in city centre car parks was another specific location that was frequently suggested.

> *'Where people use – in all the cark parks'.* (ID 72)

Others suggested specific areas of city centre.

> *'We need sharps bins around Piccadilly'.* (ID 24)

> *'There should be more public bins for the homeless – around Piccadilly Gardens'.* (ID 87)

> *'The back of the [Piccadilly] train station'.* (ID 49)

> *'The back streets near Piccadilly [Gardens] where people score and use'*. (ID 61)

It is important that these insightful views of PWID are considered when making decisions on where to locate sharps bins to maximise their usage.

5.5.7 Secure and vandal proof

In addition to reservations about the effectiveness of sharps bins, there was concern regarding perceived risk of PWID accessing used needles or of sharp bins being vandalised.

> *'Anything that you put in the public realm gets trashed really quickly'.*
> (City Centre Management & Partnership Consultancy)

> *'Would you end up with a situation where you've got people kicking these boxes all of the place and potentially smashing up a box with 200 needles in all over the place?'* (Waste Collection General Manager)

Therefore, the importance of ensuring the security of sharps bins was often raised.

> *'They [sharp bins] need to be kept secure, so they [users] can't get into one. So, I don't really think leaving on the city centre streets, whether that's practical'.*
> (Waste Collection General Manager)

As noted below, in addition to the location, careful consideration should be given to the design of any public sharps bins.

> *'Having the bins around the city, I think that's a really good idea but also it can't just be the bins we have, it has to be a specially designed bin that people can't get the pins back out of them'.*
> (Treatment Service Outreach & Needle Exchange & Harm Reduction Worker)

A number of different suggestions were made in terms of the type of sharps bins used in other towns and cities.

> *'The ones in Blackpool, for example, it was a toilet with a solid wall, with a push foot and everything and the sharp box was literally a little hole where you put the needle in and, bumph, right to the bottom [I: So, there's no actual box fixed onto a wall?] No, it just dropped right down. So, something that will stop the reuse of needles as well. Which is good for everything'.*
> (Treatment Homeless Outreach Worker)

> *'Why don't we just put a sharps bin on the wall? A proper fitted one, it's on the wall, you don't pull it off or anything like that. And someone just comes along once a month and empties the needles'.*
> (City Centre Neighbourhood Police Officer)

> *'I'd go for that [sharp bins]. ... Stick them on the walls like the cigarette bins. ... Proper secure, with a proper lid on it and where you couldn't pull it off the wall, you couldn't break into it'.* (IV Heroin and Crack User)

> *'You've got the ones with the drop thing, haven't you, like the drug boxes where the shelf comes up to flush, you put it on, it drops down, and you actually can't reach it, so you'd not be able to get in there, would you?'* (City Centre Neighbourhood Police Officer)

In line with these stakeholder fears, DEFRA advice states that bins should be secure, weatherproof and vandal proof and designed to avoid any 'booby trapping'. Building in or recessing bins will minimise the risk of vandalism. It should be safe for people disposing of the bin and should be able to be 'shut down' if needed. A consultation with users should determine if it should allow individual needles or allow whole sharp containers to be deposited. The bins should be capable of receiving 'other' items without being blocked and should be regularly maintained and where possible, be graffiti resistant to promote reassurance *(DEFRA, 2005:38).*

The regular maintenance and costs incurred of emptying them was also noted as another practical issue to be addressed.

> *'What are the consequences of it? Who empties it? Who picks up the cost?'*
> (Manchester City Council Community Safety Manager)

> *'You've got to have someone to empty it, pick up the sharps waste. It's hazardous waste so that has costs implications'.*
> (Needle Exchange Harm Reduction Worker)

DEFRA also recommend that bins should not be located in areas overseen by large numbers of the public or CCTV cameras as this will discourage use and high visibility can fuel opposition. Having highly visible sharp bins was also discouraged by residents and businesses concerned about the message it was portraying. The message this would send out and the image it would portray of Manchester was also raised as a concern.

> *'Imagine Manchester saying, "We're the first place where we are going to have sharp disposal bins on the streets in key hotspot areas" or something like that. You can imagine that being in the Daily Mail, can't you? It's a kind of no-win situation'.* (City Centre Resident)

Sharps bins were also viewed as having the potential to attract more users to a location.

> *'It's just advertising it [a car park] more as a drug den'.*
> (City Centre Car Park Manager)

> *'People see it as something that will attract drug users to the area'.* (City Centre Sexual Health Manager)

Conversely, they were seen as having the opposite effect for customers with publicly visible sharps bins viewed by some as *'bad for business'.*

> *'If a member of the general public sees it, they may think, "Well, if they're the type of people who are hanging around here, I'm not coming back around here again"'.*
> (Manchester City Council Community Safety Manager)

> *'[I: Do you think it would be helpful to have Sharp bins that were, like, fixed to the wall, in a public setting?] No, because of the customer perception. We don't want customers seeing that'.*
> (City Centre Car Park Manager; City Centre Car Park Staff)

> *'Whilst I agree that there's a point and a need, everyone will always say, "Not in my space. Not close to us. Not where our visitors can see"'.*
> (City Centre Business Management)

> *'Is it going to say, "Oh this area's got a drugs problem." It's how aesthetically they fit in to that particular area'.*
> (City Centre Business)

Similar reservations were raised at the prospect of sharps bins in residential areas of the city centre.

> *'Well you'd get local property owners saying, "This has just devalued our property", and, "See that down the road, you've just taken £10,000 of our property". You'd get everyone objecting'.* (Homelessness Outreach Team)

Therefore, many called for any future introduction of sharps bins to be located in settings that are more discreet and for the design to also be discreet.

> *'If it was something that was quite well disguised, probably yeah, that I'd agree with'.*
> (City Centre Business Management)

> *'It needs to be discreet. Not something that screams sharps bin'.* (City Centre Business Management)

> *'To be fair this estate is a £3 billion estate. We don't want that association [with drug users]. ... If there was a way of doing it a little less conspicuous than... That's the kind of thing we support, but something bright yellow, it doesn't go with the premium of the estate'.*
> (City Centre Business Management)

Some went as far as suggesting they were disguised as something else.

> *'I was like, "Well, can we not get something that looks something else but is a sharps bin? Like a dog bin that's also a sharps bin, like a dog waste bin", stuff like that'.*
> (City Centre Neighbourhood Police Officer)

However, a bin that is too far from the public gaze is more likely to be broken into. Bins will also need to be in a location where they can be easily emptied without fear of risk to staff *(DEFRA, 2005:38)*. As we noted in section 4.5, operations managers raised concerns regarding the safety of waste disposal staff when clearing up DRL.

DEFRA advise that these problems can be resolved by locating public sharp bins in public toilets as they can be relatively unobtrusive, discrete and likely to be an existing hotspot. A bin could be fitted outside a block, to allow 24-hour access or it can be placed inside cubicles, with their presence signalled through discrete signage, using an appropriate logo that is well known to users and can be promoted on that basis *(DEFRA, 2005:39).*

In keeping with this guidance, it was often suggested by a range of stakeholders that sharp bins should be located in public toilets.

'Is it Scotland ... where you have the public toilets? They have them on the wall, but they have the tiniest hole to push them and there's no way you can get them off the wall because you will find that people would use those pins'.
(Treatment Service Outreach and Needle Exchange and Harm Reduction Worker)

'I go into public toilets, and there's sharps bins in public toilets, all over. There's like Peak District, right in the middle of nowhere'.
(Needle Exchange Harm Reduction Worker)

'It's a tricky one, but you could do simple things like public toilets, having sharp boxes'.
(Treatment Homeless Outreach Worker)

'I know there's places in the US that have put sharps bins in public toilets and stuff, that previously had massive issues with it and they've actually found that they are used. If you give people the opportunity to use a sharps box, then they will'.
(City Centre Neighbourhood Team)

However, it was noted that there were limited public toilets in the city centre, especially outside high street opening hours.

'Having it in a public toilet, I think is a more reasonable thing. I think it's easier and better to manage. ... But there are very few public toilets in Manchester, that's one of the things'. (Homelessness Outreach Team)

Furthermore, as we note in section 5.5.1, Manchester has explored the use of sharps bins before and the suggestion of locating sharps bins in public toilets has met with resistance.

'Owners of the toilets, like Arndale Centre or McDonalds, well, "We don't want a load of heroin users coming in here using the toilets"'.
(Needle Exchange Harm Reduction Worker)

Scottish guidance advises that opportunities for safe disposal can also be increased by locating return bins outside NSPs for disposal when the service closes and locating sharp bins on the premises of other agencies, such as hostels *(Scottish Government, 2010).*
It was suggested that public sharps bins should at least be trialled and monitored for their use.

'Why not give them the opportunity to use a sharps box? If we trial it for a few weeks and it doesn't work, then we can take the sharps boxes out and think again but I think it's certainly worth a try'.
(City Centre Neighbourhood Team)

In light of some of the concerns expressed above, it was suggested that a trial should take place in some of the less public facing areas where open drug use and DRL are routinely reported.

In summary then, despite widespread support amongst PWID and many other stakeholders, a number of concerns were raised regarding whether they would be used and the negative effect they might have. However, as noted below, the deployment of sharps bins around the city in identified hotspot areas for DRL would only address the issue of discarded needles and syringes.

'I personally think it would be potentially seen as an easy "cheap" solution. ... As we said before, it's only a symptom. The real issue is a much deeper issue'.
(9 Locks Rochdale Canal Volunteer)

As we highlighted in section 3.5, there was a widely held perception that open, publicly visible injecting drug use was on the increase. The following section focuses on a potential solution to both DRL and public injecting: drug consumption rooms.

Section 6.

ADDRESSING OPEN INJECTING DRUG USE

6. Addressing open injecting drug use

6.1 Responding to public injecting

As we have illustrated in section 3.5, sighting of open injecting drug use is widely perceived to be on the increase. A number of potential explanations were offered during the research. This included a rise in the number of rough sleepers in the city centre and the impact of 'Spice' and other previously 'legal highs' in making the open use of these substances acceptable and thus creating a culture of more open and blatant drug use that has moved on from 'Spice' to traditional substance use. This apparent increase is in part accounted for by the redevelopment of the city centre and surrounding areas (Northern Quarter, Ancoats, Angel Meadows and the Ancoats and Rochdale canal pathways). What were once scarcely inhabited public spaces, consisting of derelict industrial buildings and unused stretches of canal pathways are now thriving night-time economies and desirable city centre living and business spaces. There is no doubt that this has contributed to the increased visibility and subsequent reporting of both DRL and injecting drug use in public spaces that we highlight in sections 3.2 and 3.5 of this report. This stark reality of the juxtaposition of injecting drug users and city centre dwellers and the challenges this poses is outlined in the fieldnote extract below.

I had a meeting today with somebody from the Friends of Angel Meadows (FOAM). I arranged to meet at the entrance to Angel Meadows near the gravestones at 10am but arrived half an hour early. As I waited at the top of the park, I could not believe the amount of open drug dealing taking place. At two different entrances to the park, people were clearly waiting for a dealer to arrive. When they did (one on a Mobike!) some users went to the end of the park and immediately began to use. I counted eight different people purchasing drugs. When I met the member of FOAM I mentioned this. I was informed this was a daily occurrence and coincided with busy commuter times for begging - users would beg for money in the morning, lunchtime and evening periods then go and 'score'. I was then taken on a walk around the park and as we chatted, disused syringes and needles were pointed out in approximately eight to 10 different locations. I photographed these to illustrate how many were hidden under fallen leaves or stuck into park benches. The location at the bottom of the park where I had seen three users go and use after scoring their drugs was particularly bad in terms of the number of discarded needles and other drug litter. Apparently, this area used to be worse before it was partially fenced off. In addition to the open drug use in the park, the resident informed me of people using drugs in the refuge areas in their building and on the surrounding streets. The frustration was tangible, as numerous reports to the police and council were recalled. The park is often visited by people on Manchester walking tours - it doesn't present a good image of the city and as the main green space in the 'Green Quarter' it presents a far from inviting environment for local residents.
(Fieldwork notes, Friday 8th December 2017)

During the course of our fieldwork, it was common to come across open drug use in this park and to witness DRL, including used needles and syringes scattered on the floor. Residents were clearly frustrated with the levels of open drug use and dealing and subsequent DRL. Likewise, police officers expressed their frustration with the limited options they could suggest to those openly using in public when they are called out to respond to complaints. With no alternative options, these drug users who are being asked to move on are faced with moving further to the margins of the city, typically into derelict and decayed buildings. While this may improve the view from the window of a waterside apartment and reduce the number of police and local authority complaints, the users themselves are subsequently placed at increased risk and harm. As we elucidate further in section 6.2.4 below, using drugs in remote derelict properties increases the risk of having an accident or fatal overdose. These locations will be dark and dimly lit and therefore, will make intravenous injecting more hazardous and less safe. In addition, the risk of a fatal overdose increases due to the user being less visible and reachable. Yet at present, the alternatives are lacking. The Harm Reduction Coalition's Alternatives To Public Injection provides an excellent introductory overview.

One alternative that featured prominently in the research is to establish a safe space for injecting drug users. These are variously referred to as 'shooting galleries', 'safe injecting rooms', 'supervised injection sites (SIS)', 'supervised injection facilities', 'safe injection sites fix rooms', 'safer injection facilities (SIF)', 'drug consumption facilities (DCF)' or 'medically supervised injection centres (MSIC)'. We refer to them in this report as 'drugs consumption rooms' and use the abbreviation 'DCRs'.

The following sections outline the strong support for DCRs together with the numerous decisions and challenges that would need to be carefully considered if Manchester was to move towards this model.

6.2 DCRs

'We've pretty much got shooting galleries and consumption rooms now, but they're doing it on the canals or they're in the car parks or whatever'.
(Northern Quarter Bar Owner)

As the above assertion make clear, Manchester city centre has open injecting drug use. As we illustrated in section 3.5, residents and businesses are witnessing open injecting drug use on an increasingly regular basis. In recognition of the existence of what many perceived to be a rising occurrence, the research team uncovered overwhelming support for the establishment of a DCR in the city centre. Before highlighting this support, we commence this section with a brief overview of DCRs.

6.2.1 Overview of DCRs

In recent decades, harm reduction services have been extended to include DCRs. DCRs are 'professionally supervised health care facilities where drug users can consume drugs in safer conditions' *(EMCDDA, 2017:2)*. They can be integrated into existing services, such as NSPs or drug treatment centres, be a specialised service or a mobile facility. Though there can be significant variation in service design (see Appendices 9.1 & 9.2), a DCR will typically have an assessment and intake area, drug consumption room area and after-care area where other services can also be accessed.

The reasons that people may attend a DCR are to: seek safety, receive sterile equipment, receive adequate care in case of overdose, free access, hygiene and injection safety *(Small et al., 2012; Small et al., 2011; Kimber & Dolan, 2007)*. Service provision will commonly include: sterile injecting equipment; counselling services before, during and after drug consumption; emergency care in the event of overdose; and primary medical care and referral to appropriate social healthcare and addiction treatment services *(EMCDDA, 2017).*

The first DCR was established over thirty years ago (1986) in Switzerland. By 2017, the number of DCRs had grown to over 100 with facilities in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece, France, Canada and Australia. Support for DCRs in the UK and Republic of Ireland has grown in recent years with cities such as Dublin, Glasgow and Birmingham driving the debates on DCRs. In 2018, the city of Dublin put out the tender for a Dublin-based DCR.

6.2.2 Evaluating the effectiveness of DCRs

Key reviews of evidence have recently been collated by *Potier et al. (2014) 'Supervised injection services: What has been demonstrated? A systematic literature review', and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) overview of evidence (EMCDDA, 2017).* It can be challenging to isolate the effect of DCRs from other interventions and no research control trials have been conducted on them. In this respect, it is telling that over four fifths (85 per cent) of the literature used in the *Potier et al.'s* evidence review originated from Sydney and Vancouver, which both operate a standalone, medicalised model. European studies were not as included as they are less available in the databases commonly used for literature research. Potier and colleagues conclude there is a lack of visibility of European data on DCRs, even though they are the most numerous in Europe *(Potier et al., 2014)*. This has occurred alongside there be a substantial body of evidence in Canada and Australia as facilities in Sydney and Vancouver have been established as pilot projects, accompanied by well-funded university-based evaluation studies using elaborate designs (including cohort study) *(EMCDDA, 2017).*

6.2.3 Support for DCRs

We commence this section with a demonstration of the widespread support for DCRs across stakeholders and the potential benefits for users that research participants discussed. As the following quotes demonstrate, this support spanned all stakeholders including city centre businesses, residents, health care professionals, police and PWID.

'Well people are using nearby anyway, so at least they're safe and at least there's no litter'.
(City Centre Councillor)

'I really honestly believe that it would be better if people could go somewhere safe to use'. (City Centre Resident)

'I think anywhere that gets these people in off the streets into a safer environment where they can get professional help, or at least spoken to on a regular basis, can only be a good thing. ... I mean I don't see how it can do any harm'. (City Centre Business)

'For me, that [a DCR] is a much more practical solution in that it's managed, you've got ongoing interaction, ... you've got the opportunity to have an ongoing relationship with that person with a chance then to maybe do something about it'.
(9 Locks Rochdale Canal Volunteer)

The success of a DCR relies to a large extent on collaboration and strong working relationships with the local police. With this in mind, it was particularly positive to see DCRs advocated by several city centre neighbourhood police officers during the fieldwork.

'That was the point of the galleries to us. If I come across somebody shooting up in the street, I can then turn round and say, "Yeah, but you've got somewhere to go. You don't need to come to this park"'.
(City Centre Neighbourhood Police Officer)

Members of the city centre neighbourhood team also commented on the widespread support of GMP officers for DCRs.

In summary, DCRs were viewed as offering a safer drug-using environment and garnered widespread support.

Overdose prevention and access to services was commonly raised as a potential benefit.

'Having somewhere that's dignified and warm and perhaps got access to services and somewhere where you're not going to be in a manky car park somewhere and overdose with no one seeing you, I would approve of that'.
(City Centre Management and Partnership Consultancy)

'If we had a room that was really clinical and we could have somebody supervising it, I don't think there would be an objection. If they overdose, then you are there and all of the bad things that come with people injecting would be able to be supervised. You would obviously have to have somebody there all the time. You couldn't just let them go in because it would just turn into a crack house'.
(City Centre Street Health Practitioner)

Reviewing existing research into DCRs, there is sufficient evidence to make the claim that DCRs are efficacious in managing overdose situations as though overdoses frequently occur, no death by overdose has been reported in a DCR *(Kerr et al., 2006b, Milloy et al., 2008b, Van Beek et al., 2004)*. There is also some evidence to suggest that DCRs could reduce drug related deaths at a city level, where coverage is adequate *(EMCDDA, 2017:5). Marshall et al. (2011)* concluded that there was a 35 per cent reduction in the number of overdoses within 500 metres of the DCR, compared with the rest of Vancouver. *Salmon et al.'s (2010)* evaluative 'before and after study' of the Sydney MSIC identified that there was a 68 per cent reduction in ambulance callouts for overdoses near the MSIC five years after the facility was opened, in comparison to three years before.
In line with this evidence, police highlighted the potential for DCRs to reduce emergency calls as a benefit of DCRs.

'Rather than these people take the drugs, and then go out into the city centre causing problems and generating calls for ambulances, they will be in a safe place there where people can keep an eye on them and they're safe from anything happening to them potentially. Yeah. I can see some good points for it, I really can'. (City Centre Police Officer)

In the current climate of concern regarding fentanyl deaths, it was noted that a DCR could also provide a drug testing facility on site to further reduce the risk of fatal overdose.

'You know, like a clinic, where somebody can go, where there are health professionals, where people can be testing what people are taking. You know, just start the process of getting this thing out of the underground and into, not the mainstream, but into the open. I think it would just reduce the harm'.
(City Centre Resident)

6.2.4 Safer injecting environment

'People need, if they are going to be drug using, somewhere safe to do it'.
(Treatment Homeless Outreach Worker)

'They've got nowhere safe and clean to inject. Because it's all right to start talking to people about safe injecting, but if they haven't got a safe environment to do it in, well, how are they going to do it safely?'
(Treatment Homeless Outreach Worker)

It was also suggested that it would reduce the number of injecting related abscesses, skin and muscle tissue damage.

'It would help with NHS costs for people being admitted because they have got really bad abscesses and sores if prevention was going on in a using room. You could give people informed advice like, "It looks like it is getting sore. You need to be careful with that" or you could talk to them about it before it got worse. It's having those advanced facilities'.
(City Centre Street Health Worker)

'People are going to take drugs. The idea that they won't is silly in my personal opinion. So, offer them a safe place, somewhere to go that's safe that they're watched, that their health can be managed. For me would make a lot of sense. That's a proper service. It's not a sticking plasters thing you just slap up like sharp bins'. (Waste Recycling and Cleansing Team)

Evaluative observational studies have shown that there is some evidence that DCRs are associated with the initiation of drug addiction treatment *(De Beck et al., 2011). Wood et al. (2007)* observed that detox attendance, initiation of methadone treatment and addiction treatment increased one year after the DCR opening and DCR attendance declined in the months following the initiation of addiction treatment.

Another reported association is a reduction in self-reported syringe sharing *(Kerr et al., 2005; Millroy & Wood, 2009)* and syringe reuse *(Stoltz, 2007)*. Evidence has also shown that regular DCR attendance encourages the use of sterile injection materials and the elimination of soiled materials *(Fast et al., 2008l; Stolz et al., 2007)* and is associated with more frequent visits for education on safer injection practices *(Wood et al., 2008).*

Potier et al.'s literature review concluded that DCRs promote access to primary care, which can include care and treatments of infections following injection, a service that was highly valued among service users *(Small et al., 2008)*. A descriptive and analytical study identified an association of better health outcomes among people who attended the DCR, as hospital stays were significantly shorter among participants sent by a DCR nurse compared to those who were not sent by one *(Lloyd-Smith et al., 2010)*.

It was significant to note that rather than the nimbyism that is often discussed in relation to DCRs, the research team often found that it was city centre residents and the business community who were amongst the strongest advocates of DCRs.

> *'[I: So, it's the residents who are actually calling for it?] Yeah'.* (Angel Meadows Resident)

> *'There need to be somewhere to be able to go to in the city centre and then they could go and speak to somebody. We don't have an NHS drop-in centre here in the city centre, and that's the next best thing. There needs to be something to help people'.*
> (City Centre Business Management)

6.2.5 PWID support for a DCR

> *'[I: Do you think people would use it?] Yes. It's been discussed on a daily basis with people coming into a needle exchange. ... People [users] come in and go, "They complain, we get complaints, we get looked down on but if we had somewhere safe to go then we wouldn't have all these problems"'.*
> (Needle Exchange Harm Reduction Worker)

Our subsequent discussions with users during city centre outreach and needle exchange-based interviews and survey administration with PWID provided clear evidence of support for drug consumption rooms amongst Manchester's injecting heroin and crack population.

> *'A room or place to inject for those who are homeless'.* (ID 27)

> *'A room to inject'.* (ID 17)

> *'Safe injecting space'.* (ID 92)

> *'A safe room to inject'.* (ID 87)

> *'Somewhere to take the drugs, somewhere to test them'.* (ID 5)

> *'A place I can inject in a safe space'.* (ID 25)

> *'A room/place to inject safely'.* (ID 67)

> *'A room to inject in'.* (ID 19)

> *'They would be great. It would mean people would stop using used pins and prevent ODs – you'd have professionals on hand to help you and that. I've said it for years me. I've been saying it for ever. We should have had them [DCRs] 20 years ago. It would be so much safer. You wouldn't be worrying about the building you're in falling down, walls collapsing, bricks hitting your head. Not being jumped by kids, using dirty pins. No sharing and swapping. It can only be a good thing'.* (IV Heroin and Crack User)

> *'If we had a safe place to shoot up that would be the best solution. If you OD you've got support'.*
> (IV Heroin User)

> *'I think they would a really good idea because a lot of people do it outdoors [which is] not ideal for the public and not ideal for us, so if there was a safe place that we could go, that would be good'.*
> (IV Heroin and Crack User)

In addition to the harm reduction benefits outlined above, the advantages of DCRs increasing levels of user engagement were often highlighted.

> *'[You need to engage with users] rather than go to a needle exchange, just having some needles lobbed at you. Job done'.*
> (Treatment Homeless Outreach Worker)

> *'I think it would be a great idea. It's a clinical area, it's sterile and there are clinicians in some of them. I know there are in Germany and it's supervised. There is good lighting for getting veins. There is somewhere to discuss if they have issues around abscesses or poor injecting sites'.* (City Centre Street Health Practitioner)

> *'If you're actually going in to inject in a waiting room, you're going to be there quite a while and that gives you time to break down those barriers and build up the relationship a lot quicker with people and them to feel they trust you enough. Build that trust with them to get them into services. So, yes, I think it would be a really, really positive thing and I just think we're so behind the times with the drugs policies'.*
> (Needle Exchange Worker)

'Injecting rooms is the ultimate, really, isn't it? You know, someone who really doesn't want to stop, they are going to continue injecting drugs. Get them in, are they injecting safely? Show them, you know, have those conversations with them, get them tested, that sort of thing. Only give them the pins on the way in, and they can leave them there on the way out'.
(Homelessness Outreach Team)

6.2.6 Benefits of DCRs beyond drug users

Whilst discussion often centred on the many benefits for the user, it was also widely acknowledged that setting up a DCR would have wider benefits. As this city centre councillor alludes to here, this includes a natural reduction in the amount of DRL on the city centre streets.

'It [a DCR] would greatly improve the support services available for people who are taking drugs. That, to be honest, is my main concern, is the people who are addicted to the substances and don't have a route out at the moment and a by-product of that would be improving the litter'. (City Centre Councillor)

Proponents of DCRs argue that in addition to reducing a range of harms to injecting drug users, they also help alleviate the problems associated with injecting on the street, including DRL. However, reviewing the existing evidence base, it is apparent that the most confident claims can be made about the interventions that occur inside the drug consumption rooms.

Nonetheless, in contrast to other suggestions to address DRL in the city, such as public sharps bins and increasing the use of pharmacies (see sections 5.5 and 5.4), there was far more confidence in the benefits that some form of safe injecting space would have.

City centre businesses and residents often viewed DCRs has having more impact on reducing current levels of DRL than sharps bins.

'Even if we get a small percentage of the drug users using it, it would reduce the issues we have. Well, potentially reduce the issues we have with people injecting on stairwells and drug litter'.
(City Centre Car Park Manager)

As noted in Section 1, this study was commissioned by Manchester City Council as part of an ongoing Community Safety Partnership response to complaints regarding DRL. DCRs have historically been established as a response to open drug scenes, with common indicators including public injecting and DRL that we outlined in sections 3.5 and 3.2. Therefore, in addition to reviewing the impact to users' health, recorded drug-related deaths and overdose, some studies have assessed the impact of DCRs in reducing drug-related nuisance in public spaces by surveying PWID and people who live or work in the vicinity of the DCR. For example, through surveying PWID in Vancouver, *Petrar et al. (2007)* and *Stolz et al. (2007)* both concluded that DCR attendance was associated with a reduction in self-declared syringe dropping or public injecting. When surveying people who live or work in the vicinity of the Sydney DCR, *Salmon et al. (2007)* reported a reduction in public injecting, discarded syringes and fewer complaints about PWID nuisance. Another study conducted by *Wood et al. (2004)* counted the number of syringes dropped six weeks before the Sydney DCR was opened and 12 weeks after and observed a significant reduction. Moreover, after the facility was opened, the study found there was a reduction in the mean number of people publicly injecting.

Further support for the view that DCR facilities may lead to reductions in DRL and incidents of public injecting are garnered from a Barcelona study. The authors report that, 'the opening of a facility with a supervised drug consumption room in the inner city was associated with a huge reduction in the number of abandoned syringes in the city, while its number did not rise in the district where the facility was located' *(Vecino et al., 2013:333*). Taking this evidence collectively, we concur with *Potier et al.'s (2014)* conclusions that DCRs are associated with reduced levels of public injecting and discarded syringes. This promising evidence, combined with the support for DCRs we encountered across the range of stakeholders we engaged with, would suggest that DCRs should be explored further in Manchester. In the following sections, we highlight a range of considerations and challenges that would need to be carefully deliberated.

6.2.7 Developing a Manchester Model

'We could draw from everybody's experience and find the best way of doing it without the most impact ... on the community'.
(Needle Exchange Harm Reduction Worker)

As we noted in section 6.2.1, there are over 100 DCRs in 66 cities spanning Europe, North America and Australia. Approximately half of these are located in Germany (31) and the Netherlands (24). There are a range of models that span new builds with build costs running in to the millions with similar annual running costs through to more scaled down services attached to existing health care and NX services. We provide some examples of different international models in the Appendices (see sections 9.1 & 9.2).

In short, DCRs can, and should be, tailored to meet the needs of the local population. Careful consideration needs to be given to the location of the DCR, its capacity, opening times and the services offered. In this section, we report on user and stakeholder views on who would engage with a DCR and what type of DCR is needed in Manchester.

6.2.8 Establishing the user profile

It is imperative to establish who would use DCR facilities together with estimates of the size of this user group. Studies that have attempted to profile the people who use a drug consumption room have homogeneously shown that the service attracts socially precarious people with poor life conditions, suggesting they are successful in attracting marginalised groups of people who use drugs *(Potier et al., 2014:64)*. Poitier and colleagues literature review identifies that the majority of DCR users were male, 30-35 years in age *(Dubois-Arber et al., 2008; Kimber et al., 2003; Tyndall et al., 2006; Wood et al., 2006c)*, with frequent housing insecurity and unemployment *(Kimber et al., 2003; Richardson et al., 2008)* and with a previous history of incarceration *(Stoltz et al., 2007)*. DCR service users were also likely to frequently use heroin, cocaine, opiates, amphetamines and their derivatives *(Kimber et al., 2003, Tyndall et al., 2006)* and had a higher frequency of overdose, daily drug injection and public injecting *(Wood et al., 2005c)*. They also had elevated rates of HIV *(Salmon et al., 2009b; Wood et al., 2005c)* and Hepatitis C *(Wood et al., 2005a)*.

Establishing the take-up is important in developing the service model. PWID that we spoke to generally asserted that most users from inner city areas would not travel into the city centre to use a DCR.

'[I: So, would someone score and then come into the City Centre to use it [DCR]?] Not really, no. ... They need a reason to come into town, like you said, to go and score. So, to make their way, all the way up there, no, and it depends what the weather's like, as well!'
(IV Heroin User)

'So, if it [a DCR] was in the City Centre, it would mainly be people that are sleeping in the City Centre that would use it'.
(IV Heroin User)

'If that was their routine to come into Manchester to get the pins and then use there and then. But then if someone was using five times a day, they're not going to come into the city centre five times a day, are they?'
(Needle Exchange and City Centre Outreach Worker)

However, other respondents suggested that users from the inner city probably would utilise a city DCR facility, provided it was centrally located.

'If you are living on an estate you usually have somewhere to go, a gaff you can use at. [But] if you live close to the city centre, ... and the DCR is closer than your home you would get people using it'.
(IV Heroin and Crack User)

'I think so yes, because a lot of people travel in to the city centre to score you know so they are there anyway. So as long as it was central and not too far out of the way then yes, I think they would'.
(Needle Exchange Harm Reduction Worker)

Nevertheless, it appears that the core user group who would utilise DCR provision would be rough sleepers and those with street-based lifestyles who are sleeping or hanging out in the city centre. As we discuss in the recommendations (see Section 7), it is important that commissioners have a clear understanding of the scale of city centre injecting drug use in order to establish DCR facilitates on an appropriate scale. In presenting the recent case for a Glasgow DCR, estimates were provided of 13,600 problem drug users, of which it was suggested that in the region of 400 to 500 were regularly using in the city centre. With this in mind, during the course of the research, as it became clear that DCRs were strongly supported, we attempted to obtain the views of PWID, rough sleepers and those with street-based lifestyles on the size of the injecting drug using community in the city centre.

For many, they found this impossible to estimate although for the handful who did offer an estimate, the highest figure was a hundred. Although reluctant to put a figure on injecting drug use in the city centre, users often recounted their own experiences of scoring drugs in the city with other users as an indicator of its scale.

'Put it this way in five mins this morning there were 37 of us trying to score at the same time. We all got kicked out of the church [cold weather provision] at 9 o'clock - I can't tell you where it was obviously but 37 of us scoring together in five mins!'
(IV Heroin and Crack User)

'I couldn't put an exact figure on it and I wouldn't like to 'cos I'd be guessing but I can tell you this now. Every morning at 9 o'clock you'll see them hanging around the phone box outside Primark. Anything between five and 10 of them waiting to score and they are not just doing it for themselves, each one of them will be scoring for one or more others - they all chip in after the morning rush hour. That's just one spot!'
(IV Heroin User)

6.2.9 Location

It is clear that careful consideration must be given to where any potential DCR would be located. There were two distinct narratives to emerge when discussing where a DCR should be located. It was noted that location was key to ensure that users would engage with the service. In this respect, a DCR would have to be central for ease of access. Contrary and running parallel to this discourse was the view that establishing a DCR in the heart of the city would not be well received by city centre businesses, residents and the wider public. We document these two schools of thought below.

It was common for stakeholders to highlight the fact that users would be unlikely to travel far to use a DCR to use.

> *'[I: Would it be good for it to be central?] I'd say yes because not everybody is going to walk to it, but you never know'.*
> (Treatment Service Outreach and Needle Exchange and Harm Reduction Worker)

> *'You'd need a few in Manchester because people wouldn't be bothered walking to it'.*
> (City Centre Business Group)

> *'It should be central, to the most central public building, the town hall'.*
> (City Centre Business Management)

> *'Well I would probably look in the Northern Quarter, you know what I mean? Some premises around there really. You want an injecting room near where your people are, don't you?'* (Homelessness Outreach Team)

However, when discussing where a DCR should be established, the need to locate it on the margins of the city centre was often expressed. Echoing the discussion of sharps bins locations in section 5.5, the common narrative was that a DCR should be in a discreet location away from the public gaze and residential and business premises.

> *'I don't think that any of the residents I represent who live here actually want it down their street'.*
> (City Centre Councillor)

> *'You don't necessarily want it near a high density of residents'.*
> (City Centre Management & Partnership Consultancy)

> *'It'd be really good if it was somewhere at the back of the train station or something like that, which is neither business or residential'.* (City Centre Business)

> *'Where would you position it? I suppose, in a non-residential area'.* (New Islington Resident)

> *'I'm not saying put the building down a back alley or something like that but you're not going to stick it in the middle of Piccadilly Gardens, are you?'*
> (City Centre Management & Partnership Consultancy)

> *'It depends where it was. So, if you've got multimillion pound high stakes investment in Spinningfields for example, it's unlikely that you'd want to site a shooting gallery within that space'.*
> (City Centre Management & Partnership Consultancy)

The suggestions offered were often at odds with the stated needs of users and stakeholders for a central location.

> *'We're all quick to say [Piccadilly] trading estate'.*
> (Manchester City Council Community Safety Manager)

> *'I believe the only way it would happen in Manchester is if it was in some warehouse outside of the area'.*
> (Local Councillor)

The tension between finding a suitably central location that would ensure sufficient take-up whilst ensuring the support of city centre residents and businesses was recognised by this city centre business consultant.

> *'You need to take the service to where the people are but commercial pressures on property and so on, the realistic view is you can't get some sort of healthcare in that space'.*
> (City Centre Management & Partnership Consultancy)

With the ever-expanding city centre redevelopment and night-time economy many stakeholders struggled to come up with a viable location that would appease the concerns of objectors whilst also providing the convenient location that users desire.

> *'There isn't a good place. I can't suggest anywhere where it wouldn't impact on anyone'.* (NQ Forum)

6.2.10 Opening times

In addition to careful consideration required on the most suitable location to maximise usage, discussion often centred on the need to ensure adequate opening times. As this heroin user typifies below, the majority of users advocated a 24/7 set-up.

> *'It would have to central, probably near the [Piccadilly] train station - that would be convenient for everyone. It would have to be a 24/7 job. You can't switch off your rattle. I'm sweating my back off now cos I'm rattling you know what I mean? You can't switch your rattle off, so it needs to be open all hours'.* (IV Heroin User)

Opening a service 24-hour, seven days a week has clear staffing and financial implications. As these experienced Needle Exchange Harm Reduction and Homelessness Outreach Team professionals note.

> *'I reckon it would be expensive, because you've got to open it a lot, you've got to have at least three or four staff there. You need someone who's medically trained. You need a nurse. You're going to need some way of like making the staff safe, especially if it's open at night. So, it's going to end up being quite expensive'.*
> (Needle Exchange Harm Reduction Worker)

> *'24 hours a day might be ideal, but I think that would be very expensive to run'.*
> (Homelessness Outreach Team)

One DCR that offers an almost 24/7 model - the Danish DCR, 'Skyen' - opens 23 hours a day and has the capacity for nine injecting users and eight smoking users. This typically results in the service housing between 500 to 700 drug intakes each day. Annual running costs are in the region of £1million. However, a review of the international literature reveals a number of different models of operating hours (see Appendices in section 9). Service opening ranges from a 12-hour opening window (e.g. 8am to 8pm; 9.30am to 9.30pm) through to intermittent opening times in three or four-hour blocks (7am to 10am; 2pm to 5pm; 7pm to 10pm). Some services open Monday to Friday where others offer a seven-day service, often with reduced opening times at the weekend. Others provide the same provision daily. The proposed Glasgow model for example, is based around opening hours of 9am to 9pm seven days a week (see section 9.2).

In our survey with over 100 PWID, we found that of those who stated they injected drugs on a daily basis, over half (52 per cent) stated they injected drugs two or three time a day with a further 44 per cent stating they injected between four and six times a day. Therefore, although the opening times of any DCR should be agreed by all stakeholders, it is imperative that any safe injecting facility meets the needs of the local user group.

6.2.11 Financial implications

As noted above, DCRs can require significant funds to set up and run, depending on what form they take. However, cost benefit analyses, including for NHS Glasgow, have shown they are good value for money and engage hard to reach populations.

As we have outlined above, dependent on the model, scale and opening times, start-up costs and annual running costs could feasibly run into the millions. The estimated annual cost of the recently proposed Glasgow safer Drug Consumption Facility for example, was £2.36m, paid for by the city council and NHS Greater Glasgow and Clyde.

The largest DCR (H17) opened in Copenhagen in August 2016. This 1000 square metre facility has capacity for 24 drug users – 12 people who inject drugs, and 12 who smoke them – at any one time. However, this is far from the norm, with many services having smaller capacity, typically between two and eight users at a time.

While it is clear that set-up costs and annual running costs can be expensive, conversely, some viewed DCRs as providing a cost saving solution for Manchester.

> *'I think injecting rooms will be a good idea. ... I know it's a political hot potato, but I think the cost of setting up something like that would save money in the long run'.*
> (Treatment Homeless Outreach Worker)

As we have outlined in other sections of this report, the potential financial savings span a reduction in BBVs, overdoses and resultant emergency callouts, A & E and hospital admissions.

In presenting a case for the establishment of a DCR in Glasgow, the Integrated Joint Board stated that savings would be recuperated on spending across the wider NHS. Dr Saket Priyadarshi, the health board's associate medical director stated: *"There will be a benefit to the costs experienced in our acute services, hospitals, A&E departments, GP appointments, prisons, criminal justice system, housing etc"*.

Due to the focus of the research – reducing DRL – the discussion of DCRs tended to focus on injecting drug use. However, many of the established DCRs also provide smoking booths. Although traditionally this has been associated with the smoking of heroin and crack cocaine, in the local context, the use of synthetic cannabinoids (aka 'Spice') could be an option.

Like many other models across the globe, users attending the proposed Glasgow services will be offered health care and other support such as housing and financial help. The need to offer more than a safe place to inject was also routinely stated during interviews with stakeholders. In addition to providing a safe place to use drugs, many stakeholders discussed a model that would also include support from other services.

> *'Somewhere people can go and safely inject. It may be that there are agencies down there who can try and engage with some of these individuals. I would prefer that as an alternative to putting sharps [bins] in various locations. Because many of these people*

will have different needs and different problems with regards to health and mental health, perhaps easy access to support workers, access to being able to put your name down on the housing register'.
(Community Safety Manager)

A 'one stop shop' that included testing for BBVs and health care to treat leg ulcers was often discussed.

'People can use in a safe environment, they're engaging where there's more staff members on hand and integrating them into services. Clean works, having the BBV testing. I think it should be like a bit of a one-stop shop where they could get their legs dressed, a bit of a needle exchange, ... where they can access lots of different things and [they're] more likely to then engage in services'.
(Treatment Service Outreach Worker)

An uptake of service user engagement has a range of criminal justice and health benefits. Cost effectiveness studies have typically been calculated through modelling expected reductions in HIV, with significant savings anticipated as HIV treatment can be costly. In light of the cost of treating diseases like hepatitis C and HIV, even relatively small reductions in the number of infections from needle sharing can mean a DCR is a cost-effective intervention. The Glasgow proposals followed a public health concern in relation to a steep rise in the number of HIV cases among people who inject drugs. There were an estimated 90 new cases of HIV diagnosed in Glasgow among people who inject drugs in the city. Health officials estimated that the 78 cases diagnosed in Glasgow between 2015 and 2017 alone could potentially create lifetime costs to the health service of £29.64m. However, whether DCRs do reduce incidents of HIV is unclear and hard to estimate *(Hedrich et al., 2010; Kimber et al., 2010)*, due to the DCR facilities limited coverage of the target population and also to methodological problems with isolating their effect from other interventions' *(EMCDDA, 2017:5)*. In presenting the case for a DCR, the Glasgow Integrated Joint Board estimated the annual cost of each 'problem drug user' at £31,438.

As we highlighted in section 6.2.3, there is evidence that DCRs have many positive impacts in terms of reducing overdose and related ambulance callouts and hospital admissions. One standout statistic is that, to date, there have been no fatal overdoses recorded in any of the 100 plus DCRs around the world. This is in stark contrast to the 1,707-illicit heroin-related deaths that occurred in the UK in 2016 alone *(Transform, 2018)*. The increased engagement with health care and treatment professionals also reduces incidents of infection. To date, no cost effectiveness studies have been modelled on the stronger associations and causal relationships identified in the literature, such as reducing nuisance associated with public drug use and improving access to primary care. In the context of this study, as we noted in section 6.2.6, DCR facilities have also been viewed as effective in reducing incidents of DRL.

6.2.12 New beginnings or an extension of existing provision?

As outlined above, the set-up and annual running costs can be expensive and off-putting. However, there are many different models in operation. During the fieldwork, several respondents with a long history of working in this sector or of using city centre services bemoaned the loss of the old Lifeline Oldham Street set-up. The following interview extract with a member of the homelessness outreach team typifies this narrative.

'Well I think we had a lot better needle exchange facilities here a few years ago. So, I think a Lifeline needle exchange was very good, a treatment room in the back and nursing staff there, very well managed and very little anti-social behaviour involved in a well-managed needle exchange and I can't see how that would be changed if you just expanded that a bit more into a drug consumption facility'.
(Homelessness Outreach Team)

City centre residents also suggested an extension of existing NX facilities to offer an injecting room. In particular, it was suggested that the current Ancoats health centre and NX would make a suitable location to develop this service in Manchester.

'Why is there not a room in the health centre in Old Mill Street where people can actually use the syringes?'
(New Islington Resident)

'We're letting it happen in the city centre and we're not dealing with it. So yes, there should be a drug consumption room in that building [needle exchange], with several rooms'. (City Centre Business Manager)

'For example, Ancoats and Clayton [NXs], should we not look at supervised injections essentially, or should we not at least have that conversation'.
(Ancoats Resident and Canal and River Trust Volunteer)

For some, they seemed to perceive DCRs as a replacement rather than extension of NSPs. As the following interview extracts with members of the city centre business and residents illustrate.

'I did see it in Glasgow, they have done some drug rooms. So why don't the needle exchanges have them? "Sorry, you can't take the needle. You have to take your drugs here"'. (City Centre Car Park Manager)

'*I would expect them to be a clean needle exchange where people just use the drug in the service, they don't just pick up the needle and go and take it somewhere, they can use it there and that's the basis on which you give them the needle, is you can use it in this environment but not anywhere else'.*
(City Centre Councillor)

Other respondents suggested a DCR could be added to existing GP surgeries, medical centres or treatment services.

'Ideally it could be at GP surgeries'.
(Northern Quarter Resident)

'People could go in a medical centre or a hospital and there would be a room they could use there, where they could safely inject'.
(Manchester City Council Community Safety Manager)

'Have them [DCRs] attached to existing treatment services'. (City Centre Sexual Health)

So far, we have focused on the decisions that need to be made in establishing the location, opening times, model, size and service offer. We now turn attention to a number of identified challenges that we have identified from a combination of the review of the international literature and data collection process.

6.2.13 Challenges and objections to the establishment of DCRs

Section 6.2 has outlined a number of perceived benefits of DCRs. Yet the discourse around DCRs was not always so positive. As we outlined in section 6.2.9, users and stakeholders highlighted the need to ensure the DCR was centrally located with appropriate opening hours if the DCR was to be successful in engaging street-based users. In addition to this, some respondents suggested that a DCR would not appeal to users.

'Would we get drug users saying, "Well, no I don't want to go to a drugs room. I don't feel comfortable there. I feel supervised. I feel that people are watching me"'.
(Manchester City Council Community Safety Manager)

'There is a lot of them out here who are just not going to be interested. "Why do I want to go there? If I go there all I want to do is take my heroin ... but then I'm going to have to go there and they're going to talk to me"'. (City Centre Business)

'I think the reason that people go to where they do go, particularly in relation to my experiences of the canal, they go there because it's isolated, because there isn't anybody there and they can effectively do it without anybody being around'.
(Canal and Riverside Trust Volunteer)

Police officers advocated using a carrot and stick approach that involved taking a hard-line approach to those who persisted in open drug use.

'You'd have to do the enforcement outside of that. So, when you've got somebody who goes into Angel Meadows and shoots up, we'd have to come down on them like a ton of bricks to show them that, no, the gallery is the place to go. "Because you've got no excuse now, there's no reason for you to be in Angel Meadows. You know as well as I do, there's a clean clinic over there, go and use the clinic"'.
(City Centre Neighbourhood Police Officer)

In addition to reservations regarding the uptake, concern was raised about the image of the city if a DCR was established. Indeed, Manchester has had its fair share of negative media attention in recent years in relation to its city centre substance use. This has included both local and national news coverage of the use of 'Spice' in the city centre. During the course of this research project, local TV news channels and the Manchester Evening News also ran features on the problem of DRL in the city centre. These experiences understandably led to apprehension amongst local councillors, businesses and residents around how the introduction of DCRs might be portrayed by the media.

'You know what it's like, the media will inevitably spin it to something that is not a great thing for the local area, and you will get objections'.
(City Centre Councillor)

It was also noted that establishing a DCR might be perceived as condoning drug use.

'It's as it is perceived, it's like condoning drug use'.
(Homelessness Outreach Team)

'I'd much rather that we didn't have people injecting drugs. I can see logically the arguments for it, but I feel very uncomfortable with the, sort of acceptance that that [a DCR] brings'. (City Centre Councillor)

In short, having a DCR in Manchester City Centre was viewed as something that would portray a negative image of the city to perspective investors and visitors.

'Because the type of people that we attract to the area, we bring a lot of investment in to the city and to have this sort of facility with people who are probably, ... they're not washed or whatever and have been sleeping rough and that, it detracts from our customer journey to a certain extent doesn't it? ... It's not great for our business, it's not great for our brand and definitely not, I'm sure, for Manchester'.
(City Centre Business)

Some respondents even went as far to suggest it would drive existing businesses out of the area.

> *'You're going to drive businesses out of there'.* (City Centre Business)

The recent challenges to the establishment of a DCR in Dublin highlight the potential for the business community to oppose a DCR. The Dublin Business Alliance – a lobby group made up of the Licensed Vintners Association, the Restaurants Association and the Temple Bar Company – vocally opposed the introduction of supervised injecting centres and sought a number of Section 5 Declarations in relation to planning laws around the centres.

6.2.14 Community resistance

Despite evidence demonstrating that DCRs have a beneficial impact on local communities, the experiences of establishing DCRs in other global cities points to the likelihood that residents are likely to harbour concerns that a DCR will create more drug-related disorder. Fear of increased illegal activity in the surrounding area in a natural reaction. Despite the overwhelming positive evidence around the benefits of DCRs, there remains concern amongst those who oppose DCRs that they may increase drug use, frequency of injecting, drug dealing, and drug trafficking or drug-related crime in the surrounding environment. Unsurprisingly, we came across similar concerns during the research.

> *'It may be a focus for lots more drug users to go to that area'.* (City Centre Business)

> *'[I: What would be their [the public's] concerns?] That people would be using nearby'.* (City Centre Councillor)

> *'That would be a concern for me, personally. From a security point of view would it ... cause an increase in drug related crime, or issues around that area?'* (City Centre Business)

> *'Wasn't it in King's Cross in [Sydney] Australia where they started to attract loads of dealers obviously just to, you know, that was the place to meet. Buy your drugs, use your drugs, you know'.* (Needle Exchange Harm Reduction Worker)

These concerns regarding increases in drug use, drug dealing and other criminal activity in the vicinity of DCRs is commonplace. However, as we highlighted earlier in this section, throughout the research, we were struck by the lack of resistance and the widespread advocacy for DCRs from the vast majority of local resident groups and business forums.

Furthermore, a review of the existing international evidence found no indication that these commonly held fears have materialised. Drawing on police data, *Wood et al. (2006)* concluded that after the opening of the Vancouver DCR, there was no increase in crime, violence or drug trafficking in the vicinity. In contrast to the above interview suggestion, studies by *Fitzgerald et al. (2010) and Freeman et al. (2005)* revealed that data collected over a 10-year period showed no increase in offences related to the trafficking or consumption of drugs in the areas surrounding the Sydney MSIC. A survey of residents and businesses in the vicinity of a DCR also reported that they had seen no increase in the number of drug deals *(Salmon et al., 2007)*. *Poitier et al.'s* literature review also concludes that no studies had found any increase in the total number of PWID in the local area, irrespective of the DCR studied *(Poitier et al., 2014)*.

6.2.15 Public and political objections

It was commonplace for respondents to express reservations regarding the likelihood of a DCR being established in the city.

> *'[I: Why wouldn't it work?] Because firstly, it would have to go out to public consultation. The public generally would not like the fact that there was a place in the city where people could legally take Class A drugs, they just wouldn't like it. Especially if, like I say, you lived nearby and stuff. It would fail at consultation level. Rightly or wrongly, it would'.* (Local Councillor)

Consultation is essential to minimise community resistance, though evaluation studies have shown that community support increases after establishment *(Salmon et al., 2007)* and the facilities are generally accepted by the local community *(Thein et al., 2005)*.

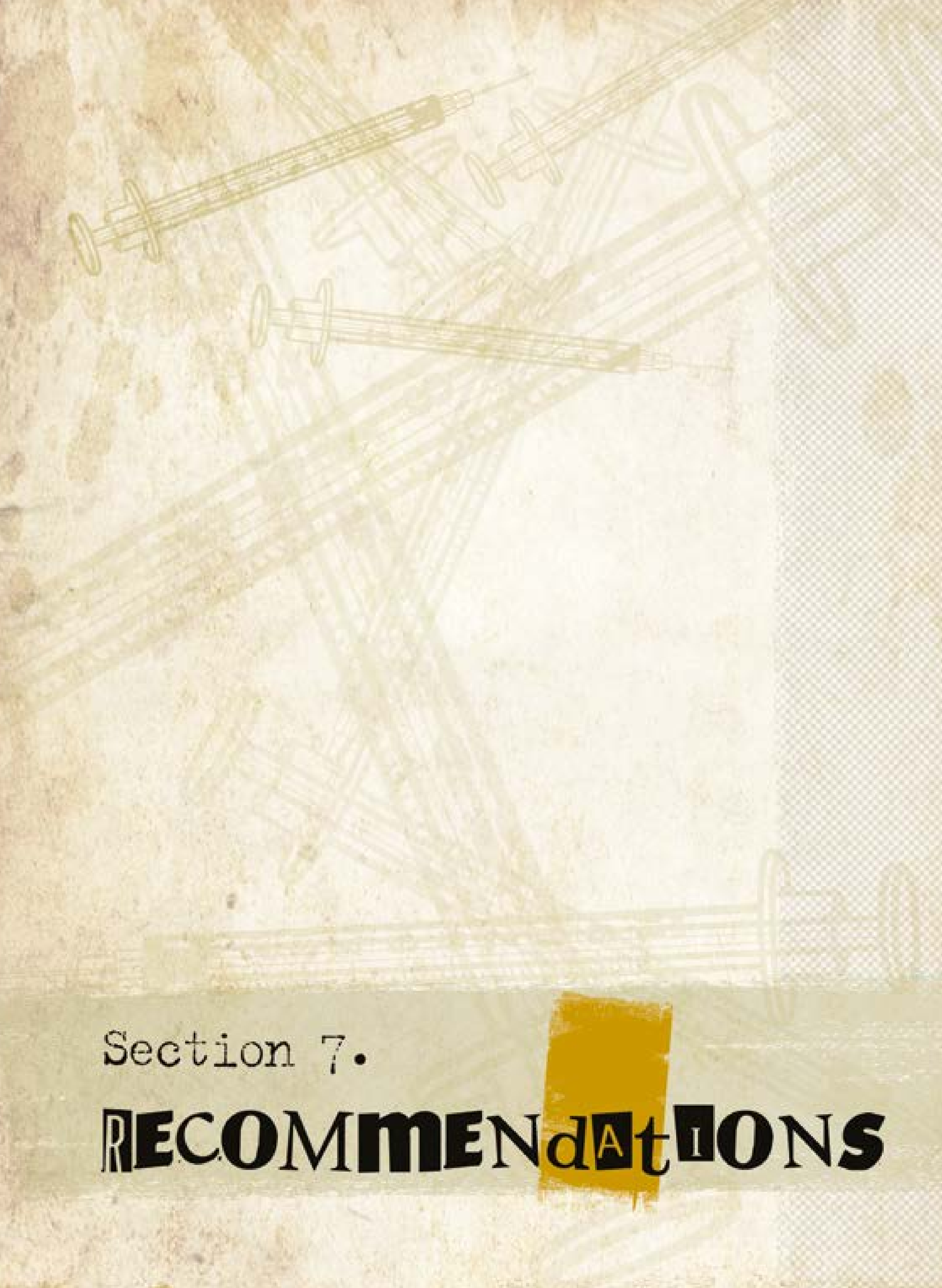
6.2.16 Legal barriers and policing

Leaving public and local political residence aside, there are legal barriers that would challenge the operation of a DCR in the UK. This has been evident in the recent case of Glasgow. However, there is flexibility within the law for the police to take a reasonable approach to law enforcement, exercising discretion in the public interest. The success of a DCR relies to a large extent on collaboration and strong working relationships with the police. It is likely that police procedure will not be a significant departure from existing procedure for policing drug addiction services, but forces would benefit from observing models of practice in countries where DCRs have been in place for some time. Clear guidance or legislation would make it less likely that any law enforcement issue would impact negatively on the facility.

A DCR could operate through a discretionary model, pursuant to guidance given by the police and prosecution service. Such guidance would be susceptible to changes of policy and senior personnel within the police or prosecution service and is also vulnerable to legal challenge as the guidance would not have the force of law. However, the courts will not lightly interfere with the exercise of discretion that is reasonable and rational. Alternatively, a discretionary model could operate without legal guidance from the prosecution service and instead rely solely on multi-agency support, with local stakeholders signing a document regarding the establishment and running of the DCR. Though feasible, such a protocol would be exposed to the potential for political, legal and administrative challenges. A legislative route entails a longer process but is a more stable and permanent legal solution. However, evaluations of a facility, operating on a discretionary model, could be used to build the case for legislative change.

These concerns and likely objections led to a degree of scepticism on the likelihood that a DCR would be established in the city.

In summary, whilst we found widespread advocacy and support for the establishment of a DCR in Manchester, there are numerous legal, financial and planning considerations. Therefore, we would suggest, as we discuss further in the next section, that a more robust and thorough feasibility study is conducted to explore the possibility of establishing a DCR in Manchester in the future.



Section 7.

RECOMMENDATIONS

7. Recommendations

7.1 Introduction

'We have to come to the conclusion that it is not acceptable for people to inject openly in private parks in full view of the public and leave discarded drug paraphernalia about'.
(Manchester City Council Community Safety Manager)

In this final section, we outline a number of recommendations that we believe will assist in addressing the issues raised in this report. These recommendations focus on recording, removing, reducing and responding to DRL and public intravenous drug use. They have been developed in line with the national NICE and DEFRA good practice guidance and draw on examples of evidence-based good practice identified during the international literature review. Whilst we have endeavoured to take on board all of the feedback we received from research participants, we acknowledge and are mindful of the constraints of existing legislation, government stance and the current local Public Health budget. Therefore, the recommendations that follow are based around what we believe are tangible within the constraints of existing resources and commissioning frameworks.

7.2 Recording of DRL

In Section 4, we highlighted a number of resident and business frustrations and suggestions for improving the current recording system. In light of these findings, we recommend the following:

- Awareness raising of the existing reporting mechanisms.
- A more streamlined online system that is easier to navigate and includes the capacity to upload images to ensure a more accurate location of DRL that will reduce the number of incidents of DRL not being found (at first attempt) by waste disposal teams.
- A reporting App that builds on the current Manchester City Council on-line reporting system. We recommend a more general litter/tipping App that has an option to select DRL.

We also encourage the more accurate recording of the actual number of discarded needles and syringes by waste disposal contractors and other regular collectors of DRL.

7.3 Removal and safe disposal of DRL

7.3.1 Guidance on safe removal and disposal of DRL

As we highlighted in section 4.5, the 24-hour response time is too long for many residents and businesses, leading to the regularly reported risky practice of members of the public picking up and disposing of DRL. We recommend that clear guidance on safe removal and disposal of DRL is made available to local businesses and residents. In addition to guidance on clear health and safety practices on handling DRL, this should also include information regarding the safe disposal of DRL such as the locations of sharps bins, local pharmacies and needle exchanges that accept used needles and syringes.

7.3.2 Collection of all drug paraphernalia

As we highlighted in section 4.7, the current contact for responding to DRL is focused on removing needles and syringes. We recommend that this be extended to include the removal of all associated drug using paraphernalia and related litter (e.g. condoms) present at a reported site of DRL.

7.4 Reducing and responding to DRL

7.4.1 Promotion of services – needle exchange locations and opening times

In addition to awareness raising for residents, volunteers and businesses on disposal options, as we illustrated in section 5.4, the research uncovered a lack of knowledge amongst PWID on where to dispose of DRL. We highlighted in sections 5.4.5 and 5.4.6, how many people who inject drugs were unaware of NXs other than Ancoats and/or unaware of late opening times and, in particular, weekend opening times. We therefore recommend the routine promotion of the existing needle and syringe programme offer to ensure an awareness of where and when users can obtain and return needles. This should include, but not be limited to, those involved in city centre outreach, treatment services, homeless, sexual health and supported accommodation services.

7.4.2 Reviewing secondary distribution

The common practice we highlighted in section 5.4.14 of PWID (from traditional heroin and crack users through to chemsex and IPED users) collecting and returning needles and other drug paraphernalia on behalf of other PWID, directly impacts on the levels of user engagement and the opportunity for health checks and harm reduction advice. We therefore propose a review of existing practices and intravenous user engagement strategies that sets out to improve existing levels of primary engagement with NX provision and harm reduction practitioners.

7.4.3 Accessible needle and syringe service provision

As we outline in section 5.4.6, the relocation of the old Oldham Street NX was lamented by PWID and a range of stakeholders. Its move to Carnarvon Street has placed extra pressure on the Ancoats NX service. The lack of a central city centre NX is viewed as a key contributing factor to the current level of DRL, in particular DRL in the Ancoats, New Islington and Northern Quarter areas. In addition to contributing to current levels of city centre DRL, many stakeholders viewed it as leading to a reduced level of engagement with injecting drug users. In the short term, this may involve utilising existing city centre pharmacy provision. However, as we highlight in section 5.4, there are a number of reasons why a more discreet and empathetic service provided by substance use treatment providers is preferable. Many PWID also prefer the 'one stop shop' model of service provision on offer at the Ancoats Medical Centre. Therefore, long-term we suggest that additional city centre NX provision may be best located in a Homelessness Primary Care Hub.

7.4.4 Accessible service provision for non-traditional injecting drug users

As outlined in the 2017 Drug Strategy, there is a need for commissioners to ensure an accessible service for non-traditional users (IPED users and those engaged in chemsex). We therefore recommend the reviewing of the current targeted response for service accessibility for these non-traditional users.

7.4.5 Establishment of a NSP service improvement 'Task & Finish' Group

The recommendations provided here would benefit from the oversight of a dedicated working group to drive service improvement in this area and to ensure that the commissioning of both generic and targeted needle and syringe programmes is meeting the local need.

7.4.6 Choice of needles and other drug paraphernalia

As we discuss in section 5.4, during the research we received complaints about the quality and range of needles on offer through NSP provision. This included the lack of 'Nevershare' (coloured) needles, and a lack of needle choice and access to wider drug using paraphernalia from pharmacies. Commissioners immediately addressed these issues. Nevertheless, the research highlights the importance of continued monitoring of the existing choice and quality of NSP provision.

7.4.7 Public sharps bins

As we outlined in section 5.5, the use of public sharps bins divided stakeholder opinion. Many injecting drug users and stakeholders viewed them as a central part of the solution to reducing DRL but many residents and businesses were against them. In light of the various concerns and reservations articulated in section 5.5.2 and 5.5.3, we recommend an initial pilot in suitable hotspots for DRL with a view for further rollout, subject to positive pilot results.

7.4.8 DCRs and safer injecting spaces

'If you don't make a choice to say we're going to look at some kind of supervised injection, then you say, "Okay we're fine with unsupervised injections"'.
(Ancoats Resident and Canal Trust Volunteer)

The research revealed a consistent narrative relating to the perception of more open intravenous drug use (see section 3.5). Whilst a large number of participants in the research called for some form of DCR/safer injecting space, the general findings from the research are not robust enough to recommend that there should be this type of provision implemented in the short term. Whilst the findings offer strong support and evidence of need, the remit of this research project on DRL did not allow a full gathering of evidence. These should include BBV rates, overdose incidents, drug related deaths and the scoping of the city centre injecting drug use population that have been used to make a robust case for DCRs in other cities such as Dublin and Glasgow. In addition, as we illustrate in Section 6, there are a number of challenges and practicalities that need to be explored. We therefore recommend the undertaking of a feasibility study to better understand the need (i.e. the number of users in the city centre and surrounding areas, the level of blood borne virus infections etc.), the different models (see for example Appendices 9.1 & 9.2), and the legal challenges.

7.4.9 Working with people with street-based lifestyles

As highlighted above and in Section 6, the establishment of a DCR is unlikely to take place soon. Therefore, a more immediate response is needed to address the open injecting drug use we report in section 3.5. We recommend a more targeted focus on trying to engage with the cohort of drug users who are regularly coming into the city centre to purchase and use drugs. This should include targeting beggars and those engaged in sex work.

Section 8.

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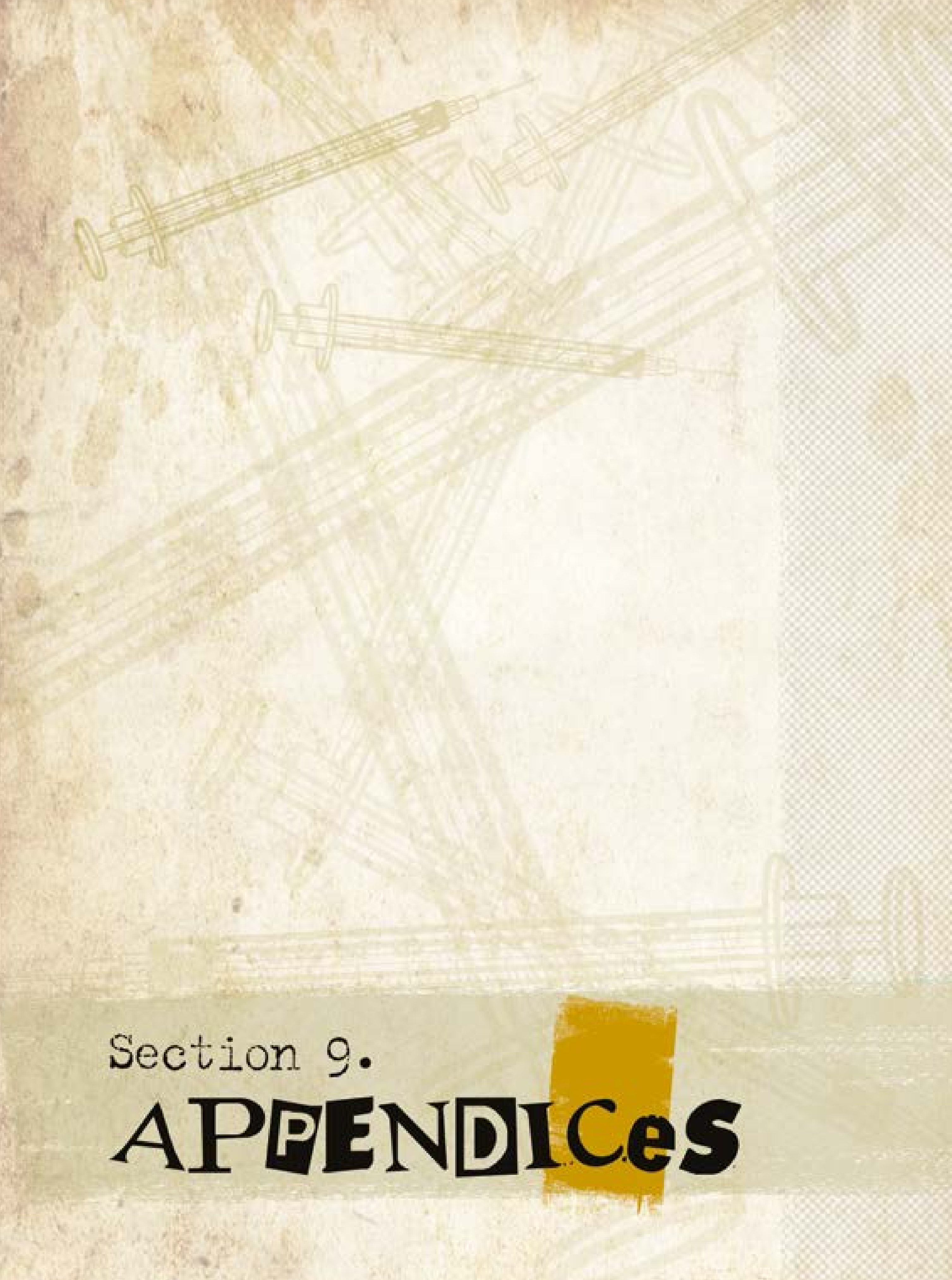

Section 9.
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9. Appendices

9.2 Dublin

Service type: Injecting only

Length of pilot: 18 months

Staffing per shift: Assessment area requires a minimum of one receptionist and one/two security person(s) at all times. The security person will manage front of service and stop people congregating. The injecting and clinical area requires three nurses to be on duty at all times, two registered nurses and one clinical nurse manager reporting through an appropriate nursing governance structure. A doctor is required to be on duty a minimum of five days per week, and for an overall minimum of 30 hours in total with their time split between the available sessions appropriately. The 'chill out' area requires a minimum of two project workers to provide support in relation to accessing 'wrap around' services.

Annual cost: Estimated to be €1 million

Service design:
1. An assessment and intake area where basic details of the service user can be obtained and the person is welcomed. Information on the DCR, house rules (for example no dealing, sharing of drugs) and information on sterile injecting is provided and a basic health needs assessment is carried out. The area is of sufficient size to prevent 'on-street congregation' of people waiting to use the facility. The area is equipped with a reception desk and can seat between 10 to 15 people.
2. A clinical area comprising of six injecting booths where sterile injecting equipment can be distributed and supervised injecting can occur in a space protected from public view. Resuscitation equipment is available and the individual is monitored in case of overdose or adverse reactions. The area is equipped with a desk and chairs for nursing staff and a lockable cupboard for medical consumables.
3. A relaxation or 'chill out' area where people can relax and be monitored for about 30 minutes post-injection. The area is equipped with a self-service coffee/tea machine, comfortable chairs and small tables for service users. Space is available for project workers to interact with attendees and access to clinical rooms is readily available.

Provider: Fully managed by a third sector provider or by the Health Service Executive

Operating procedures: The service will provide for adult (18+) established drug users who are on the premises of the supervised injecting facility with the permission of the licence holder, for the purposes of consuming drugs by injection only, during its normal opening hours. The facility shall not be used for the consumption of drugs in any other manner, and such consumption of drugs by any other means (for example smoking) is strictly prohibited. Sharing or dealing drugs is not permitted at the facility.

Additional services: Clinical rooms for medical interventions, crisis interventions, counselling interventions (if requested) and where referrals for social services/housing/treatment can occur. Specific medical clinics (e.g. bloodorne viral testing, vaccinations and wound and abscess care) will be available each day to allow individuals access to appropriate medical care. Naloxone training and distribution, and injecting equipment provision will be offered to individuals on leaving the facility.

Opening hours: The facility will open from 6:00-10:00 to meet the needs of the vast majority of injectors who use at the beginning of the day. The facility will also be open in the afternoon with suggested timings being 14:00-1700 and 20:00-22:30 hours daily. Staggered or sessional opening is required to facilitate use prior to individuals returning to hostels at night. The service will open seven days a week (Health Business Services, 2017).

9.3 Glasgow

Service type: Injecting and inhalation

Length of pilot: Three years

Staffing per shift: To be confirmed

Annual cost: Estimated £1 million, final cost is dependent on site

Eligibility criteria: Those aged 16 and over who are consuming illicit drugs. Proof of age or pregnancy status is not required at registration. However, staff will be vigilant and trained to respond appropriately to anyone who appears ineligible to use the service.

Referral Routes: Self referral with statutory and other agencies promoting the safety and harm reduction aspects of the service.

Opening hours: 9am-9pm, 7 days a week

Service design: 12 drug consumption booths, including a reception and aftercare area

Provider: Reception and aftercare area provided by third sector, DCR area provided by the NHS.

Operating procedures: Booths are for individual use only. Sharing or preparation and injection of one client by another is not permitted. Both of these practices constitute offences of "supply" under the Misuse of Drugs Act and under section 23 of the Offences Against the Person Act. Alcohol consumption or cigarette smoking will not be permitted in the facility.

Additional services: Supplies of take home naloxone and injecting equipment, including the supply of foil to promote transition from injecting, will be available to clients on leaving the facility. Further preventative and supportive health, social care and peer support, including advice and referral to specialist treatment options can be accessed in the after-care area (Millar, 2017b).

Source: McCulloch, M. (2018) Back Yard:
An investigation into the feasibility of establishing drug consumption rooms.