

IDPC Briefing Paper

Drug consumption rooms Evidence and practice

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Introduction

For the past 10 to 20 years, drug consumption rooms (DCRs) have become an integrated part of the drug treatment and harm reduction strategy in a variety of countries in Western Europe, North America and Australia. However, they have not yet been established in the majority of countries worldwide.

This briefing paper provides a short summary of the background, history and objectives of DCRs, and analyses available evidence regarding their impact. The second part of the briefing paper consists of an overview of the various DCRs in different countries, with a particular focus on the concepts used to develop these facilities with regard to the local political, cultural and social situation of each country.

Background

In the face of the burgeoning HIV epidemic among people who use drugs in the 1980s, the existence of open drug scenes in many Western metropolitan areas and rising numbers of drug-related deaths, some policy makers and practitioners have come to realise that repressive criminal justice measures and abstinence-based programmes alone were not able to reduce of drug use and associated harms.

The implementation of harm reduction programmes such as needle and syringe programmes (NSPs), opioid substitution treatment (OST) and low-threshold services, as well as the emerging body of evidence of the effectiveness of these measures for public health and public order policies, became the starting point for considering the establishment of DCRs (see Box 2).

Box 1. Methodology

The data presented in this report was provided by individuals working in DCRs in countries of focus. For most countries, data provided is country-wide. However, for countries such as Germany and Switzerland, where it has proven to be difficult to gather country-wide information, we have provided local or regional data.

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Box 2. Definition of 'drug consumption room'

DCRs are protected places used for the hygienic consumption of pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff. They constitute a highly specialised drugs service within a wider network of services for people who use drugs, embedded in comprehensive local strategies to reach and fulfil a diverse range of individual and community needs that arise from drug use.

The aim of DCRs is to reach out to, and address the problems of, specific high-risk populations of people who use drugs, especially injectors and those who consume in public. These groups have important health care needs that are often not met by other services and pose problems for local communities that have not been solved through other responses by drug services, social services or law enforcement.¹

The late 1980s and early 1990s saw the early implementation of the first initiatives for DCRs in Switzerland, Germany and the Netherlands. Although these countries started experimenting with this new harm reduction measure, at the time DCRs were not officially included in national legislations.

In many instances, the driving forces behind the opening of DCRs were people who use drugs, harm reduction service providers or outreach workers, but also local authorities and law enforcement agencies. From the very beginning, DCRs were regarded as serving two main objectives: to reduce individual health risks associated with drug use, and to reduce public disturbance.

In the 1990s, Switzerland, Germany and the Netherlands scaled-up DCRs to ensure wider access to the facilities. Meanwhile, DCRs were opened in Sydney, Australia and Vancouver, Canada in the early 2000s. Spain, Luxembourg and Norway complete the list of countries that have included these facilities in their drug policy and practice. However, only the Netherlands and Switzerland provide nation-wide coverage of DCRs for people who use drugs. In most countries, DCRs have only been established in the capital city (e.g. Australia, Canada, Luxembourg and Norway) or in specific regions (e.g. in Germany and Spain).

In many other countries, efforts have been undertaken by service providers, politicians, researchers, grass-roots organisations and drug user advocates to introduce DCRs in their own country, most of them without success. One notable exception is that of Denmark. In 2011, a NGO in Denmark opened a mobile DCR in Copenhagen. For 10 months, this mobile unit provided services for people who use drugs without interference from the police or any other government authorities. The initiative significantly contributed to ongoing discussions regarding the legality of DCRs under Danish law. In June 2012, the Danish parliament passed a law giving municipalities a clear legal mandate to operate DCRs with permission from the Minister of Health.²

General settings

A DCR aims to fulfil several objectives:

- to improve access to healthcare services for the most vulnerable groups of people who use drugs
- to improve their basic health and well-being
- to contribute to the safety and quality of life of local communities
- to reduce the impact of open drug scenes on the community.

Most DCRs are therefore embedded in a wider range of service provision and are implemented in collaboration with a variety of stakeholders, including local authorities, law enforcement officers, and social and healthcare service providers. In addition to the core services provided in the DCRs – supervised injection, NSP, basic healthcare and social and educational interventions – the visitors can also be referred to more extensive support services if necessary. Depending on the local circumstances, some DCRs may focus more intensively on a medical approach and choose to include medical doctors and nurses in their staff, while others may choose to play a ‘social function’ and focus on community outreach. All DCRs have established admission criteria and set out strict house rules. A number of DCRs have developed participation and peer-support models in order to include people who use drugs in service delivery and decision making processes.

Legal contexts

A DCR operates within the legal system of the particular country in which it has been established, either as an independent legal entity, as a unit of a healthcare facility, as a non-governmental organisation (NGO), which is very common, or as part of a local governmental or public health service. In most countries, it has been necessary to modify specific laws in order to decriminalise drug consumption in the DCRs and to regulate the functioning of the rooms. In Canada and Australia, the DCRs have been set up as scientific pilot projects under legal exemptions. Despite the tolerated use of certain drugs in the facilities, the purchase of such drugs is criminalised in all of the countries that have developed DCRs.

At the international level, the United Nations (UN) drug control conventions may create an obstacle to the widespread introduction of DCRs.³ The International Narcotics Control Board (INCB), the UN body responsible for monitoring the implementation of the UN drug conventions has repeatedly expressed its concerns regarding the development of DCRs although its stance

towards other harm reduction measures has softened over time.⁴ The INCB objects to DCRs on the basis that allowing the possession of drugs obtained through illicit means facilitates ‘drug trafficking’ which must be established as a criminal offence.⁵ The INCB also argues that DCRs allow drug use that falls outside of scientific and medical purposes which therefore contravenes the conventions. However, this narrow interpretation of the conventions is not universally held. Indeed, responding to a request from the INCB to look into the relationship between a range of harm reduction measures and the drug control treaties, the forerunner of the United Nations Office on Drugs and Crime (UNODC) came to the conclusion in 2002 that many interventions, including DCRs, were not contrary to the conventions. This interpretation is supported by the interpretative flexibility of the conventions, a lack of definition of what exactly constitutes ‘medical and scientific’ purposes and language within the 1998 Political Declaration on the Guiding Principles of Drug Demand Reduction. In practice, therefore, while countries that have introduced DCRs have faced criticism from the INCB with regards to their international obligations, particularly within its annual report, this can easily be countered by robust legal justification.

The evidence for drug consumption rooms

DCRs are an innovative approach to reduce drug-related harms, but remain controversial measures in the drug policy framework. It is therefore crucial to evaluate the effectiveness of these facilities carefully and continue to build the evidence base that justifies their implementation. The evaluation process is particularly used in countries where DCRs are still at the experimentation stage, such as in Australia and Canada. So far, however, broad-based randomised controlled trials and extensive studies on the cost-effectiveness of DCRs have not been achievable, mainly because methodological problems have made it difficult to justify the link between the existence of DCRs and the changes that have taken place in practice.

The most recent extended evaluation report on DCRs was issued in 2010 by the accounting firm KPMG in Sydney, Australia, on the DCR trial period 2007-2011.⁶ The report suggests that:

- The DCR had a positive impact on reducing drug overdoses
- It functioned as gateway towards drug dependence treatment
- It reduced significantly the security problems related to injecting in public settings and discarded needles
- It contributed to a decline in new HIV and hepatitis C infections.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published two extensive reports on DCRs.⁷ These reports reviewed available evidence about the effects of DCRs and concluded that they:

- Reach out to vulnerable groups and are accepted by their target groups, communities and other key actors

- Help to improve the health status of people who use drugs and reduce high-risk behaviour
- Can reduce overdose deaths
- May have an impact on HIV and hepatitis C virus infection rates, although more evidence is needed to prove this effect
- Can reduce drug use in open spaces and related nuisance, if this measure is part of a comprehensive local strategy.

The International Network of Drug Consumption Rooms

In 2007, the International Network of Drug Consumption Rooms⁸ (INDCR) was established in Bilbao, Spain. The objective of the INDCR is to share knowledge and experiences, to improve methodologies and to support the implementation of DCRs in new settings. The network delivers surveys and reports and aims to contribute to legal and political debates on DCRs. Currently almost all DCRs worldwide are members of the Network.

World overview of drug consumption rooms

Country	DCR	Eligibility and services	Client profiles	Results
Australia	<p>Location 1 in Sydney</p> <p>Staff 1 in injecting room Training: At least 1 nurse, 3 officers with health training</p>	<p>Eligibility 18 years and over Already drug dependent Not pregnant nor with child Not intoxicated No dealing of drugs on premises</p> <p>Services Stage 1: Waiting room/assessment area Stage 2: Injecting room with 8 booths Stage 3: After care room Resuscitation room Links to health, legal, housing, welfare services</p>	<p>12,050 clients between May 2001 and April 2010 3 new clients a day on average 74% men / 26% women 33 years of age on average 13 years of average time injecting</p> <p>Principal substances used Drop in heroin use (40% in 2005) Increase in other opioid use (60% in 2012) Decline in cocaine use (15% in 2012) 10% methamphetamines 1-2% buprenorphine</p>	<p>Cost-effective Contacts vulnerable groups – 9,500 referrals to health and social welfare services 4,400 overdose interventions (no fatalities) Reduced risk of blood-borne virus transmission Reduced public injecting and injection-related litter No adverse impact on local community (e.g. increase in drug-related crime in area)</p>
Canada	<p>Location 1 in Vancouver called 'Insite'</p> <p>Staff 9 staff Training: nurses, programme workers (PHS), peer support workers</p>	<p>Eligibility No admission criteria</p> <p>Services Low-threshold, anonymous service with 12 drug consumption booths Supply of clean injection equipment and safer use counselling Primary healthcare services Voluntary detox (Onsite) Links to longer-term drug dependence treatment programmes Links to housing and community support</p>	<p>1.8 million visitors since 2003 Between 1st Jan 2010- 31st Dec 2010: 312,214 visits by 12,236 clients 855 average daily visits 587 average daily injections 74% men / 26% women 17% identified as Aboriginal</p> <p>Principal substances used 36% heroin 32% cocaine 12% morphine</p>	<p>221 overdose interventions (no fatalities) 3,383 clinical treatment interventions 5,268 referrals to other social and health services 458 admissions to Onsite detox programme (completion rate in 2010: 43%) Reduced risk of blood-borne virus transmission Reduced public injecting and injection-related litter No adverse impact on local community</p>
Germany	<p>Location 26 in 17 cities country-wide</p> <p>Staff Number of staff variable according to size of DCR and financial constraints Training: Doctors, nurses, educators, qualified student assistants and freelancers</p>	<p>Eligibility Age eligibility varies according to state regulation Already drug dependent Not under OST (except in Hamburg) Not intoxicated</p> <p>Services DCRs integrated with harm reduction facilities Open between 3.5 and 12 hours a day 3 to 20 drug consumption booths Links to medical and social services</p>	<p>In Frankfurt⁹ from 2003 to 2009: Up to 4,700 visitors per year 26-35 years of age on average 85% men / 15% women</p> <p>Principal substances used 82% heroin 36% crack¹⁰</p>	<p>Since 1994, no drug-related deaths recorded in Germany Increased client awareness of safer use techniques Less drug-related health problems (e.g. fewer abscesses)</p> <p>Data from North Rhine Westphalia (2001-2009): 3,271 drug emergency cases 710 CPRs</p>
Luxembourg	<p>Location 1 in the City of Luxembourg called 'Abrigado'</p> <p>Staff 23 multilingual staff Training: Medical staff, psychologists social workers, educators, sociologists</p>	<p>Eligibility 18 years and over Already drug dependent Not under OST Not pregnant or with child Not intoxicated No dealing of drugs on premises Sign a 'terms of use' contract</p> <p>Services Integrated in low-threshold centre with 7 injection booths Pilot project 'Blow room' with 3 inhalation booths Open 6 days a week, 6h a day) Night shelter (42 beds) and nursery Drop-in centre (Kontakt Café) with primary medical care On-site HIV/hepatitis C testing Needle exchange programme Safer use counselling</p>	<p>170,000 supervised drug consumptions (since 2005) 26,929 visits to DCR in 2011 207 average visitors per day (Kontakt Café) 96 average visitors per day (DCR) 25-34 years of age on average 80% men / 20% women</p> <p>Principal substances used 87% heroin 8% cocaine 5% mixtures</p>	<p>1,025 overdoses successfully managed (no fatalities) General decrease in overdose deaths and proportion of people who inject drugs in newly diagnosed HIV infection cases since the opening of the DCR Citizens hotline established to encourage public acceptance of DCR A few complaints from neighbouring communities recorded</p>

Country	DCR	Eligibility and services	Client profiles	Results
The Netherlands	<p>Location 37 in 25 cities country-wide</p> <p>Staff 3 staff members Training: Medical staff, social workers, former drug users, security staff</p>	<p>Eligibility Registered in city where DCR is located Sign a 'terms of use' contract No dealing of drugs on premises Different admission criteria according to each DCR</p> <p>Services 5 'stand-alone' DCRs, others are integrated within low-threshold services Separate rooms for injectors and smokers 15 booths for smokers, 5 for injectors Medical and safer use counselling</p>	<p>24 clients per day on average 90% clients are non-injectors 45 years of age on average¹¹ 90% men / 10% women¹²</p> <p>Principal Substances used¹³ Heroin Crack/coke base</p>	<p>Decrease in needle sharing Only 4% of new diagnoses of HIV, Hepatitis B and C among people who use drugs HIV incidence rates among people who inject drugs dropped from 8.6% in 1986 to 0% in 2000 94 acute drug-related deaths in 2010 with 20 non-municipal registered people Significant decrease in public disturbance High acceptance of DCRs (80%) by social/health providers, neighbourhoods and police</p>
Norway	<p>Location 1 in Oslo</p> <p>Staff Minimum of 5 staff on duty during opening hours, including at least 1 nurse. Training: Nurses, auxiliary nurses and social workers</p>	<p>Eligibility Heroin only substance allowed 18 years and over Sign a 'terms of use' contract Long term history of injecting heroin</p> <p>Services Limited to one dose of heroin per client per visit Integrated with harm reduction services Links with social and health services Links to drug dependence treatment programmes</p>	<p>2,480 registered clients since 2005 1,500 clients per year 109 clients per day on average (2011) 37 years of age on average 70% men / 30% women</p> <p>Principal substances used Heroin is the only substance allowed to be used in the DCR</p>	<p>Reduced perception of social exclusion among the user group Increased access to professional assistance in overdose situations Increased access to health and social services</p>
Spain	<p>Location 7 in 4 cities country-wide, including 1 mobile DCR</p> <p>Staff Number of staff variable according to each DCR Training: multidisciplinary, with at least 1 nurse</p>	<p>Eligibility 18 years and over Sign a 'terms of use' contract (in the Barcelona DCRs)</p> <p>Services 3 DCRs allow smoking Links to social and health services Links to drug dependence treatment programmes In Barcelona: HIV testing and counselling, health care and social, psychological and legal support</p>	<p>105,804 visits from 5,063 clients (2009) 34 years of age on average 80% men / 20% women</p> <p>Principal substances used Cocaine most popular (except in Bilbao and Sala Balaard in Barcelona, 2009) Heroin most popular (Barcelona, 2011) Speedball most popular (Madrid, 2011)</p>	<p>Decrease in overdose deaths from 1,833 in 1991 to 773 in 2008 Decrease in new HIV infections among clients from 19.9% in 2004 to 8.2% in 2008 High acceptance and demand for DCRs Reduced injection-related litter in public spaces Community awareness about DCRs as a public health strategy Development of common guidelines on harm reduction and DCRs</p>
Switzerland	<p>Location 13 in 8 cities country-wide</p> <p>Staff No country-wide data In Berne: Training: nurses and social workers.</p>	<p>Eligibility 18 years and over Already drug dependent Have official documentation No dealing of drugs on premises No consumption tolerated outside the DCR itself (e.g. cafeteria, toilets)</p> <p>Services Booths for intravenous use, smoking and sniffing (numbers vary according to the DCR) Cafeteria with food and non-alcoholic beverages Medical treatment Consultations for social problems Hygiene services (showers, provision of clothes) NSP Links to drug dependence treatment programmes and clinics</p>	<p>No country-wide data</p> <p>In Berne: 38 years of age on average 992 registered clients a year 200 clients a day 74.1% men / 25.9% women</p> <p>Principal Substances No country-wide data</p> <p>In Berne: Heroin Cocaine Benzodiazepines Cannabis Substitutes Alcohol</p>	<p>Decrease in drug-related deaths Increased client awareness of safer use techniques Reduces risk of blood-borne virus transmission</p>

Drug consumption rooms in Australia¹⁴

Current political situation

The Sydney Medically Supervised Injecting Centre (MSIC)¹⁵ is Australia's only DCR. The MSIC is administered by Uniting Care, a non-government, Christian organisation that runs several community services in the state of New South Wales.

In May 2001, MSIC opened its doors for a trial period of 18 months. The trial required an amendment of the Drug Misuse and Trafficking Act. It was extended three times so the MSIC operated under 'trial' conditions for nearly a decade, leading to the politicisation of the service and uncertainty about its future. In October 2010, the New South Wales Parliament passed legislation to end the MSIC's trial status, making it a legitimate health service without needing an act of Parliament every four years to continue its operation.

There is no political support for further DCRs to be established in Australia. In May 2010, Melbourne's inner city Yarra Council in the state of Victoria voted to establish a DCR because of the high prevalence of street injecting in the suburb of Richmond. The State Government rejected the idea immediately and the (opposition) Labour Party also refused to support it despite having advocated for DCRs in the past.

Regarding public support, the local community of Kings Cross in inner urban Sydney was already open to the concept of a DCR before the MSIC opened, and has become increasingly supportive since the service began. Australians in general have also been supportive of harm reduction measures and of DCRs specifically. In 2010 the National Drug Strategy Household Survey showed that the majority of Australians supported DCRs.

Concept and objectives

The four objectives for the MSIC are to decrease drug overdose deaths, provide a gateway to drug dependence treatment and counselling, reduce problems associated with public injecting and discarded needles and/or syringes, and

consequently reduce the spread of diseases such as HIV and hepatitis C.

Service provision

MSIC clients must be aged 18 years or over and already have developed a dependence on drugs; they must not be pregnant, nor accompanied by a child; clients cannot sell, buy or share drugs in the centre or be intoxicated when arriving on the premises.

The staff in the centres include at least one registered nurse (on an average day, there are usually three registered nurses), and officers with health training.

The MSIC operates a one-way client flow in three stages. Stage 1 is the waiting room and assessment area where clients are assessed for eligibility. Assessments include demographic information and medical history, including overdose and treatment history. Stage 2 is the injecting room that is staffed by at least two people, including a registered nurse, and has eight booths with two chairs, enabling the staff to supervise the injection procedure. Clients receive clean injecting equipment and advice, and first aid if required, including resuscitation in the resuscitation room. Clients place used equipment in sterile waste bins. Stage 3 is the after-care room where clients are observed until they are ready to leave. From the after-care room they must leave the premises and they cannot re-enter the injection room. MSIC staff can also provide clients with links to health, legal, housing and welfare services.

Clients' profile

From service commencement in May 2001 to the end of April 2010, 12,050 people who inject drugs registered with MSIC as clients with a monthly average of 111 new clients (with 3 new clients a day on average). Most clients are male (74%) with an average age at registration of 33 years old. Clients usually have a long history of injecting drug use (an average of 13 years). At the time of registration, 70% were unemployed, approximately 35% had completed only

some secondary education, 16% were in unstable accommodation, and 23% had been imprisoned in the previous 12 months. 46% of all new clients reported that they had injected in a public place in the previous month, and 40% had never accessed any drug dependence treatment before coming to the MSIC.

The types of substances used in the DCR have varied considerably since its opening. Between May 2002 and September 2005, heroin use declined from 80% to 40%, while other opiate use increased from 40% in May 2006 to 60% in January 2012. Cocaine use has largely declined since 2001 (when cocaine use was reported by 50% of the clients) and stabilised at 15%. Finally, methamphetamine use has been reported by 10% of the clients while buprenorphine use remains low (1 to 2% of the clients).

Results

The MSIC was independently evaluated¹⁶ for nearly a decade by a number of different organisations. Eleven reports were released by five different agencies, all of which concluding that the DCR is meeting its objectives. More specifically, these reports show that MSIC is:

- saving lives and reducing harms from drug overdose – the MSIC conducted 4,400 overdose interventions, none of them leading to fatalities
- is making contact with a vulnerable and hard-to-reach group of people who inject drugs and referring them to relevant health services – a total of 9,500 clients were referred to health and social welfare services
- is reducing the risk of blood-borne virus transmission
- is reducing public injecting and the number of syringes discarded in public locations – public injecting and injection-related litter have halved in Kings Cross since MSIC opened
- is cost-effective, and is operating without any adverse impact on the local community.

Challenges and next steps

The challenge in Australia is for state and national political leaders to be courageous enough to contribute more positively to shifting the stigma associated with people who use drugs. Establishing DCR in other parts of Australia is an essential part of this to ensure that all people who use drugs have access to a DCR across the country.

Drug consumption rooms in Canada¹⁷

Political situation

According to the Canada's *Controlled Drugs and Substances Act (CDSA)*, the possession and/or trafficking of certain controlled substances constitute a criminal offence. Section 56 of the Act gives the federal Minister of Health the authority to issue an exemption to 'any person or class of persons' from the application of sections of the Act if, in the Minister's opinion, 'the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest'. It is with such an exemption that the Canadian DCR, Insite, is able to operate.

In September 2003, Vancouver's regional health authority received a legal exemption from the federal Minister of Health to operate Insite, the first legally approved medically-supervised DCR in North America. The PHS Community Services Society operates Insite under contract with the health authority. In 2006, under public pressure, the new Minister of Health granted an extension for the exemption, first until December 2007, and then again until June 2008. However, he rejected requests for a long-term solution permitting Insite to continue operating indefinitely.

Faced with the possibility of Insite's closure, harm reduction activists began two court actions that sought to keep Insite open. The court cases challenged both the application of Canada's drug laws to Insite and the laws themselves as being unconstitutional.

In September 2011, the Canadian Supreme Court issued a unanimous judgment ruling in favour of Insite.¹⁸ The Court was persuaded by evidence that people who use drugs are considerably safer administering their own injections under medical surveillance rather than injecting drugs on the streets. As the Court succinctly declared, 'Insite saves lives. Its benefits have been proven'. It ruled that shutting Insite would constitute an impermissible violation of the human rights of some of those who are most vulnerable. It ordered the Minister to grant an exemption to Insite immediately, in order to respect the constitutional rights of the DCR's users and staff.

Concept and objectives

Insite seeks to reduce the risks of disease and overdose death often associated with injection drug use; connect clients to drug dependence treatment and other health and social services; and reduce public drug use, injection-related litter and other related public disturbance problems.

Service provision

Insite is located in Vancouver's Downtown Eastside (DTES), a neighbourhood that has a high concentration of poverty, of people affected by drug dependence and mental illness, and an open drug scene, including public injecting. The original exemption for Insite was based on feasibility data suggesting that a DCR could help reduce public drug use, overdose deaths and public disorder in the area.

Insite is designed as a 'low-threshold' service. All clients can remain anonymous, although client service use and outcomes are tracked at an individual level. As opposed to DCRs in most other countries, there are no admission criteria for clients wishing to go to Insite. The DCR was designed as a research pilot project (originally deemed necessary to obtain the original exemption from the CDSA), but participation in surveys and other aspects of the research into Insite's operation and effects is optional for the clients.

The Insite staff are a mix of Vancouver Coastal Health and Portland Hotel Society employees, as well as peer-workers who are employed by L.I.N.E.S. (Life Is Not Enough Society). 2 nurses (VCH), 5 program workers (PHS), and 2 peer workers are present in the DCR at all times. In the injection room, the staff-to-client ratio is 1:6, and in the 'chill-out' lounge, it is 1:10.

Insite has 12 injection booths where clients can inject pre-obtained controlled drugs under the supervision of nurses and healthcare staff. Insite supplies clean injection equipment such as syringes, cookers, filters, water and tourniquets. If an overdose occurs, medical staff can intervene immediately. Nurses also provide other healthcare services, such as wound care and immunisations. Current protocols do not allow staff to assist directly with injection, although they educate clients about ways to reduce risks associated with injection.¹⁹

In addition, the facility includes Onsite, which consists of 12 rooms with private bathrooms where people can enter detox (including OST) on a voluntary basis, with support from mental health workers, counsellors, nurses and physicians. Once stabilised, people can move on to transitional recovery housing, also on-site, and get connected to longer-term drug dependence treatment programmes, housing and community support services.

Clients' profile

Since it opened in 2003, Insite received more than 1.8 million visits (by 12,236 clients), which represents an average of 855 visits daily. 74% of the clients were men, and 26% were women. 17% of the clients were identified as aboriginal. The principal substances reportedly used in the DCR were heroin (36%), cocaine (32%) and morphine (12%).

Results

Insite has had more than 1.8 million visits since it opened in 2003, and there are more than 12,000 registered clients. In 2010, there were:

- An average of 587 injections daily
- 221 overdose interventions with no fatalities
- 3,383 clinical treatment interventions
- 5,268 referrals to other social and health services, the vast majority of them were for detox and drug dependence treatment
- 458 admissions to the Onsite detox service (which recorded a programme completion rate of 43% in 2010).²⁰

Partly as a condition of its original exemption from Canada's drug laws, Insite has been subjected to rigorous scientific evaluation. The research has produced more than 30 peer-reviewed studies of the impacts of Insite, which demonstrate that the DCR:²¹

- is being used by those for whom it was intended, that is, those most at risk of overdosing or becoming infected with HIV or hepatitis C, and those who would otherwise inject drugs in public places
- has reduced HIV risk behaviour – people who use Insite are less likely to share injection equipment, and also have greater access to condoms and safer sex information
- promotes access to drug dependence treatment and other health services. In the first year after it opened, there was more than a 30% increase in the use of detoxification programmes among Insite clients. It also offers on-site care for injection-related infections and frequently connects clients with off-site medical treatment
- has improved public order – near and around the facility, there has been a measurable decrease in the number of injections done in public and in the amount of injection-related litter
- has reduced deaths from overdose – because medical staff are constantly present

to respond to emergencies, no overdoses that have occurred at Insite have been fatal; modelling suggests that Insite may have prevented as many as 48 overdose deaths over a four-year period. It has also reduced overdose deaths within the surrounding neighbourhood by 35% in the two years after opening

- provides safety for women who inject drugs by providing a safe space away from the dangers of street-based drug scenes
- prevents more than 80 HIV infections per year and saves CDN \$17.6 million in HIV-related medical care.

Studies looking at potential harms of Insite have found no evidence of any negative impacts. Insite has not led to increased levels of drug use, nor has it deterred people from stopping using drugs or seeking drug dependence treatment. In the area around Insite, there has been no increase in drug-related crime since Insite opened, and the rate of vehicle break-ins has decreased.

Challenges and next steps

The judgement by the Supreme Court of Canada in September 2011 has made it clear that the federal Minister of Health must entertain applications for exemptions to allow the operation of DCRs without risk of criminal prosecution. The Court identified some criteria that the Minister must take into account in considering each application. Following the decision, a number of community organisations in other cities have developed plans to apply for Ministerial exemptions, and several municipalities have expressed interest in establishing such facilities. In October 2011, it was announced that community agencies in Montreal and Quebec City would move ahead with plans for a number of sites, and the provincial Minister of Health has publicly stated support for those proposals, although some local community opposition has emerged. Feasibility studies have also been undertaken in Ottawa

and Toronto,²² although local politicians in each city have publicly declared their opposition to such facilities. It remains to be seen how the federal government will respond to requests for additional exemptions if and when they are filed.

Drug consumption rooms in Germany²³

Current political situation

Large open drug scenes near major train stations, a high number of drug-related deaths, consumption in public spaces, and visible impoverishment in tourist attraction areas constituted the premises for more and more city residents, businessmen, law enforcement officers, and HIV and drug counsellors to argue for the establishment of DCRs in Germany.

The legal opinion of a public prosecutor and director of the Central Office for Combating Drug-Related Crime in May 1993 laid down the ground to get the already operating health facilities in Hamburg and Frankfurt legal within existing laws. The analysis formed the basis for the creation of a uniform federal regulation in 2000, amending the national Narcotics Act. Provinces were then given the opportunity, through local regulations, to establish a legal basis for setting up DCRs. As a result, German DCRs are anchored in local politics. The conditions of operation are discussed and agreed in regular meetings gathering local working groups composed of local government representatives, law enforcement officers, municipal health and social services and service providers.

Concepts and objectives

All DCRs are integrated in existing harm reduction facilities and aim to support social, mental and health stabilisation, to avoid blood-borne infections and overdose casualties, and to provide timely referrals to other medical and social services. Strong emphasis is given to 'safe use' regulations. DCRs also aim to reduce public disturbance.

Service provision

Ten years after the reform of the Narcotics Act, not all provinces have adopted corresponding

legal regulations and established DCRs. There are currently 26 DCRs available in 17 different cities.

Regarding admission criteria, people who are under opioid substitution treatment, are excluded from accessing DCRs (with the exception of Hamburg). New injectors and people intoxicated by alcohol or other substances are also denied access to the facilities. Some DCRs have an age requirement, which varies according to each state. In the Berlin DCR (in Lower Saxony), for example, the minimum age for accessing a DCR is 16.

The DCRs are opened between 3.5 and 12 hours a day and have a capacity of 3 to 20 clients.²⁴ DCRs are supervised by professional multi-disciplinary staff, including doctors, nurses and educators, supported by qualified student assistants and freelancers (training-on-the-job and first-aid training for drug emergency cases). At least one employee is constantly present in most DCRs, enabling him/her to directly address the clients' needs, provide safer use counselling and initiate emergency measures if necessary.

The services provided at DCRs include:

- Distributing injection paraphernalia to ensure a hygienic consumption and lower health risks, in an anxiety- and stress-free environment
- Supervising of drug use and providing safer use counselling – safer use principles must be adhered to during consumption in a DCR. Safer use rules practiced in DCRs are often adopted in daily life and, as a result, successfully influence individual consumption behaviours. DCRs therefore provide an important bridge between healthcare provision and psychosocial support in a low threshold environment
- Offering a 'contact centre' for people who use drugs – in addition to distributing/selling/exchanging drug consumption materials and condoms, many DCRs also regularly offer affordable warm meals and/

or small snacks and beverages. Some DCRs also have showers and laundry facilities, and supply clothing to clients

- Providing basic health care to clients, enabling physicians and/or nurses to intervene in case of crisis and provide first aid in case of overdose
- Providing advice and counselling – counselling is goal-oriented, and includes providing drug dependence treatment counselling and referral to treatment programmes (including detoxification programmes) supervised by qualified social workers.

DCRs are integrated within a wide range of HIV and drug facilities that provide counselling and a space to reach out to people who use drugs.

Clients' profile

It has proven to be difficult to collect nation-wide data about clients in Germany. Between 2003 and 2009, the frequency of visitors in the DCR in the Frankfurt DCRs rose by almost 50%, with up to 4,700 visitors per year. The average age of clients is 26 to 35. The drug most widely used is heroin by injection, followed by crack. Drug use patterns in the DCRs in North Rhine Westphalia are slightly different, with a decrease in injecting and an increase of inhalation.

Results

Available data clearly demonstrates the positive impact of DCRs on overdose cases and drug-related deaths. DCRs have now been used by several million clients to date, and no drug-related deaths have been recorded within the facilities. In North Rhine Westphalia, the largest province of Germany, a 2001-2009 survey documented 1.2 million consumption processes, among which DCR staff were responsible for responding to 3,271 drug emergency cases and performed 710 CPRs. Experience shows that the clients have less abscesses and are affected by less other drug-related health problems. They have also adopted safer forms of consumption in comparison to the people who inject drugs who do not use DCRs.

Challenges, next steps

The positive results, which can be drawn from the perspective of local authorities and DCR operators, support the expansion and further development of DCRs. The ultimate goal should be for all provinces to adopt appropriate regulations which allow the operation of DCRs, in order to ensure that people who use drugs have access to the facilities throughout the country.

In the short term, it is essential that access to DCRs be extended to people under substitution therapy, as it is currently not the case in most German provinces. Admission criteria to the DCRs should therefore be revised to that end.

Drug consumption rooms in Luxembourg²⁵

Current political situation

Since 1999, the Luxembourg Ministry of Health has been entrusted with the national coordination of drug-related demand and harm reduction interventions. This led to the creation of the National Drug Coordinator's office in 2000.

The 2009 government programme set the framework for the elaboration of the third National Strategy and Action Plan (2010-2014) on drugs and drug dependence. The current national Action Plan relies upon the priorities of the Ministry of Health and a sustained collaboration with field actors and civil society. The general objective of the National Strategy and Action Plan is to contribute to a high level of protection in terms of public health, public security and social cohesion. It relies on two pillars – demand reduction and supply reduction – and on four transversal axes: 1- Reduction of risks, harms and public disturbance; 2- Research and information; 3- International relations; and 4- Coordination mechanisms.

The first DCR was established in the City of Luxembourg in 2005, within the framework of the second National Action Plan on Drugs for 2005-2009 under the heading of 'Reduction of risks, harms and public disturbance'. The Ministry of Health designed the original concept of the DCR and included the facility in

a financial convention with the 'Comité National de Défense Sociale' (CNDS) which was already managing a low-threshold centre for people dependent on drugs in the City of Luxembourg called 'Abrigado'.

The National Action Plan on Drugs anticipated the further development of harm reduction services in other regions of the country and, notably, the creation of a second DCR in the south of the country.

Concept and objectives

Before the DCR was established in Luxembourg, a needs-assessment study was conducted and concluded that harm reduction services needed further diversification to respond to the needs of people who use drugs in the country, who then mainly injected drugs. Opiate overdose deaths among people who inject drugs had been increasing for several years and there was a need to reach out to this highly marginalised group of users.

The philosophy of Abrigado is based on the idea that low-threshold and acceptance-oriented support will help to reduce risks and harms associated with drug use, and promote safer use. A major objective of the facility is therefore to respect the clients' right to self-determination and to promote their self-responsibility. Of great importance in this approach is the fact that a purely medical approach to drug use would not meet the individual needs of the clients. The main focus of the DCR is not drug consumption itself but communication and the development of interpersonal relations. The DCR is therefore perceived as a 'drug communication room'.

Service provision

There are a number of criteria to be fulfilled for clients to have access to the DCR. Clients must be 18 years and over, already be drug dependent and not under OST, they should not be already intoxicated when arriving in the DCR and are not allowed to deal in the premises. Pregnant women or users with children are denied access to the facility. Finally, all clients

must sign a 'terms of use' contract when they first arrive at the DCR.

The DCR in the City of Luxembourg currently has capacity for 7 simultaneous supervised injections. A pilot project offering 4 additional spaces for smoking or inhalation started in February 2012. The centre also hosts a night shelter with a capacity of 42 beds, a nursery (healthcare) and a drop-in centre called the 'Kontakt Café' with a part-time medical service offering primary health care. Abrigado also participates in the national needle and syringe exchange programme.

The DCR and the Kontakt Café share the same opening hours – both are opened three days a week in the morning (for 6 hours) and three days a week in the afternoon (for 6 hours). Two staff members are permanently present in the DCR. They are assisted by the six employees of the Kontakt Café. The Abrigado team (23 staff members) is multidisciplinary and include psychologists, social assistants, educators, sociologists, a doctor and nurses who are multilingual (Luxembourgish, French, German and English) to account for the multiple and diverse social and linguistic backgrounds of the clients.

Clients' profile

There were approximately 170,000 supervised consumptions since the opening of the DCR seven years ago, and about 1,200 clients have signed a DCR user contract. The average number of visits per day is 96 (including repeated visits). In 2011 alone, there were a total of 26,929 visits to the DCR. Only one third of the Kontakt Café visitors use the DCR. The ratio of male to female clients in the DCR is 80%/20%. Most clients are aged 25 to 34 years old (44%), and 35 to 44 years old (37%). The age group of clients aged 18-24 only represents a proportion of 9%. Heroin is the most commonly used substance in the DCR (87%) followed by cocaine (8%).

Results

Public acceptance of the DCR is an ongoing process. Abrigado provides a permanence phone

number for residents in the neighbourhood to allow them to report any incidents, problems or disruption they witnessed. A cooperation committee composed of delegates from the Ministry of Health, the Ministry of Justice, the Public Prosecutor's Office, the City of Luxembourg, law enforcement authorities and other specialised drug agencies, also meets on a regular basis to support the project and to rapidly solve emerging problems. Thus far, only a few complaints from neighbouring citizens have been recorded.

In 2009 an external evaluation of the Action Plan on drugs for 2005-2009 was performed by the Trimbos Institute based in the Netherlands.²⁶ The evaluation states that: 'The injecting room [...] is judged as 'positive' by the stakeholders. It is functional and its capacity is seen as sufficient'. Indeed, the functioning of the DCR has been accompanied by an overall decrease in overdose cases in the Grand-Duchy of Luxembourg. 1,025 overdoses (one third with loss of consciousness) were managed successfully with no fatalities since 2005. Safer use counselling, on-site testing for HIV and hepatitis C and the implementation of an on-site primary medical care service also greatly contributed to reducing drug-related harm.

The opening of a 'blow room' offering 3 places for inhalation in February 2012 will provide clients with the option to switch to less harmful use patterns of use.

Challenges and next steps

In early 2012, Abrigado moved into new facilities which provide 4 places for inhalation in addition to the already existing spaces for intravenous consumption. The move to a new facility has been accompanied by a change of name for the institution in order to avoid stigmatisation of the target group. It changed from its original name 'Tox-in' to 'Abrigado'.

Future challenges include optimising networking with other institutions and increasing the number of DCR impact studies by further developing and

monitoring evidence-based measures. In order to make services more efficient, DCRs should also focus on tailoring services to specific target groups such as women, young people and clients with co-morbidity.

Finally, DCRs should be made available to a wider number of people, in more geographical areas. To meet this challenge, the Ministry of Health is currently planning to open a second DCR in the south of the country.

Drug consumption rooms in the Netherlands²⁷

Current political situation

In 1990, a church-operated social institution in Rotterdam began to allow people to consume drugs on its premises. It was not until 1994 that this became a regular part of the services provided by the institution. The establishment of official DCRs became possible with the development of legal guidelines by the *College van Procureur-generaal* in 1996. These guidelines clarified that the possession of controlled drugs in DCRs was tolerated provided that the facilities fit into the local drug policy framework as defined by the mayor, the police and the public prosecutor.²⁸

Today, DCRs constitute an integral part of the harm reduction response in the Netherlands. In the past decade, the profile of people who use drugs has changed with an increasing number of smokers, cocaine users and alcohol users. There has also been a shift in focus within public health policies – the approach towards drug use is now embedded in general healthcare provision and is multidisciplinary, taking into account the social, legal and health situation of a person.²⁹

Concept and objectives

DCRs in the Netherlands have a limited number of registered clients from a well-defined target group – mainly homeless people. However, some DCRs have wider access criteria or target specific vulnerable population groups, such as immigrants or sex workers. The general objective is to provide

a safety net for these vulnerable groups, to reduce public disturbance, and to improve the welfare and health status of individuals.

Service Provision

Starting first with a few DCRs in 1995, the number of DCRs increased significantly between 2001 and 2005. In 2010, 37 facilities were registered in 25 different cities. Most rooms are integrated in facilities providing low-threshold services, while five of them are 'stand-alone' DCRs.

To access a DCR, certain criteria have to be fulfilled. There is a minimum age requirement to access the DCR and the individual must be registered in the city where the DCR is located. The client must sign a contract to agree on the house rules and should already possess the drug before entering the premises (dealing is not allowed in the premises). Not all rooms have the same regulation rules and many are flexible in their implementation.

Most rooms have staff comprising medical and/or social workers and a third of the facilities have ex-drug users working as staff. Rooms are usually open every day, for up to 15 hours a day. The time a client is allowed to stay per visit is limited – from 20 minutes to two hours. Most DCRs have separate rooms for smokers and injectors. The average number of places is 15 for smokers and 5 for injectors. In the early years of functioning of the DCRs, the police used to refer 75% of the clients to the room. In 2010, however, that number dropped to 47%. 75% of the rooms have some form of client participation, involving them in the daily routine and in decision making processes. Most of the DCRs offer practical support, medical counselling and training on safer use.

Clients' profile

The average number of clients is 24 per day (ranging from 2 to 60). The number of clients to the DCRs has decreased in the last couple of years, because of a decrease in the number of targeted individuals and changing patterns of drug consumption. Today, 90% of the clients

are non-injectors. Clients are 45 years of age on average, and 90% of them are men.³⁰

Results

There has been no rigorous evaluation regarding the impact of DCRs over a certain time period. However the overall results are generally regarded as positive³¹:

- Public disturbance related to drug use, such as dealing and using in the streets, decreased significantly
- There was an important shift from injecting to smoking – only 10% of DCR clients now inject drugs. Although there was an increase in smoking, this has led to a significant decrease in needle sharing
- Recent research shows that acceptance of the DCRs by social and health care providers, the neighbourhood and the police is very high in the areas where DCRs have been established (more than 80%)
- There are very low infection rates of HIV and hepatitis C among DCR clients.

Challenges and next steps

The objective of the Dutch policy is to implement social and health based programmes to reduce the number of people included in the target group who has access to the DCRs (i.e. homeless people who use drugs) to eventually make DCRs unnecessary. However, this might create problems for vulnerable and hard-to-reach groups of people who use drugs as many may continue to use drugs problematically despite social and health programmes, and therefore continue to need DCRs. It is necessary that the government continues to support DCRs as a long-term harm reduction strategy.

In addition, particular groups in the Netherlands do not have access to DCRs, even though they are at risk of health-related problems and of causing public disturbance. This includes young people who use drugs, users who do not live in the street, people dependent on

both drugs and alcohol, and users who are not officially registered in a particular city, such as illegal migrants. It is necessary to broaden the admission criteria so that these vulnerable groups also have access to the DCRs.

Another challenge is the rise in alcohol dependence among people who use drugs and how to deal with the related issues. Alcohol consumption is currently allowed in only 25% of the DCRs.

Finally, there are concerns, in the current political and economic context, that public and political support for the DCRs may decrease and budget cuts may take place. This would put the country at risk of losing the benefits created by the successful implementation of the government's integrated harm reduction approach.

Drug consumption rooms in Norway³²

Current political situation

The supervised drug injection facility in Oslo, Norway, was opened on 1st February 2005 after years of political debate. The DCR was established as a three year trial under temporary legislation, which was prolonged until a permanent legislation was passed in 2009. Initially, the DCR was located within a low-threshold health clinic and a needle and syringe exchange programme, but was subsequently relocated to a more suitable stand-alone location in 2007.

Concept and objectives

The objective of the DCR is to increase the dignity of people with a long-term history of injecting drug use, by providing a hygienic and safe environment to inject heroin. The DCR aims to provide a multidisciplinary specialised model to improve the health status of people who inject drugs through the presence and supervision of healthcare workers in order to prevent injection-related infections, to assist in case of overdose, and to link the client with other social and health services and drug dependence treatment programmes.

Service Provision

The DCR is operated by the Oslo Municipality's Agency for Alcohol and Drug Addiction Services, and is jointly funded by the Oslo Municipality and the Norwegian Directorate of Health. The injection room in Oslo is the only facility of its kind in Norway – no other municipality has yet chosen to follow Oslo's example.

Under Norwegian legislation, heroin is the only substance allowed to be used in the DCR. Clients have to register and sign a contract containing the terms of use of the facility. All users have to be over 18 years of age, and must have a long-term history of injecting heroin use. The legislation limits the use of the DCR to the injection of one dose of heroin per client per visit.

The room is open from Monday to Thursday between 9:00am and 7:30pm and from Friday to Sunday between 9:00am and 3:00pm. The DCR staff is multidisciplinary, including nurses, auxiliary nurses and social workers, and there is always at least one nurse on duty during the DCR's opening hours. The DCR is integrated with other harm reduction services and staff members can refer clients to social and health services, as well as drug dependence treatment programmes.

Clients' profile

2,480 registered clients have used the DCR since it opened in 2005, and about 1,500 of them use the room each year. In September 2011, an average of 109 clients used the room every day. Approximately 70% of the clients are men and the average age of the clients is 37 years old. Less than 1% of the injections that took place in 2011 have led to an overdose.

Results

The DCR in Oslo was evaluated by the Norwegian Institute for Drug and Alcohol Research (SIRUS) in 2007 and 2009.³³ The two evaluations were carried out when the room was operating in two different locations, reflecting the importance of suitability of infrastructure. Both evaluations conclude that the objectives are difficult to evaluate. However, they both point out that the

DCR increased the promotion of the dignity of the group in question, both generally and for the individual. Findings also concluded that clients felt less socially excluded. The DCR also increased access to health and social services, and to professional assistance in case of overdose.

Challenges and next steps

The main challenge today is linked to the strict admission criteria which limit access to the DCR. This includes the fact that only one injection of heroin is permitted for each client per day, while the amount of heroin that can be injected is often disputed. People who use other drugs, combine heroin with other substances or wish to inject more than once a day, and those who consume drugs through smoking, snorting, inhaling, etc. are also excluded from the DCR. The minimum age limit of 18 also automatically excludes young people who use drugs, who are usually highly vulnerable to drug-related harms. Finally, only people who have a 'severe heroin dependency' have access to the DCR, which presents challenges as the status of 'severe heroin dependency' is not clearly defined.

Another major challenge is the difficulty for the DCR staff to refer clients to adequate social, health and treatment services. The DCR will be relocated in 2012 within other services, which will hopefully strengthen links with other social and healthcare services and increase access to drug dependence treatment facilities.

Drug consumption rooms in Spain³⁴

Current political situation

As drug policies are decentralised in Spain, it is the responsibility of regional and local governments to develop services for people who use drugs.³⁵ Drug trafficking is considered as a crime in the Spanish penal code. The use of controlled drugs and leaving injection equipment in public spaces is not a crime but it is a serious misdemeanour that can result in a fine of between 300 to 30,000,000 euros. This fine can, however, be replaced by alternative measures, including drug dependence treatment. Under the law there is no legal impediment for the

development of DCRs. At the national level, DCRs are supported by the National Agency of Drugs, the National Agency on AIDS and the corresponding regional and local institutions.

The first Spanish DCR opened in 2000 in Madrid. Today there are seven of these facilities in four different cities (Barcelona, St. Adrià del Besòs, Bilbao and Lleida). Six more safe injection facilities are planned to open in Barcelona within already existing drug treatment centres over the course of 2012. For political and financial reasons, the DCR 'Dave' located in Madrid closed at the end of 2011.

DCRs in Spain commonly belong to the local and regional Health Ministries and agencies, such as Sala Baluard, which belongs to the Public Health Agency of Barcelona.³⁶ One DCR in Spain – CAS Vall d'Hebrón in Barcelona – belongs to the National Health Service, and is located in a public hospital. The rest of the DCRs – Munduko Medikiak, SAPS, La Mina and Arrels – are not directly linked to the public health system but work in collaboration with it. All DCRs in Spain receive public funds from different public administrations.

Most of the DCRs are managed by NGOs – Fundació San Ignasi de Loyola, Fundación IPSS Instituto para la promoción social y de la salud, Institut Català de la Salut, Servicio de Psiquiatría del Hospital Universitario de la Vall d'Hebrón, Asociación Bienestar y desarrollo, Médicos del Mundo and the Red Cross.

Concept and objectives

DCRs throughout Spain share common objectives. As with most DCRs operating in other countries, they aim to promote safer drug use by providing more hygienic drug consumption conditions. Spanish DCRs also seek to:

- promote safer use through the provision of more hygienic conditions
- supervise and provide counselling services to clients before, during and after drug consumption

- offer social and health care, and refer clients to appropriate social, healthcare and drug dependence treatment services
- gather data on new drug use patterns, emergent problems or needs among people who use drugs
- raise awareness among the community about the need and benefits of DCRs as a public health strategy
- reduce drug use in public spaces.

Service Provision

To access the DCRs, the clients need to be aged 18 and over. In Barcelona, clients also need to sign a 'terms of use' contract to access the DCRs.

Three DCRs offer booths to clients who smoke drugs, while all others are only used for drug injection. Facilities have multidisciplinary staff (including at least one nurse) who supervise and provide safer use counselling to clients during all stages of drug consumption. Staff can also refer clients to social and healthcare services or drug treatment centres. In Barcelona, the DCRs also offer HIV testing and counselling and social, psychological and legal support.

Clients' profile

In 2009, Spanish DCRs had a total of 105,804 visits from 5,063 clients.³⁷ The average age of clients in Spanish DCRs is 34 years old (28 to 38), about 80% of them are men. The majority of clients are Spanish or European, but a great number also come from Eastern Europe and North Africa. In 2009, cocaine was the most popular drug used (except in Bilbao and Sala Balaurd in Barcelona), but in 2011 this was surpassed by heroin in DCRs in Barcelona. The DCR in Madrid was the only one to register speedball as the most used substance, before it closed its doors last year. Injection remains the most common way to use drugs in DCRs, except Bilbao where inhalation is more frequent.

Results

In Spain DCRs are well accepted and are in high demand from harm reduction professionals, health and social service providers, and people who use drugs. Since these facilities opened:

- overdose deaths have decreased from 1,833 in 1991 to 773 in 2008
- the number of new HIV infections has also decreased among DCR clients from 19.9% in 2004 to 8.2 in 2008
- users' awareness of safer injection techniques has improved
- community awareness about DCRs and the country's public health strategy towards drugs has increased
- injection-related litter in public spaces was reduced.³⁸

Another important achievement includes the development of common guidelines on harm reduction and DCRs, the active participation of Spanish DCRs in the International Network of Drug Consumption Rooms,³⁹ and constructive interactions with the local community.

Challenges and next steps

One of the main challenges in Spain is the need to reconsider harm reduction as a more holistic intervention among people who use drugs. DCRs and harm reduction services should be normalised at political and social level by integrating DCRs into a public healthcare network. More comprehensive services such as harm reduction based healthcare should be expanded and there should be a greater attention given to the social needs of long term and chronic users.

The welfare of the client and the working conditions of staff should always remain paramount – services should, for example, improve the social conditions of people who use drugs who are already in a socially deprived

situation. The incorporation of a substance analysis service into DCRs would have the potential to provide more information about drug use patterns, and increase the health and safety of people who use drugs. It is also important that referrals to OST be facilitated.

There should also be a greater number of DCRs available for smoking users (with the ability to distribute smoking paraphernalia), and DCR opening times and locations should also be extended.

Monitoring and evaluation of DCRs through data collection and an assessment of harm reduction services also need to be improved. In the current economic climate, it is essential that DCRs and harm reduction programmes become consolidated and stabilised.

Drug consumption rooms in Switzerland⁴⁰

Current political situation

The world's first DCR was opened in 1986 by Contact Netz in Bern, Switzerland. At the time, it was becoming clear that strategies focused exclusively on repressive measures and abstinence could not cope with the high level of new HIV infections, the increasing numbers of drug-related deaths and the open drug scene in the city. The creation of the DCR was a paradigm shift in drug policy, creating a radical new approach to the drug epidemic at the political, health and social level. Contact Netz started providing medical and social services, including needle and syringe exchange, warm meals and shelter. DCRs were subsequently set up in several other cities in Switzerland and open drug scenes disappeared.

DCRs are now accepted and supported by most political parties in the country. The latest federal vote in 2008 concerning the revision of the national narcotics law showed a clear acceptance of harm reduction policies and programmes by the public, and the term is now included in the Swiss federal drug policy system – the Swiss drug policy is based on four pillars: law enforcement, treatment, prevention and harm reduction.

Concept and objectives

The fundamental objectives of Swiss DCRs are to provide people who use drugs social and healthcare services, improve the health of people dependent on drugs and reintegrate them into society. DCRs also seek to reduce public disturbance created by drug use in public areas.

Service Provision

There are 13 DCRs in 8 cities in Switzerland, most of them in the German part of the country. DCRs reach out to, and are accepted by, their target population.

In 2011, national standards were developed for all DCRs in Switzerland.⁴¹ These new standards provide guidelines on the provision of services, including HIV and hepatitis prevention and care, general health care (drug dependence treatment, voluntary counselling, and services to improve hygiene and treat abscesses) and the good functioning of the DCRs, such as the admission criteria and rules.

Entry admission criteria include a minimum age of 18, drug dependency (occasional users do not have access to the DCRs) and being in possession of official documentation. Rules that must be followed include no violence, no dealing on the premises and no consumption outside the DCR (such as in the cafeteria or in the toilets). House rules also include guidance on the conditions of the DCRs, the working conditions of staff members, the evaluation instruments to control the quality of the services, legal protection of data, and public networking and collaboration with the police.

The staff is composed of nurses and social workers. Services include booths for intravenous use, smoking and sniffing, a cafeteria providing food and non-alcoholic beverages, healthcare services, consultations for social problems, hygiene services (such as showers and the provision of clothes), NSPs, and referrals to drug dependence treatment programmes and clinics for those clients who request it.

Clients' profile

It is difficult to collect nation-wide data regarding the profiles of the clients in DCRs. In Berne, the majority of clients in DCRs are male (74.1%), over 35 years old and have a long history of drug use. The drugs most commonly used are (in order of popularity) heroin, cocaine, benzodiazepines, cannabis, substitutes and alcohol. In a low-threshold DCR in Geneva, the ratio between men and women is 72.2% / 27.8%, the average age of clients is 32, and they mostly inject cocaine and heroin.⁴²

Results

After the introduction of DCRs, the number of drug-related deaths has decreased. Several studies have demonstrated the effectiveness of DCRs in reducing HIV or hepatitis C virus infections among people who use drugs. Positive changes were also observed in injecting behaviours and hygiene for many clients. This was confirmed by several surveys in Switzerland concluding that syringe sharing had decreased in the country.⁴³

Challenges and next steps

Harm reduction and low-threshold facilities have adapted their services to the changing needs of their clients, in order to respond to changing patterns in consumption, substances and differential services for special target groups such as young users and older users with a long history of drug use.

For example, 18 months ago there was a significant shift in the strategy of Contact Netz. This shift resulted in a move away from acceptance-oriented harm reduction to development-oriented services. The anonymity of clients was lifted to gather more information about the situation of target groups and to enable predictability during the care process. The shift led to target-group-oriented services, including the provision of a daily structure for older, long-term users or special counselling for younger users instead of integrating them into treatment programmes outside the DCR. The experiences of these shifts in functioning have been positive. Collaboration with other service providers has also become more efficient over time.

Political support and good networking and constructive cooperation with the local police are also necessary for the long-term existence of DCRs, and there is room for improvement in that domain.

Conclusions and remaining challenges

DCRs are at the frontline of discussions in the harm reduction and drug policy field. Although available evidence suggests that these facilities have a positive impact on the health and well-being of individual users and the wider community, many policy makers and mainstream media function as a barrier to the introduction and/or scaling up of DCRs. Recent initiatives for the need of opening such rooms started in Antwerp, Belgium, Marseille, France, Torino, Italy, the United Kingdom and others, with no concrete move forward so far. The only exception to this is the experience of Denmark, where the Parliament has recently passed a law which creates the legal foundations for the development of DCRs in the country.

It is worth noting that although public opinion is generally against the introduction of such facilities, public acceptance of DCRs is considerably high in most of the locations where they have been established, as health problems have been reduced, and law and order have been improved. Communities, neighbourhoods and local authorities are usually involved in the good functioning of the facilities through cooperation and communication. The involvement of people who use drugs in the design and running of the facilities is an essential part of the acceptance and success of the initiative as well.

In terms of effectiveness, it seems clear that as consumption patterns evolve DCRs will need to adapt their services to those new ways of consuming (inhaling, smoking) and new substances being used (such as 'legal highs') by potentially new target groups (such as younger

users). The challenge for DCRs is to adapt to the new realities in order to provide adequate services to people who use drugs.

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The International Drug Policy Consortium is a global network of non-government organisations and professional networks that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces occasional briefing papers, disseminates the reports of its member organisations about particular drug-related matters, and offers expert consultancy services to policy makers and officials around the world.

Notes

- 1 Hedrich, D. (2004), *European report on drug consumption rooms* (Lisbon: European Monitoring Centre for Drugs and Drug Addiction), <http://www.emcdda.europa.eu/html.cfm/index54125EN.html>
- 2 Reported by the Street Lawyers, Denmark. For more information, please read: <http://www.talkingdrugs.org/danish-parliament-paves-the-way-towards-increased-safety-and-dignity-for-people-who-use-drugs>
- 3 Bewley-Taylor, D. & Jelsma, M. (2012), *TNI/IDPC Series on legislative reform of drug policies Nr. 18 - The UN drug control conventions: The limits of latitude*, http://dl.dropbox.com/u/64663568/library/limits-of-latitude-tni-idpc_0.pdf
- 4 INCB Report 2004, para 510,511
- 5 INCB, *Report of the International Narcotics Control Board for 1999*, (New York: United Nations, 2000), p. 26
- 6 KPMG Further evaluation of the Medically Supervised Injecting Centre 2007-2011
- 7 Hedrich, D. (2004), *European report on drug consumption rooms* (Lisbon: European Monitoring Centre for Drugs and Drug Addiction), <http://www.emcdda.europa.eu/html.cfm/index54125EN.html>; Hedrich, D. et al (2010), *Drug consumption facilities in Europe and beyond in: Harm reduction: evidence, impacts and challenges* (Lisbon) <http://www.emcdda.europa.eu/publications/monographs/harm-reduction>
- 8 For more information, please visit the International Network of Drug Consumption Rooms website: <http://indcr.org/index.php?lang=en>
- 9 There is no nation-wide data on German drug consumption rooms.
- 10 Data collected in 2009 in Frankfurt drug consumption room. The ratio can be explained by people reporting both heroin and crack use.
- 11 Numbers collected among clients at the Rainbow Foundation

- 12 Numbers collected among clients at the Rainbow Foundation
- 13 No percentages available
- 14 Information provided by John Rogerson, Australian Drug Foundation
- 15 <http://www.sydneymsic.com/>; <http://www.sydneymsic.com/how-the-centre-works>; <http://www.sydneymsic.com/images/resources/images/factsheetoct2011.pdf>
- 16 Sydney Medically Supervised Injecting Centre website, *Background and evaluation – Independent evaluation of the MSIC*, <http://www.sydneymsic.com/background-and-evaluation#Independent-evaluation>; Sydney Medically Supervised Injecting Centre (2011), Fact Sheet, <http://www.sydneymsic.com/images/resources/images/factsheetoct2011.pdf>; Sydney Medically Supervised Injecting Centre (2011), *Report to New South Wales Health*; SAHA International Limited (2008), *Final report: Economic evaluation of the Medically Supervised Injecting Centre at Kings Cross (MSIC) (SAHA: Sydney)*, http://www.druginfo.nsw.gov.au/__data/page/1189/MSIC_Final_Report_26-9-08.pdf
- 17 Information provided by Richard Elliott, Canadian HIV/AIDS Legal Network
- 18 *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, online: <http://scc.lexum.org/en/2011/2011scc44/2011scc44.html>.
- 19 For more information, see Vancouver Coastal Health, “Supervised Injection Site”, online: <http://supervisedinjection.vch.ca/home/>
- 20 Data from Vancouver Coastal Health, “Supervised Injection Site” (User Statistics), online: http://supervisedinjection.vch.ca/research/supporting_research/user_statistics
- 21 Urban Health Research Initiative, *Insight into Insite*, online (in both English and French) via: <http://uhri.cfenet.ubc.ca/content/view/57/92/>
- 22 Bayoumi, A.M. & Strike, C. (2012), Report of the Toronto and Ottawa Supervised Consumption Assessment Study, 2012, <http://dl.dropbox.com/u/64663568/library/report-toronto-ottawa-supervised-consumption-assessment-study-tosca.pdf>
- 23 Information provided by Dirk Schäfer, Drogenreferent der Deutschen AIDS-Hilfe (DAH)
- 24 Deutsche AIDS-Hilfe e.V. & Akzept e.V. (2011), *Drogenkonsumräume in Deutschland, Eine Bestandsaufnahme des AK Konsumraum*, <http://dl.dropbox.com/u/64663568/library/Drug-consumption-rooms-GERMAN.pdf>; AK Konsumraum (2011), *Drug consumption rooms in Germany – A situational assessment* (AK Konsumraum & Deutsche AIDS Hilfe e.V.), http://www.akzept.org/pdf/aktuell_pdf/DKRO7af1Eng.pdf
- 25 Information provided by Patrick Klein, Abridado, Comité National de Défense Sociale and Alain Origer, National Drug Coordinator, Ministry of Health
- 26 Trimbos Instituut (2009), *Evaluation of the national drug action plan (2005-2009)* (Luxembourg, Utrecht)
- 27 Information provided by Eberhard Schatz, Rainbow Foundation and Project Coordinator of the Correlation Network
- 28 Hedrich, D. (2004), *European report on drug consumption rooms* (Lisbon: European Monitoring Centre for Drugs and Drug Addiction), <http://www.emcdda.europa.eu/html.cfm/index54125EN.html>
- 29 Schatz, E., Schiffer, K. & Kools, J.P. (2011), *IDPC Briefing Paper - The Dutch treatment system and social support system for drug users: Recent developments and the example of Amsterdam* (International Drug Policy Consortium & The Correlation Network), <http://dl.dropbox.com/u/64663568/library/IDPC-briefing-paper-dutch-treatment-systems.pdf>
- 30 Numbers collected among clients at the Rainbow Foundation
- 31 Havinga, P. & Van der Poel, A. (2011), Gebruiksruimten in Nederland: Update van de handreiking bij organisatie en inrichting (Trimbos Institute), http://www.trimbos.nl/webwinkel/productoverzicht-webwinkel/alcohol-en-drugs/af/~/_media/files/inkijkexemplaren/af1051%20gebruiksruimten%20in%20nederland_web.ashx; European Monitoring Centre on Drugs and Drug Addiction & Trimbos Institute (2011), *The Netherlands Drug Situation 2011, Reitox National Focal point* (EMCDDA & Trimbos Institute)
- 32 Information provided by Joakim Hauge, Manager Field Health Services, Agency for Alcohol and Drug Addiction Services, Oslo Municipality
- 33 Hilgunn Olsen og Astrid Skretting. Nye lokaler - andre resultater? – viderført evaluering av sprøyteromsordningen i Oslo. SIRUS-rapport nr 7/2009, <http://www.sirus.no>; Hilgunn Olsen og Astrid Skretting. Hva nå? Evaluering av prøveordning med sprøyterom. SIRUS-rapport nr 7/2007, <http://www.sirus.no>
- 34 Information provided by Olga Díaz Grau and Elena Adán Ibáñez, Red Cross Barcelona
- 35 Depending of the local government's ideology, it can be more or less easy to develop a DCR
- 36 Munduko Medikiak (2007), *Report on drug consumption rooms*
- 37 Data from Spanish DCRS 2009, with the exclusion of those from La Mina, Catalonia
- 38 European Monitoring Centre on Drugs and Drug Addiction (2010), *2010 National Report (2009 data) To the EMCDDA by the Reitox National Focal Point SPAIN – New Development, Trends and in-depth information on selected issues* (Lisbon: EMCDDA)

- 39 Spanish DCRs have been active members of the International Network of Drug Consumption Rooms (INDCR) since its foundation in 2007
- 40 Information provided by Jakob Huber, Director of Contact Netz, and Ines Bürge, Head of DCR Berne of Contact Netz
- 41 Standards Kontakt- und Anlaufstellen, 2. Überarbeitete Version 2011, Infodrog und Fachverband Sucht
- 42 Dubois-Arber, F., Benninghoff, F. & Jeannin, A. (2008), 'Typology of injection profiles of clients of a supervised drug consumption facility in Geneva, Switzerland', *European Addiction Research*, **14**: 1-10
- 43 Dubois Arber, C.H. et al. (2008), *Profiles of clients* (Europ Addiction Research); Gutachten zur rechtlichen Zulassung von Fixerräumen Schultz Bundesamt für Gesundheit BAG 1989; Spreyermann, C. and Willen, C (2002), *Evaluationsbericht Pilotproject Cactus. Evaluation der Kontakt- und Anlaufstelle des Contact Netz Drop-in Biel* (Berne: Sfinx)

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