

# Feasibility study on drug consumption rooms in Belgium

A study commissioned by the Belgian Science Policy Office (BELSPO)

Freya Vander Laenen

Pablo Nicaise

Tom Decorte

Jessica De Maeyer

Brice De Ruyver

Pierre Smith

Laurens van Puyenbroeck

Louis Favril



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## *Coordinator*

Prof. dr. Freya Vander Laenen<sup>1</sup>

## *Promoters*

Dr. Pablo Nicaise<sup>2</sup>

Prof. dr. Tom Decorte<sup>3</sup>

Dr. Jessica De Maeyer<sup>4</sup>

Prof. dr. Brice De Ruyver<sup>1</sup>

## *Researchers*

Pierre Smith<sup>2</sup>

Laurens van Puyenbroeck<sup>1</sup>

## *Principal researcher*

Louis Favril<sup>1\*</sup>

<sup>1</sup>Universiteit Gent, Institute for International Research on Criminal Policy (IRCP)

<sup>2</sup>Université catholique de Louvain, Institut de Recherche Santé et Société (IRSS)

<sup>3</sup>Universiteit Gent, Instituut voor Sociaal Drugsonderzoek (ISD)

<sup>4</sup>Hogeschool Gent, Expertisecentrum Quality of Life (E-QUAL)

\*Correspondence to:

Louis Favril

Universiteitstraat 4, 9000 Gent, Belgium

[louis.favril@ugent.be](mailto:louis.favril@ugent.be)



In memory of our beloved colleague prof. dr. Brice De Ruyver,  
founding father of the Belgian integrated drug policy, Belgium's  
*drug czar*, and a guiding influence to countless drug researchers.



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The ‘Drugroom’ research team

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# LIST OF ABBREVIATIONS

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EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
DCR	Drug consumption room
HAT	Heroin-assisted treatment
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HRI	Harm Reduction International
IDU	Injecting drug use
INCB	International Narcotics Control Board
MSIC	Medically supervised injection centre
NSP	Needle and syringe programmes
OST	Opioid substitution treatment
PWID	People who inject drugs
PWUD	People who use drugs
SIF	Supervised injection facility
SIS	Safe injection site <i>or</i> Supervised injection service
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization



## ABSTRACT

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People who use illicit drugs (PWUD) experience a wide range of drug-related harms. The goal of harm reduction is to reduce these adverse effects of drug use, without necessarily reducing drug use itself. By providing a safe and hygienic environment to consume pre-obtained drugs under the supervision of trained staff, drug consumption rooms (DCRs) aim to reduce both individual-level and public-level harms associated with illicit drug use. A substantial body of evidence has accumulated over the past three decades to support the effectiveness of DCRs in achieving their primary health and public order objectives, and therefore supports their role within a continuum of services for PWUD. Despite the abundance of scientific evidence supporting DCRs, there continues to be social and structural barriers to the implementation of this public health intervention in communities across the globe. Yet, the debate about implementing new DCRs remains high on the political agenda in a number of countries worldwide. To date, Belgium does not offer a DCR to its drug using population. Against this background, the Belgian Science Policy Office (BELSPO) commissioned a first-ever study to assess the feasibility of DCRs in Belgium.

The objective of the current feasibility study was to identify (legal) preconditions, design and operational considerations that would allow a DCR to be added within a continuum of policy initiatives for PWUD in five Belgian cities: Ghent, Antwerp, Brussels, Charleroi and Liège. The aims were threefold: (1) provide an up-to-date overview of the effectiveness, models, and barriers of DCRs worldwide, with particular attention to DCRs in Belgium's four neighbouring countries; (2) conduct an in-depth analysis of the legal framework within a DCR could operate in Belgium; and (3) conduct a feasibility study with local stakeholders and PWUD from each of the five cities.

Based on our findings, we formulate 18 recommendations specifically tailored to the Belgian context: essential preconditions (including legal options); main considerations when implementing a DCR; the implementation process; and monitoring and evaluation.

Executive summaries in English, Dutch and French are available upon request





# CHAPTER I

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## HARM REDUCTION AND DRUG CONSUMPTION ROOMS

*Louis Favril*

*Freya Vander Laenen*

*Tom Decorte*



## CHAPTER 1

# HARM REDUCTION AND DRUG CONSUMPTION ROOMS

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### 1. DRUG-RELATED HARMS

Illicit drug use is a well-recognised contributor to the global burden of disease (Degenhardt *et al.*, 2013) associated with a wide range of individual, social and environmental harms (Degenhardt & Hall, 2012; EMCDDA, 2014; Hartnoll & Hedrich, 2015; Jones *et al.*, 2011; Lievens *et al.*, 2016; Nutt, King, & Phillips, 2010). Both chronic and acute health-related problems are linked with the use of illicit drugs, which are compounded by various factors, including type and properties of the used substances, route of administration, individual vulnerability, and the social context in which drugs are consumed. Although relatively rare, the use of opioids (e.g., heroin) accounts for much of the morbidity and mortality associated with drug use (EMCDDA, 2017d). Elevated public health risks and public safety concerns especially arise from *injecting* drug use (IDU).

At the individual level, the estimated 8–19 million people who inject drugs (PWID) worldwide (UNODC, 2016) carry a disproportionate burden of health problems. The transmission of blood-borne infections, particularly human immunodeficiency virus (HIV) and hepatitis C virus (HCV), are of the main challenges among PWID worldwide owing to unhygienic practices, needle-sharing or re-using syringes (Degenhardt *et al.*, 2016, 2017; EMCDDA, 2017b; Hickman & Martin, 2016; Mathers *et al.*, 2008; Nelson *et al.*, 2011). About 13% of PWID worldwide are thought to be living with HIV, and new HIV infections among PWID rose by 33% from 2011 to 2015 (UNAIDS, 2017). Other IDU-related health risks include non-viral injuries and diseases such as cutaneous abscesses and infections, osteomyelitis and endocarditis (Dahlman *et al.*, 2015; Larney *et al.*, 2017; Lloyd-Smith *et al.*, 2008; Smith *et al.*, 2015). Acute risks include overdose-related morbidity and mortality (Degenhardt *et al.*, 2011; EMCDDA, 2015c; Mathers *et al.*, 2013; Strang, 2015). In addition, PWID exhibit enhanced marginalization from society, increasing exposure to social precariousness, unemployment and homelessness (Scott *et al.*, 2017). Consequently, social harms include stigma, discrimination and social exclusion (Ahern, Stuber, & Galea, 2007; Simmonds & Coomber, 2009). Aside from the individual-level harms experienced among PWID, at the community level, injection in (semi-)public spaces and associated injection-related litter (such as improperly discarded syringes) constitute a source of public disorder and community concern resulting from IDU (Cusick & Kimber, 2007; Rhodes *et al.*, 2006; Small *et al.*, 2007). A wide variety of factors, including lack of housing, poverty, and current drug policies contribute to risk environments (Rhodes, 2002) that increase the likelihood of people injecting in public (unsafe) places.

Owing to their visibility, this group of PWID is subject to increased police attention and public hostility, which, as users try to avoid detection (e.g., by rushing IDU), increases their vulnerability to injection-related complications, blood-borne infections, and risk of overdose (Hedrich, 2004; Vallance *et al.*, 2017). Partly because of its illegal nature, IDU is also responsible for numerous societal consequences, including violence, drug dealing, (acquisitive) crime, and public space degradation (Connolly, 2006; De Ruyver *et al.*, 2008; Kerr, Small, & Wood, 2005a; Renn & Lange, 1996), which affects cities with neighbourhoods experiencing considerable nuisance, and create a feeling of lack of public order and safety. Collectively, it is safe to say that illicit drug use, and IDU more specifically, places a heavy burden on both society and drug users' health.

## 2. HARM REDUCTION

To address these drug-related problems, communities across the world have responded with policies and strategies designed to reduce demand for illicit drugs, reduce the supply of illicit drugs, and reduce drug-related harms (Csete *et al.*, 2016; EMCDDA, 2015a; Strang *et al.*, 2012). National drug strategies support the balanced approach to drug policy put forward in the EU drug strategy (2013–2020), reiterated in the most recent EU Action plan 2017-2020 (EMCDDA, 2015b; EU, 2017). Similarly, in Belgium, a four-pillar approach is adopted (see BOX 1), entailing enforcement, prevention, treatment, and harm reduction (EMCDDA, 2017a; Plettinckx *et al.*, 2014). This latter pillar, harm reduction, refers to both a philosophical approach and a specific set of interventions. According to HRI (2016), harm reduction refers to “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption”. The defining features are the focus on the prevention of harm—rather than on the prevention of drug use itself—and the focus on people who continue to use drugs (Ritter & Cameron, 2006). Harm reduction is grounded within a public health model, which primarily aims to improve the health and well-being of drug users alongside reducing community and societal level harms (Newcombe, 1992), and complements approaches that seek to prevent or reduce the overall level of drug use (McKeganey, 2005). Overall, harm reduction services aim to create low-barrier, non-judgemental access to evidence-based interventions that improve the health and safety of PWUD without requiring any reduction in drug consumption (Des Jarlais, 1995; Stancliff *et al.*, 2015).

Countries worldwide have been converging on a core of drug policy options aimed at reducing drug-related harms for many years. Harm reduction strategies now constitute a central pillar within a comprehensive drug policy (Cook *et al.*, 2016; EMCDDA, 2015a, 2017f; Hartnoll & Hedrich, 2015; Hedrich & Pirona, 2017; MacGregor & Whiting, 2010). International bodies identify such interventions as good practices (EMCDDA, 2010, 2017e; HRI, 2016; UNAIDS, 2016; WHO, UNODC, & UNAIDS, 2012),

in spite of continuing opposition (Ti & Kerr, 2014). A large body of scientific research has convincingly demonstrated the effectiveness of such programmes. Opioid substitution treatment (OST; MacArthur *et al.*, 2012; Schuckit, 2016; Sordo *et al.*, 2017), needle and syringe programmes (NSP; Aspinall *et al.*, 2014; Fernandes *et al.*, 2017; Palmateer *et al.*, 2010), and heroin-assisted treatment (HAT; Bell, van der Waal, & Strang, 2017; Strang *et al.*, 2015) are all considered effective interventions for addressing the health and community-level harms related to (injecting) drug use. Countries that have adopted a public health approach and evidence-informed policy framework for harm reduction for PWUD have achieved high coverage of effective programmes. Moreover, evidence suggests that providing harm reduction interventions like OST and NSP is effective in reducing HIV and HCV transmission (MacArthur *et al.*, 2014), infections (Dunleavy *et al.*, 2017), injecting risk behaviours and mortality (Kimber *et al.*, 2010) among PWID. Yet, singular interventions are even more effective when implemented together within a coherent harm reduction approach (Hedrich & Hartnoll, 2015). When compared to piecemeal approaches (i.e., OST or NSP on its own), full harm reduction interventions provided at structural level and in multi-component programmes seem to be significantly more cost-effective and beneficial in reducing drug-related harms (Degenhardt *et al.*, 2010; Des Jarlais *et al.*, 2010; Martin *et al.*, 2013; Platt *et al.*, 2017; Turner *et al.*, 2011; van den Berg *et al.*, 2007; Vickerman *et al.*, 2012; Wilson *et al.*, 2015).

### **3. DRUG CONSUMPTION ROOMS**

Harm reduction programmes, including NSP and OST, have been implemented in many countries and are shown to significantly reduce drug-related harms (EMCDDA, 2010, 2017e). These interventions, however, do not address the lack of a safe and hygienic setting for injection and drug use more generally. The lack of safe environments in which to consume drugs poses a high risk to PWUD and drug intake often takes place in (semi-)public spaces (Rhodes, 2009; Rhodes *et al.*, 2006, 2007). Illicit drugs are often consumed under stressful and unsafe conditions in these spaces, serving as so-called open drug scenes (EMCDDA, 2015a). Recognizing this unmet need, *drug consumption rooms* (DCRs) initially evolved as a response to health and public order problems posed by public drug use (open drug scenes), especially by drug injecting in streets, railway stations, public bathrooms, and other public spaces, that persisted despite the availability of a network of drug treatment, harm reduction and social services. Currently, DCRs have been implemented in many countries throughout the world, as part of various strategies to reduce the harms associated with drug use, and became an integrated component of low-threshold services offered within a larger network of drug treatment systems. These facilities were, and still are, designed to address the health and social problems not addressed by existing drug policies and strategies, by providing legally sanctioned safer environments for individuals to use pre-obtained illicit drugs under medical supervision.

**Box 1. Belgium, country report: harm reduction (EMCDDA, 2017a)**

In Belgium, the Federal Drug Policy Note of 2001 and the Communal Declaration of 2010 endorse harm reduction as one of the pillars of national drug response. The range of officially endorsed harm reduction programmes includes, among others, peer support, needle exchange programmes, drug consumption rooms and heroin-assisted treatment. Nevertheless, the two latter programmes are not presently available in Belgium. In addition, the Belgian Early Warning on Drugs system can also be considered as a harm reduction approach. Needle and syringe programmes (NSPs) at low-threshold harm reduction projects have existed in the French community since 1994. In 1998, a law was adopted allowing needle exchange in pharmacies. In 2000, the Flemish community made the necessary legislative adaptations, and from 2001 such programmes have also officially been implemented there. NSPs (stationary, mobile or in pharmacies) are now available across the country, except in the German community. In general, harm reduction projects are set up and run by NGOs, and some are managed by city authorities. These projects are funded by the community and by the regions. Between 2011 and 2013, an open-label randomised controlled trial was carried out comparing heroin-assisted treatment and methadone maintenance treatment in the city of Liège. The study concluded that the use of heroin-assisted treatment should remain a second-line treatment in patients who have resistance to methadone and recommendations were provided for setting up such a programme. Since then, discussions have been undertaken in order to proceed with this project. The introduction of drug consumption rooms has been brought up and was also discussed at a political level. A working group of the General Drugs Policy Cell has been mandated to assess the necessary conditions for the introduction of drug consumption rooms.

The harm reduction projects offer, among other things, sterile injecting material (syringes, filters, ascorbic acid, spoons, alcohol swabs and sterile water), foil, bicarbonate and containers, as well as collecting used syringes and needles. In addition, they facilitate the referral of PWID to other prevention and treatment services. Over the years, the number of distributed syringes has increased in both the Flemish and the French communities, with over 1 million syringes distributed in 2015 across the country. In addition to syringe provision by low-threshold harm reduction projects, pharmacies in the French and the Flemish communities distribute a substantial number of syringes. In the French community, syringes are distributed mainly as part of the subsidised *Sterifix* kit. In 2015, 11,077 kits were dispatched to pharmacies, in addition to the syringes that were distributed. Annual evaluations of the NSPs in the Flemish community indicate that pharmacies can play an important role in the provision of injecting materials, as 9 out of 10 NSP clients report purchasing injecting material from pharmacies. It is important to note that not every province has a good geographical spread of NSPs.

### 3.1 History, present landscape and future plans

DCRs have been operating in Europe for the last three decades. The first officially sanctioned facility opened in Berne, Switzerland, in June 1986. In subsequent years, other cities followed their example, and the number of DCRs has risen since—albeit mostly confined to Western Europe. To date, more than 90 DCRs operate in ten countries spread over three continents.

At the time of writing, Europe counted 90 official DCRs in eight countries: Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland (see TABLE 1). As of June 2017, there were 31 facilities in 25 cities in the Netherlands; 24 in 15 cities in Germany; 13 in seven cities in Spain; two in two cities in Norway; five in four cities in Denmark; 12 in eight cities in Switzerland; and one in Luxembourg (EMCDDA, 2017b, 2017c). In October 2016, France opened its first DCR in Paris, followed by another facility in Strasbourg as of November 2016. Outside Europe, there are two facilities operating in Vancouver, Canada,<sup>1</sup> and one in Sydney, Australia.

A number of ‘unofficial’ DCRs—that is, operating without legal sanction but run on a non-profit basis for harm reduction purposes—also exist in Eastern Europe and South East Asia (NHSGGC, 2016).

**Table 1.** Number of DCRs worldwide (EMCDDA, 2017b, 2017c).

Region/country	Number of DCRs	First legal DCR since
<b>Europe</b>	<b>90 (64 cities)</b>	
Denmark	5 (4 cities)	2012
France	2 (Paris and Strasbourg)	2016
Germany	24 (15 cities)	1994
Luxembourg	1 (Luxembourg)	2005
The Netherlands	31 (25 cities)	1994
Norway	2 (Oslo and Bergen)	2005
Spain	13 (7 cities)	2000
Switzerland	12 (8 cities)	1986
<b>Outside Europe</b>	<b>3 (2 cities)</b>	
Australia	1 (Sydney)	2001
Canada	2 (Vancouver)	2003

<sup>1</sup> Several additional DCRs were approved by Health Canada (the federal department that oversees public health) earlier this year and five additional applications are currently (November 2017) under review. Health Canada granted permission to two DCRs (*SafePoint* and *Quibble Creek Sobering & Assessment Centre*; both located in Surrey, British Columbia) to allow people to use drugs orally and nasally. This marks the first instance of a state approving the oral and nasal consumption of drugs in a DCR outside of Europe.

Currently, DCRs are the subject of political discussion in other countries, as their first implementation is explored and debated, in the USA (Beletsky *et al.*, 2008; Enos, 2017; Fitzgerald, 2017; Goldstein & Gunderson, 2017; Kennedy & Kerr, 2017; Wakeman, 2017), the UK (ACMD, 2016; Lloyd & Hunt, 2007; Lloyd *et al.*, 2017), Scotland (Carrell, 2016; NHSGGC, 2016), and Ireland (Atkin-Brenninkmeyer, Larkan, & Comiskey, 2017; Broe, 2016; Houston, 2016). After almost two decades of advocacy and preparatory legal work, a DCR pilot project was launched in 2015 in Ljubljana, Slovenia, by a local NGO (EMCDDA, 2017c). In other countries, such as Canada and Australia, calls for scale-up are increasing (Bayoumi & Strike, 2016; Kerr *et al.*, 2017; Thomson *et al.*, 2017). In western Europe, Norway and Luxembourg are both preparing to open a second facility, but these may not be in operation until 2018 (HRI, 2016).

## 3.2 Definition and objectives

### Terminology and definition

The term *drug consumption room* (DCR) is often used interchangeably with supervised injection facility (SIF), safe injection site (SIS), and medically supervised injection centre (MSIC). Contrary to a DCR, these other terms are more demarcated, as they refer exclusively to facilities for drug *injection*. This fails to highlight the fact that numerous facilities do not only provide for safe injection places, but also allow drug users to smoke their substances on location. For example, in the Netherlands, most facilities offer separate rooms for injection and smoking (Havinga & van der Poel, 2011). Therefore, and in line with the EMCDDA (EMCDDA, 2010, 2017c), we adopt the neutral term *drug consumption room*, to include all facilities in our analyses, irrespective of route of administration.

Although the collective term ‘DCR’ is used, this embraces a range of types of service, delivered in differing ways, targeting different populations, within different contexts. While these rooms differ in their models of service delivery, there are some basic common elements: being officially sanctioned, regulated entry, supervised drug consumption, provision of sterile equipment, immediate help in case of overdose, primary health care, and referral to drug treatment. Across types of facilities, DCRs are defined as legally sanctioned facilities that permit the use of pre-obtained drugs in safe and hygienic conditions under trained staff supervision (Kimber *et al.*, 2003). A more comprehensive definition is provided by Schatz and Nougier (2012): “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” (p. 2). DCRs differ from so-called ‘shooting galleries’ and other non-medical drug use settings, where drug consumption occurs without medical supervision or the provision of hygienic equipment.



**Heroin-assisted treatment: similar yet different**

*Heroin-assisted treatment* (HAT) is an evidence-based harm reduction intervention for entrenched heroin users who have not responded to standard treatments such as oral methadone maintenance treatment (OST) or residential rehabilitation (Strang *et al.*, 2015). As a medical treatment for refractory heroin dependence, prescribed diamorphine (pharmaceutical heroin) is taken (injected) under direct medical supervision in a clinic, thereby ensuring compliance, monitoring, safety, and prevention of possible diversion of prescribed diamorphine to the illicit market.

Although similar to a certain extent—in both cases, PWUD are provided with a supervised environment to consume illicit substances—DCRs significantly differ from HAT in respect to their concept, operation, and target population (Strang & Forston, 2004), as summarized in TABLE 2. In HAT, the attendee is a known patient, receiving treatment from their doctor, and self-administering the prescribed injectable heroin, supervised by staff within the clinic. In contrast, a DCR is not for treatment purposes, but rather a public health facility in which clients bring their own chosen and illicitly obtained substances, and choose their degree of intoxication and technique of administration. Furthermore, unlike the ‘open access’ DCRs, HAT involves screening and appropriate patient selection, structured induction and monitoring, and a high level of support and interaction with staff. DCRs rather focus on all (injecting) drug users, regardless of whether or not they are (long-term) dependent or wish to change their drug taking habits. In sum, HAT is a specialist medical treatment for those heroin users who have not adequately responded to standard treatments—as previously piloted in Liège, Belgium (the TADAM-project; Demaret *et al.*, 2011).

**Table 2.** Comparison between DCR and HAT (adopted from NHSGGC, 2017).

	<b>Drug consumption room</b>	<b>Heroin-assisted treatment</b>
Service	Supervised, hygienic environment where individuals can use drugs that they have acquired elsewhere.	Structured medical treatment prescribing pharmaceutical heroin to individuals with long-term heroin addiction.
Aims	To reduce the health risks and social harms caused by public drug use and to help people engage with health and social care services.	To reduce street drug use and provide social stability among people with long-term heroin addiction.
Target group	As many of the vulnerable population of drug users as possible, who may find it difficult to engage with other services.	People with long-term heroin addiction for whom other treatments have not worked.
Access	Run on a drop-in basis, following a short registration process. No requirement to attend at a certain time or on a regular basis.	Can only be accessed after a clinical assessment by a specialist addictions doctor; patients must attend regular appointments 2 or 3 times per day.

## **Target group and objectives**

As described above, DCRs seek to attract hard-to-reach populations of PWUD, especially marginalised groups and those who use drugs on the streets or in other risky and unhygienic conditions. This vulnerable segment of PWUD, who are less likely to access treatment services, 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. The first goal of a DCR is therefore to establish contact with this hard-to-reach group of drug users. Second, although there are different DCR models (cf. infra), these facilities typically aim to reduce morbidity and mortality risks associated with drug use, and to promote drug users' access to other social, health and drug treatment services. Third, in addition to these health goals, DCRs also seek to contribute to a reduction in drug use in public places and the presence of discarded needles and other related public order problems linked with open drug scenes. The balance of priorities attributed to DCRs varies, with some placing greater emphasis on health goals, and others on public order (Hedrich, Kerr, & Dubois-Arber, 2010). In line with the report by Hedrich (2004), the three main objectives are described below. A service model for a DCR with both public health and public order objectives is presented in FIGURE 1 (EMCDDA, 2017c).

### **1. Reach and maintain contact with target group**

In order to achieve health and public order objectives, DCRs must be able to *reach* as many members of the target group as possible, as well as *retain* contact with this hard-to-reach, marginalized target population. A particularly important group are those who inject in the streets, who are characterised by extreme vulnerability as a result of social exclusion, poor health and homelessness, amongst others. Some DCRs target specific and well-defined groups of problem drug users, such as female sex workers or illegal immigrants. As such, facilities adhere to several admission criteria, in order to delineate its specific target group (cf. infra).

### **2. Promote overall health and well-being**

DCRs are intended to promote health and well-being of their target population by (1) reducing drug use-related health risks (e.g., transmission of infectious diseases and overdose-related deaths) through the provision of a safe and hygienic environment for drug use, and through training and educating DCR clients in safer drug use; and by (2) increasing clients' access to health, welfare, and drug treatment services.

***a. Immediate health objective: provide a safe and hygienic environment***

One objective of DCRs is to reduce the immediate harms that can arise from drug use, especially those related to hurried drug use in public places or other high-risk situations. To achieve this goal, DCRs seek to ensure that drugs are consumed under hygienic conditions and safer use is facilitated, and rapid care is available in the event of emergencies such as overdoses (Hedrich, 2004).

***b. Medium term health objective: reduce morbidity and mortality***

Another health objective is to reduce morbidity and mortality among the target population, which can be achieved through health promotion and safe use education (training DCR clients in safer drug use). According to Hedrich (2004), such practices are expected to result in (1) sustainable improvements in knowledge and risk awareness among clients; (2) reduced high-risk behaviour beyond the DCR setting itself; (3) reduced exposure to and transmission of drug-related infectious diseases; and (4) reduction in overdoses.

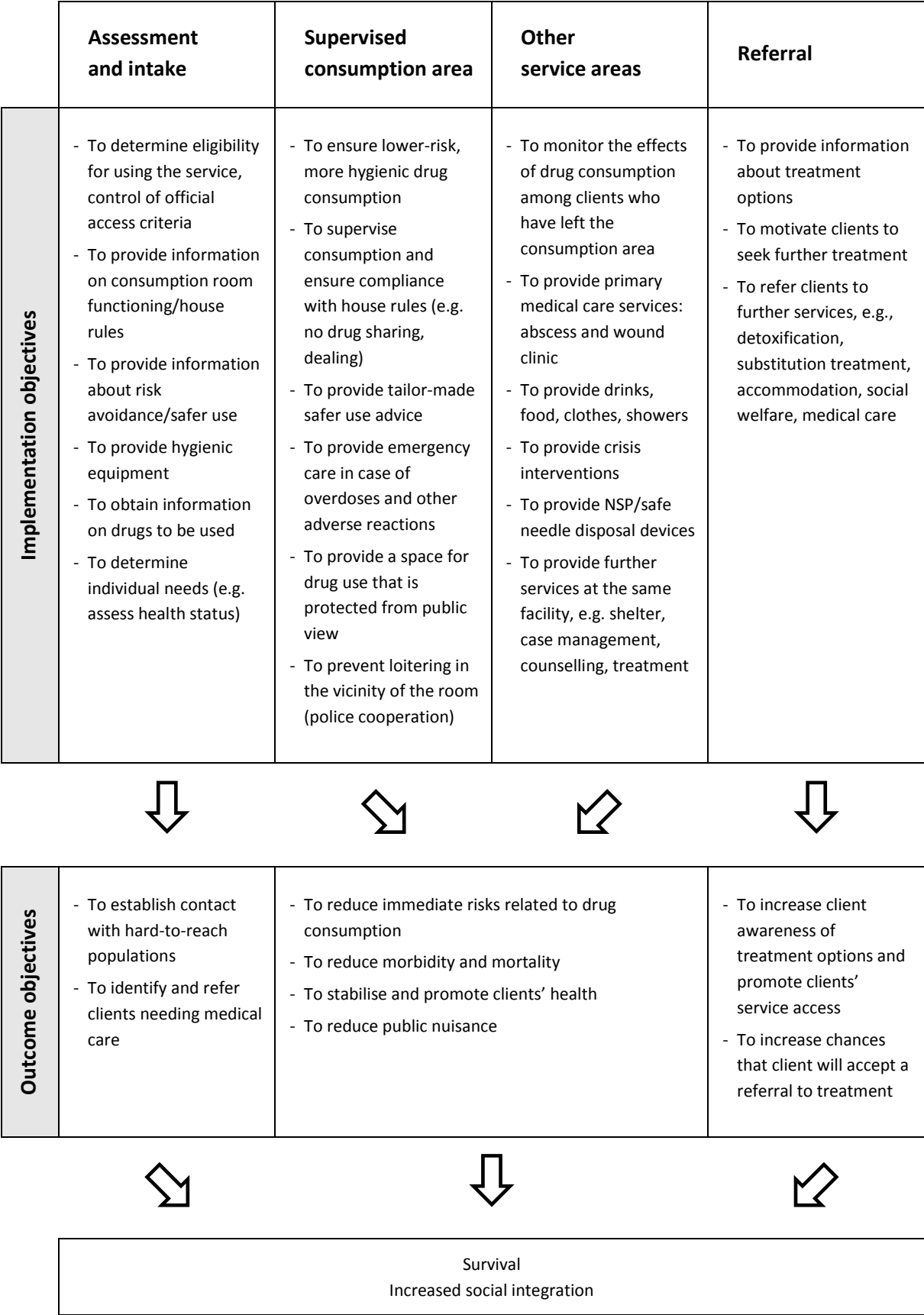
***c. Longer term health objective: stabilise and promote the health of service users***

As low-threshold facilities, a last health objective of DCRs includes promoting and facilitating access to social, health and drug treatment facilities. Expected benefits of DCRs are that they (1) increase access to and use of basic medical care and counselling through on-site services; and (2) improve drug treatment uptake and promote longer term improvements in clients' health and social functioning through referral to other services (Hedrich, 2004). As such, one intention of DCRs is to provide a setting for bridge building and guiding the service users to more specialised health care, OST, and drug-free treatment, when needed and wanted.

**3. Reduce public disorder and improve public amenity**

Lastly, DCRs also aim to create an acceptable situation for the public with regard to order and safety concerns that arise from open drug scenes, while providing a sheltered and dignified environment for drug consumption. Expected benefits with regard to public order and safety include (1) reduced drug use in public spaces; (2) reduced level of public order problems and nuisance in neighbourhoods with visible drug scenes; and (3) prevent increased crime in and around consumption rooms.

**Figure 1.** Service model for a DCR with public health and public order objectives (EMCDDA, 2017c).



## Box 2. Definition and objectives

Drug consumption rooms (DCRs) are legally sanctioned public health facilities that offer a hygienic environment where people can use pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff. They constitute a highly specialised service within a wider network of services for PWUD, embedded in comprehensive local strategies to reach and fulfil a diverse range of individual and community needs that arise from illicit drug use. Although DCRs vary in operational procedures and design, the aims of DCRs are similar across sites. The overall rationale for DCRs is reach out to, and address the problems of, specific high-risk populations of PWUD, 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. For this group, DCRs aim to reduce the risk of transmission of blood-borne infections, to reduce the likelihood of morbidity and mortality resulting from overdose, and to help people who use drugs avoid other harms associated with drug consumption under unhygienic or unsafe conditions. In addition to these health-oriented goals, DCRs also aim to contribute to a reduction in drug use in public places and the presence of discarded needles and other related public order problems linked with open drug scenes.

### 3.3 Models and characteristics

A number of features are common to the majority of DCRs, irrespective of where they are located. For example, access is typically restricted to registered service users, and certain conditions, for example minimum age limit, have to be met. They usually operate from separate areas attached to existing facilities for drug users or homeless people, while some are stand-alone units. Most DCRs target PWID, though they increasingly include users who smoke or inhale drugs (see CHAPTER 3).

Although the collective term ‘drug consumption rooms’ is used, this embraces a range of types of service, delivered in differing ways, targeting different populations, within different contexts (Hunt, 2006c). Overall, two models of DCRs are distinguished in Europe: integrated and specialised facilities (Hedrich, 2004; Hedrich *et al.*, 2010). The vast majority of DCRs are *integrated* within low-threshold facilities, where supervision of drug consumption is just one of several services offered at the same premises. *Specialised* facilities only offer the narrower range of services directly related to supervised consumption. In addition to ‘fixed’ DCRs, *mobile* rooms provide a geographically flexible deployment of the service, but typically cater for a more limited number of clients than fixed premises (Dietze *et al.*, 2012; McCann & Temenos, 2015). They are able to operate in a variety of settings across a city. Also, they offer a range of other harm reduction services, such as syringe exchange, blood-borne virus

testing, and referral to other services. Mobile DCRs avoid the risk of making one building the focus of all the activity and they can reach people who want to hide or not being seen in the different areas of a city (Schäffer, Stöver, & Weichert, 2014). Due to their smaller capacity, mobile facilities can typically see fewer clients per day compared to larger fixed-site facilities. However, mobile facilities can require similar levels of staffing as larger fixed-site facilities, resulting in higher cost per client than fixed-site facilities. A small-scale mobile facility may be most desirable and complimentary when combined with a fixed facility as an outreach programme for hard-to-reach clients (BCCSU, 2017). Here, we will focus on fixed models of DCRs.

### **The integrated model**

Integrated facilities are the most common type of DCRs in Europe, as they have frequently evolved as part of a broader and interlinked network of services, being added on to and physically integrated into existing care facilities for homeless people or PWUD, amongst others. In this case, the DCR provides an additional component of services alongside services like OST, drop-in centres, basic medical care or counselling. Supervision of consumption is provided in a separate area of the premises, to which access is controlled and which is open only to a limited group of clients (access is limited to clients who have undergone a prior assessment and have been appropriately screened for eligibility), as just one among many other services provided. In integrated facilities, DCR users are just one among several different groups of clients. The integrated model provides an important ‘one-stop shop’ for a range of different harm reduction and health care services.

### **The specialised model**

Specialised facilities focus exclusively on consumption room users. They are much less common than integrated services. These stand-alone health services are independent from other services and whose purpose is primarily to provide hygienic and supervised consumption. Besides the provision of basic services above supervised drug consumption (e.g., education, needle and syringe exchange and drug-related medical care), specialised DCRs serve as a connection through referrals to other services like OST, counselling, housing or access to employment services. They are usually set up in close vicinity to other drug services and are located near important drug markets with concentrated open drug scenes, where there is a high demand for the opportunity to take drugs in a safe and hygienic environment.

One ‘special’ model is that of an *embedded* DCR; a specialised facility at the intersection of integrated DCRs. More specifically, these are embedded within other models of service and care that traditionally do not allow non-medical drug use, like hospitals, but focus exclusively on (and are only accessible for) PWUD (BCCSU, 2017). The first known embedded DCR to operate in a hospital is in Paris.

### **Box 3. Examples of functioning of consumption rooms**

#### Integrated facilities (the Netherlands)

Upon entry, most have a front desk or a staff member that monitors who enters the premises. Clients may then continue into the common room, where they can get coffee or tea and pull up a chair. Television, music, reading material, and games are also often available. Taking drugs in the common room is strictly prohibited; a room for drug consumption is found elsewhere on the premises. Because integrated facilities provide various other services, including to non-drug users or to drug users who do not meet the access criteria for consumption rooms, a staff member controls admittance to the drug-taking area. Separate injecting and smoking rooms may be available. In addition to the common room and the consumption area, some facilities also have other rooms, such as a drug emergency room, which, when not required for that purpose, also serves as a relaxation room (Hedrich, 2004).

#### Specialised facility (Australia)

When a person comes to the DCR for the first time, they go through a 10 to 20-minute registration and interview process with a nurse or counsellor. After registering at their first visit, clients are asked less questions by staff when they return on subsequent visits. Staff still need to know what drug clients are intending to use, when they last used, and what other drugs they have used in the previous 24 hours. This helps determine their risk of overdose and provides an opportunity to counsel clients about the risks before they inject. They may then wait a short time before being allowed to go into another room. Stage two of the DCR is where clients prepare and inject drugs. Here, clients are provided with clean equipment on entry, and choose one of booths to inject in—all of which are observable by employed staff. Afterwards (in the aftercare section), there is a place to sit and relax before leaving the building. It is a place where clients and staff can interact in a more informal way; other medical, nursing, welfare or counselling staff are on hand to talk to those that want help and refer them to other services where appropriate. Once clients are ready, they are able to leave.

The main difference between both types of models concerns the physical integration within a wider network of services; DCRs may be based within existing addictions service premises, or operate independently in stand-alone locations. The latter, specialised facilities, are focused on the supervised consumption of drugs and from which referrals may be made to other, external services, whereas integrated services will typically have a variable range of additional treatment, health and welfare services directly available in one single location. Both types of DCRs can serve as a first, low-barrier point of access to the wider range of health and harm reduction services for highly marginalized PWUD, whether in-house or through referrals. A comparison between both models is presented in TABLE 3.

**Table 3.** Comparison between fixed specialised and integrated facilities.

	Advantages	Disadvantages
Specialised model	<ul style="list-style-type: none"><li>- all PWUD who come into the DCR have the same goal; to consume drugs</li><li>- as they primarily serve PWUD, the facility's services can be tailored to their needs</li><li>- may lower the threshold due to the exclusive focus on drug consumption</li></ul>	<ul style="list-style-type: none"><li>- not able to provide many additional services and clients would then need to go to a different location for other services</li><li>- more expensive due to rental costs of a building and starting a programme from scratch</li></ul>
Integrated model	<ul style="list-style-type: none"><li>- allows PWUD to access a range of services under one roof without having to go to a different location</li><li>- less expensive as many of the programmes could use existing space, staff and supplies</li></ul>	<ul style="list-style-type: none"><li>- difficult for other clients who are on OST or going through detox to know that drugs are being used in the same facility</li><li>- integration within (treatment) services may raise the threshold for individuals who are merely interested in drug consumption</li></ul>

### 3.4 Evidence of effectiveness

Irrespective of its specific model (integrated vs. specialised facilities), DCRs aim to establish contact with a vulnerable group of drug users, to improve their health and wellbeing, and to benefit public order. Since their introduction, studies have sought to evaluate the effectiveness of DCRs in reaching these objectives. Although most DCRs are currently located in Europe, evaluation studies from Canada and Australia dominate the published literature.<sup>2</sup> As scientific pilot projects, these DCRs have been the subject of large-scale evaluation studies using elaborate designs, resulting in a large body of outcome data published in peer-reviewed journals. In Europe, however, outcomes were reported directly to local and sometimes national policy makers, but data were rarely published in the international literature. Although several comprehensive reports on DCRs have been published (e.g., Hedrich, 2004), the use of monitoring data collected at the European facilities remains limited to internal evaluations or publications in grey literature. However, to date, there remains a dearth of methodologically sound evaluation studies in Europe. The following section provides a summary of (systematic) reviews and overviews on the effectiveness of DCRs globally (Bell & Globerman, 2014; EMCDDA, 2017c; Hedrich, 2004; Hedrich *et al.*, 2010; Hunt, 2006a; Kennedy, Karamouzian, & Kerr, 2017; Potier *et al.*, 2014; Schatz & Nougier, 2012), supplemented by more recent studies not included in these reviews.<sup>3</sup>

<sup>2</sup> Of 47 studies included in a recent systematic review (Kennedy *et al.*, 2017), 28 were conducted in Vancouver, Canada, and 10 in Sydney, Australia. The remaining studies were conducted in Germany ( $n = 4$ ), Denmark ( $n = 2$ ), Spain ( $n = 2$ ) and the Netherlands ( $n = 1$ ).

<sup>3</sup> Though logistical and methodological constraints have precluded randomised controlled trials on the impact of DCRs, these reviews identified a substantial body of observational evidence, of variable design and quality. The potential for confounding in such studies is significant, given the absence of randomised controlled trials and the multiplicity of factors influencing the epidemiology and harms of (injecting) drug use (e.g., changes in supply, concurrent harm reduction initiatives, and law enforcement activity). Such concerns are a particular issue for ecological studies, such as those investigating changes in overdoses at the community level (NHSGGC, 2016).



## **1. Reach and maintain contact with target group**

The success of DCRs depends to a large extent on their ability to attract and engage with their target population. In all countries, evidence indicates that DCRs attract profiles of clients that reflect their target groups. Moreover, studies show that DCRs generally succeed in attracting socially marginalised drug users who are at high risk of HIV infection and overdose, as well as those who are likely to inject drugs in public (Bravo *et al.*, 2009; Goodhew *et al.*, 2016; Hedrich *et al.*, 2010; Kinnard *et al.*, 2014; Potier *et al.*, 2014; Wood *et al.*, 2006c). The Sydney evaluation report concluded that the facility continued to reach long-term, high frequency injecting drug users who are highly socially marginalised and likely to inject drugs in public settings (NCHECR, 2007b). Similarly, retention and attendance rates at the Vancouver DCR indicate that the DCR is successful in gaining acceptance by its target group and that regular users of DCRs tend to be more marginalised, with various health and social problems, such as those related to public injecting and unstable housing (Tyndall *et al.*, 2006; Wood *et al.*, 2005b, 2006c). Regarding the latter, the first Sydney evaluation report (MSIC, 2003) indicated that the most common reason given for *not* using the DCR was injecting in the privacy of their own home. However, in some cases clients who are more socially stable also use DCRs for a variety of reasons, for example because they live with non-using partners or families (Hedrich & Hartnoll, 2015). Taken together, DCRs have the ability to reach, maintain contact and provide service for high-risk drug users who are not ready or willing to quit drug use (Potier *et al.*, 2014). This contact has resulted in health improvements for clients, as well as wider health and public order benefits, as described below.

## **2. Reduce drug-related risk behaviour**

Quantitative studies conducted in Vancouver highlighted that regular use of DCRs was independently associated with reductions in the sharing of syringes (Wood *et al.*, 2005a), syringe re-use, and public-space injecting (Stoltz *et al.*, 2007). More specifically, Kerr *et al.* (2005b) found that frequent use of the DCR in Vancouver was associated with a 70% decrease in the likelihood of sharing injecting equipment. Another study found that 75% of the DCR's clients in Sydney reported a change in injecting behaviour as a result of using the DCR: among these individuals, 80% indicated that the DCR had resulted in less rushed injecting, 71% indicated that the DCR had led to less outdoor injecting, and 56% reported less unsafe syringe disposal (Petrar *et al.*, 2007). Similar figures were found in a recent study from Denmark (Kinnard *et al.*, 2014), where upward of 75% of those visiting the facility self-reported reductions in injection risk behaviours (e.g., syringe sharing and public injecting) since using the DCR. In their meta-analysis, Milloy and Wood (2009) estimated that frequent use of DCRs was associated with a 69% reduced likelihood of syringe sharing. Similarly, in qualitative interviews, PWID who accessed DCRs reported sharing needles less frequently (Jozaghi & Andresen, 2013; McNeil & Small, 2014).

Collectively, these studies provide clear evidence that DCR use is associated with reduced self-reported and observed injecting risk behaviour, and improvements in reported and observed injecting hygiene, especially among those who use the facilities frequently. Indeed, a recent review of reviews (MacArthur *et al.*, 2014) concluded that there is tentative evidence to support the effectiveness of DCRs in reducing injecting risk behaviour, which resonates with a systematic review (Potier *et al.*, 2014) concluding that regular use of a DCR had positive effects on overall syringe sharing, syringe reuse and other high-risk behaviours. In addition to the provision of sterile (injection) equipment and other paraphernalia on-site, there are several other mechanisms through which DCRs may reduce such behaviours (Kennedy *et al.*, 2017). For example, DCRs often become a key source of sterile syringes for external use (Kerr *et al.*, 2007a), which is notable given the well-documented effectiveness of syringe exchange services in reducing risk of HIV transmission (Abdul-Quader *et al.*, 2013). Moreover, DCRs have been shown to increase access to safer injection education (see below) and to decrease the need to rush injections due to fear of arrest (Kerr *et al.*, 2007a).

### **3. Increase use of education services about safer drug use**

Since lack of knowledge regarding safer injecting practices is a major factor contributing to infections, DCRs may provide unique opportunities to deliver safer injection education to high-risk populations (Wood *et al.*, 2008). In Vancouver, service users reported substantial baseline knowledge gaps about safer injection practices, which should subsequently be addressed through nurse-delivered training (Fast *et al.*, 2008). In terms of education and improved knowledge of safer behaviours, one-third of DCR clients in Vancouver reported receiving safer injecting education from nurses within the facility (Wood *et al.*, 2005c). Regular DCR use was associated with more frequent requests for education on safer injection practices (Wood *et al.*, 2008). Another study showed that IDUs who previously required help with injections no longer needed assistance as a result of education from nurses within the facility (Stoltz *et al.*, 2007). Studies from Germany (Zurhold *et al.*, 2003) and Denmark (Toth *et al.*, 2016) echo such findings by demonstrating links between DCR use and utilization of education on safer drug use practices at the facilities.

### **4. Reduce HIV and HCV morbidity**

Although DCRs appear to significantly reduce the sharing of injecting equipment, and as such reduce the behaviours that increase the risk of HIV and HCV transmission, a systematic review found no direct evidence that DCR use induced a decrease in viral transmission (Potier *et al.*, 2014). In a similar vein, a review of reviews concluded that there was insufficient evidence to support the effectiveness of DCRs in reducing HIV and HCV incidence (MacArthur *et al.*, 2014). Thus, available evidence does not allow

conclusions to be drawn on whether or not DCRs have a specific, attributable impact on reducing HIV and HCV incidence rates, although fairly substantial reductions in self-reported HIV and HCV risk behaviour (such as syringe sharing) have been associated with DCR use (see above; Milloy & Wood, 2009; Stoltz *et al.*, 2007). This is likely due, in part, to methodological difficulties of undertaking a study to disentangle and isolate the effects of DCRs from concurrent harm reduction interventions (e.g., NSP, OST and/or outreach), or limited coverage of the target population (EMCDDA, 2017c; Hedrich *et al.*, 2010). Nonetheless, findings from a recent systematic review provide strong evidence to support the role of DCRs as an infectious disease prevention strategy through the availability of NSP and education within DCRs, and consequent reductions in syringe sharing and reuse (Kennedy *et al.*, 2017).

## **5. Reduce overdose-induced mortality and morbidity**

To date, worldwide, zero deaths by overdose have been recorded *within DCRs* since their inception, despite the millions of injections that have occurred inside (Kennedy *et al.*, 2017; Potier *et al.*, 2014). No scientifically sound data are available on the number of averted fatal overdoses, nor on the number of non-fatal overdoses occurring within the premises of DCRs worldwide.<sup>4</sup> However, many clients in Vancouver had personally experienced an overdose at the facility, or had witnessed a friend overdose, and in all cases, clients reported that DCR staff intervened swiftly and competently and ultimately averted fatal outcomes (Jozaghi & Andresen, 2013; Kerr *et al.*, 2007a). As in May 2015, the DCR in Sydney had managed over 5,925 overdose-related events on-site, without a single fatality (Goodhew *et al.*, 2016). Furthermore, the evaluation report of this DCR (KPMG, 2010) concluded that substantial proportions of overdoses managed on-site would have likely resulted in significant morbidity had they occurred elsewhere, and that approximately half would have otherwise occurred in public places. Likewise, a study found that circa 40% of all drug-related emergencies in 2013 in facilities across Germany were classified as severe and life-threatening, and according to the assessment of the DCRs staff, these emergencies could have had a fatal outcome if the client had been alone at home or at a public place (Schäffer *et al.*, 2014). Taken together, these studies highlight the impact of DCRs in preventing overdose-related mortality within facilities, likely due to the presence of trained personnel ready to intervene in emergency situations. On the other hand, it has been suggested that, with medical staff on hand to intervene and administer agents to reverse an overdose, DCR users would

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<sup>4</sup> A recent organisational overview of 51 DCRs worldwide (Belackova *et al.*, 2017) provides some cross-sectional data on overdose, self-reported by DCR representatives. On average, there was one overdose at the service every three days, but there was a great variability across the different services (median: 1 in 47 days; range: 0–3 per day). When recounted to a per-year basis, 17% of the DCRs who provided an answer stated they assist in 150 and more overdoses, 11% experienced between 52 and 150 overdoses yearly (1–3 per week), 20% reported 12–52 per year (1–3 per month), and 40% of DCRs reported they experience none or less than one overdose yearly.

take greater risks and experience more (non-fatal) overdoses. This suggestion that DCRs may increase the likelihood of overdose was however refuted by a Canadian study (Milloy *et al.*, 2008a).

Evidence from ecological studies further suggests that DCRs may also contribute to reducing drug-related deaths *at city level*. Indeed, in Vancouver, overdose mortality decreased by 35% in the neighbourhood surrounding the DCR in the two years after the facility opened, but only by 9% in the rest of the city during the same period (Marshall *et al.*, 2011). In their simulation of the impact of the Vancouver DCR, Milloy *et al.* (2008b) estimated that that between two and 12 cases of overdose deaths might have been prevented each year. Similarly, in Sydney, the number of overdose-related ambulance call-outs declined significantly (68%) in the neighbourhood surrounding the DCR after it commenced operation, and this decline was greatest within the operating hours of the facility (Salmon *et al.*, 2010; Van Beek *et al.*, 2004). This suggests that DCRs provide an environment where PWID at risk of overdose are able to receive early intervention and thus avoid the need for emergency services.

## **6. Facilitate access to health and psychosocial services**

In most DCRs, a range of other services are usually delivered *on-site* alongside supervision of drug consumption (and the provision of sterile injecting equipment, advice on safer injecting technique, and rapid assistance in the event of an overdose). Low-threshold medical care and psychosocial counselling services (other than addiction treatment) are especially well used and contribute to the stabilisation and improvement of the somatic and psychological health of users (Hedrich *et al.*, 2010). For instance, a recent multi-site cross-sectional study of DCR users in Denmark found that being advised to seek treatment for a medical condition by DCR staff was associated with an increased likelihood of receiving treatment (Toth *et al.*, 2016). In Vancouver, Canada, Small and colleagues (2009) reported that 94% of DCR clients accessed non-medical services on site, 44% accessed medical services, and 24% indicated they would not have accessed these services if they had not been made available at the DCR. The same study indicates that DCR clients especially appreciated being able to access all services at one location (Small *et al.*, 2009). Some clients reported difficulties finding time to access medical care in any other setting, and others reported not being able to recognize the severity of their condition without advice from a DCR nurse (Small *et al.*, 2008). Another qualitative study shows that clients were able to receive nursing care without feeling worried about discussing their drug use with care providers (McNeil *et al.*, 2014). In summary, DCRs increase access for specific 'hard-to reach' target populations of PWUD to health and welfare services. As such, DCRs can serve as a first, low-barrier point of access to a wider range of psychosocial, health and harm reduction services for highly marginalized PWUD. In addition to facilitating access to such services by providing much-needed care on-site, consequently improving health and well-being of clients, DCRs can also connect clients to *external* services through referrals.

## **7. Refer to detoxification programmes and addiction treatment**

Apart from the provision of on-site services, DCRs are also expected to build bridges to other health institutions, for services not provided in the DCR. Clients can be referred to drug treatment, though proportions vary and uptake rates are often not registered. Furthermore, different admission policies towards accepting clients who are already in OST affect treatment referral rates (Hedrich *et al.*, 2010). Regarding referrals to treatment, only the Vancouver and Sydney studies measure actual uptake. Four studies provided robust evidence of a positive association between DCR use and uptake of addiction treatment (DeBeck *et al.*, 2011; Kimber *et al.*, 2008; Wood *et al.*, 2006d, 2007).

In Sydney, over six years of operation, a total of 6,243 referrals to other services were provided (16 per 1,000 visits); 45 percent of referrals were to drug treatment, most frequently to OST (NCHECR, 2007b). Frequent users of the facility in particular were more likely to receive referrals to addiction treatment (Kimber *et al.*, 2008). Data from Vancouver indicates that in 2004–2005, approximately 800 health and addiction referrals were made each quarter at the Vancouver DCR, with 40% of the referrals for addiction treatment (Wood *et al.*, 2006b). Among the PWID who use the facility, 18% secondarily engaged in a detoxification scheme. Regular (weekly) use of the DCR and any contact with the facility's addictions counsellor were both associated with more rapid entry into such an external detoxification programme (Wood *et al.*, 2006d). One year after the DCR opened, these authors noted a 30% increase in the uptake of detoxification services (compared to the year prior to the establishment of the facility), which was subsequently associated with increased rates of long-term addiction treatment initiation, as well as subsequent declines in use of the DCR (Wood *et al.*, 2007). Similarly, more recent data found that nearly a quarter (23%) of respondents who had been DCR clients stopped injecting after two years of enrolment in the cohort, and another 57% had entered addiction treatment (DeBeck *et al.*, 2011).

Together, these studies indicate that DCR attendance is associated with increased uptake both of detoxification and drug dependence treatment, including OST. For frequent attenders in particular, DCRs can act as a gateway to the wider system of health care and addiction treatment (Tyndall *et al.*, 2006). This suggests that DCRs complement rather than conflict with treatment goals, and thus reflects the complementary role of DCRs within a comprehensive drug policy approach (Hedrich *et al.*, 2010).

Despite this evidence demonstrating the role of DCRs in promoting and connecting PWUD with *external* detoxification and addiction treatment services, little information is available concerning the potential of co-locating on-site detoxification services with DCRs. One recent study (Gaddis *et al.*, 2017) examined data from two prospective cohorts of PWID in Vancouver and found that usage of on-site detoxification services offered at the DCR was common among PWID; 11% enrolled in such services at least once during the two-year study period. Factors positively affecting uptake of this service included several markers of vulnerability and drug-related risk (e.g., public injecting, binge injection and recent

overdose), as well as frequent DCR use (Gaddis *et al.*, 2017). This latter finding echoes previous studies demonstrating greater uptake of external addiction treatment among frequent DCR users (see above), and further highlights the role of DCRs in facilitating entry into treatment services, despite the fact that these facilities are harm reduction programmes designed for active drug users.

## **8. Reduce public nuisance and disorder**

Evaluation studies have found an overall positive impact on the communities where these facilities are located (EMCDDA, 2017c; Potier *et al.*, 2014). DCRs have been associated with a decrease in public injecting and a reduction in the number of syringes discarded in the vicinity of the DCR, both objectively (by observing changes before and after opening a DCR) and subjectively (by self-report of PWID and local residents). In an *observational* study, counts of publicly discarded syringes in the hereabouts of the Vancouver DCR decreased after it opened than before, and the authors found a reduction in the daily mean number of individuals injecting in public after opening (Wood *et al.*, 2004c, 2006b). In Barcelona, a fourfold reduction was reported in the number of unsafely disposed syringes being collected in the area adjacent to the DCR from a monthly average of over 13,000 in 2004 to 3,000 in 2012 (Vecino *et al.*, 2013), and the opening of a DCR was followed by a general decrease in the number of discarded syringes, both locally and throughout the city of Barcelona (Espelt *et al.*, 2017).

These observational findings are substantiated by *self-report* surveys, in which DCR attendance was found to be associated with a reduction in self-reported public drug injecting and syringe dropping. Moreover, one study found that regular DCR users were more than twice as likely to report a reduction in public injecting compared to those who occasionally or rarely used the Vancouver DCR (Stoltz *et al.*, 2007). Another study found that among DCR users whose injecting behaviour had changed as a result of accessing the facility, 71% reported fewer public injections and 56% reported less unsafe needle disposal (Petrar *et al.*, 2007). This finding was confirmed by non-drug users who live or work in the vicinity of the DCR. In Sydney, between the periods prior and post opening of the DCR, resident and business respondents noted fewer sightings of public injection and less syringes and drug-related litter discarded in public places (Thein *et al.*, 2005). Five years after its initial opening, local business owners perceived significant improvements in public amenity and reported a significant decrease in public injecting or publically discarded injecting equipment (Salmon *et al.*, 2007).

Taken together, evaluation studies indicate that DCRs are largely successful in achieving their objective of reducing public disorder associated with illicit drug use through declines in public injection and discarded drug use-related paraphernalia (Kennedy *et al.*, 2017). However, these studies adopt a relatively narrow operationalization of disorder (i.e., public injection and discarded syringes); little data is available on possible congregation of clients in the vicinity or shift effects to other neighbourhoods.

## 9. Cost-effectiveness

There are only a few studies investigating the cost-effectiveness of implemented DCRs, all of them originating from Vancouver, Canada. Although estimates vary between studies, largely attributable to varying assumptions and methods, the DCR in Vancouver is predicted to avert 5–35 new HIV infections and three deaths by overdose annually, furnishing a societal benefit in excess of \$6 million annually (Andresen & Boyd, 2010; Pinkerton, 2011). Bayoumi and colleagues (2008) estimated that the DCR would represent a gain of 920 life-years over a decade of operation, and an avoidance of 1,191 new HIV infections. Over these ten years, this prevention would represent a cost savings of almost \$14 million (Bayoumi & Zaric, 2008). Similarly, Pinkerton (2010) estimated that an average of \$17.6 million in lifetime medical expenses are saved for each year that the DCR is operational, and another study found that the annual cost savings as a result of HIV infections prevented at the DCR are between \$2.85 and \$8.55 million (Andresen & Boyd, 2010). These associated savings in averted HIV- and overdose-related costs greatly exceed the DCR's operating costs (Bayoumi & Zaric, 2008; Pinkerton, 2010); the study by Andresen and Boyd (2010) for example estimated that the DCR provides an average benefit-cost ratio of 5:1 (i.e., providing benefits worth five times more than it costs to run).

Apart from Vancouver, two studies of the *potential* benefits of DCRs in other Canadian cities have also been conducted. These studies, both using mathematical modelling analyses, found that opening a DCR in Montreal (Jozaghi, Reid, & Andresen, 2013) and in Ottawa (Jozaghi *et al.*, 2014) would be viable in terms of the cost-benefit and cost-effectiveness. Similarly, recent assessments for a hypothetical DCR in Baltimore (Irwin *et al.*, 2017b) and in San Francisco (Irwin *et al.*, 2017a), USA, suggested significant savings for each dollar spent.

In short, DCRs—at least those who have been subjected to cost-effective analyses—have been estimated to be cost-saving; that is, they save more money for society than they require to set up and run, due to the reductions in deaths and HIV infections that they produce.

## 10. Smoking/inhalation facilities

Many DCRs are restricted to the target group of injecting drug users. This focus on IDU is related to the context in which DCRs initially arose. As discussed earlier, the rationale for the establishment of DCRs was to address problems posed by public *injecting* drug use. Other DCRs, however, now extend services to drug users who do not inject. In recent years, European DCRs that originally targeted only injectors have broadened their services to include supervised inhalation, such as in the Netherlands, where most facilities offer separate rooms for injecting and smoking (EMCDDA, 2017c). Such a change in service provision is taking place in areas reporting a decrease in the prevalence of heroin injecting and/or an increase in the use of inhalable drugs (especially crack cocaine smoking). In addition to responding to

changing local drug use patterns, such services were implemented to reduce health risks among non-injecting drug users. Although smoking is generally perceived as less risky than injecting, there are still significant health risks related to non-injecting drug use (EMCDDA, 2014), including the risk of blood-borne disease transmission through the sharing of smoking paraphernalia (DeBeck *et al.*, 2009; Macias *et al.*, 2008; Tortu *et al.*, 2004), as well as problems associated with (risky and rushed) public drug use (Voon *et al.*, 2016).

Drug users who inject and smoke are typically accommodated in separate spaces within the same DCR, partly for practical and health reasons (such as second-hand smoking), and partly to avoid potential problems stemming from the behavioural differences of different drug cultures (Fischer & Allard, 2007). A recent study (Watson *et al.*, 2013) indicates that such a physical separation of smoking from injecting is indeed the most feasible option since it separates drug users experiencing different highs, and reduces visibility of different modes of drug administration (i.e., DCR clients smoking crack cocaine would not have to see others injecting drugs).

To date, little evaluation studies have been noted exclusively focussing on such practices. The lack of rigorous evaluations is partly due to the fact that the vast majority of such studies stem from Vancouver and Sydney; DCRs exclusively focusing on injecting drug use—which is clearly reflected in the terminology used in Canada (supervised injection site) and Australia (medically supervised injecting centre). Nonetheless, several studies point out the (potential) benefits of such services or facilities. For example, a study conducted by Shannon *et al.* (2006) concluded that a supervised facility for crack cocaine users had a strong potential to reduce health-related harms, as well as address concerns of public order and open drug use. More recent findings also suggest that implementing facilities for smoking at DCRs offer the potential to reduce street disorder and encounters with law enforcement (DeBeck *et al.*, 2011), facilitate access to safer usage kits (for crack cocaine smokers), and to include contact with recent or younger users with the possibility of facilitating early treatment and reducing the risk of HCV infection (Hedrich *et al.*, 2010; Watson *et al.*, 2013). Recent qualitative research also indicates that these facilities have potential to promote safer smoking practices and reduce health-related harms (McNeil *et al.*, 2015; Toth *et al.*, 2016).

An additional advantage of including separate rooms for smoking is that these could promote less risky forms of consumption among PWID. As Bridge (2010) notes, the provision of a non-injecting option alongside services for PWID may facilitate transitions away from IDU. A programme promoting such transitions towards non-injecting drug use among PWID has been established within the context of DCRs in Germany (Stöver & Schaffer, 2014), and may motivate PWID to change their method of drug administration (from intravenous to inhalative use) by provision of information, prevention materials (posters and flyers) and distribution of new drug use equipment and paraphernalia (Leonard *et al.*, 2008; Stöver & Schaffer, 2014).



## **11. Summary**

Over the last decades, the impact of DCRs have been researched extensively. In summary, evaluation studies of DCRs worldwide have shown that these facilities reach and are accepted by vulnerable target populations who are often not reached by other mainstream services. In turn, use of DCRs has been associated with reductions in high-risk drug using behaviour (e.g., syringe sharing and unsafe injection practices) and reduced overdose morbidity and mortality. Furthermore, DCR implementation has also been linked with increased referral to and uptake of detoxification and other substance use treatment services; as such, these facilities constitute a central referral mechanism to a range of other community and medical resources. Beyond promoting the health of PWID, DCRs have also proven beneficial for the larger communities surrounding them. Municipalities that have implemented DCRs have observed reduced public drug use and related public nuisance (such as publicly discarded syringes) after the facilities became operational, as well as decreased drug overdose mortality rates in neighbourhoods in which the facilities are located. Studies also suggest that DCRs are cost-effective, potentially saving millions of dollars by preventing new HIV and HCV cases and overdose deaths. As such, DCRs represent a valuable piece in the puzzle of necessary and effective interventions geared to reduce harms related to high-risk drug use.

### **3.5 Controversy and opposition**

Despite this compelling body of evidence documenting the effectiveness of DCRs in addressing drug-related harms, DCRs remain controversial measures in the drug policy framework and their use is not universally accepted. Preliminary debate about the establishment of a DCR often revolves around the negative consequences such facilities may entail. Opponents of DCRs—similar to those of NSPs in the 1980s (Glantz & Mariner, 1996)—argue that DCRs condone drug use, promote the initiation of injection drug use, delay entry into drug treatment, and aggravate problems of local drug markets by facilitating the congregation of drug users and drug dealers in the surrounding area (Hathaway & Tousaw, 2008; Hedrich, 2004; Kolla *et al.*, 2017). Due to these concerns, their establishment has been contentious and much debated globally. Moreover, public opinion is generally against the introduction of such harm reduction facilities, with high resistance against DCRs at the time of (proposed) foundation. Linked with the controversy, DCR's are among the most frequently studied interventions for drug users. As a result, many studies demonstrate that once a DCR is up and running, the societal response towards these facilities tends to become more positive, and the initial resistance amongst local residents, business owners and other community stakeholders decreases after its opening (Firestone-Cruz *et al.*, 2007; Salmon *et al.*, 2007; Strike *et al.*, 2014; Thein *et al.*, 2005; Woods, 2014). The reason for increased public acceptance over the course of time is likely due to the fact that the initial fears

about the potential negative impact of a DCR fail to materialize. Indeed, two systematic reviews have shown that negative impacts of this kind are unfounded (Kennedy *et al.*, 2017; Potier *et al.*, 2014). More specifically, no evidence for an increase of drug trafficking and drug-related crime in the direct vicinity of DCRs (the so-called *honeypot effect*) was found in both Canada (Milloy *et al.*, 2009; Wood *et al.*, 2006a) and Australia (Donnelly & Mahoney, 2013; Freeman *et al.*, 2005). Similarly, no increase in acquisitive crime has been observed after the opening of DCRs in both the Netherlands and Switzerland (Hedrich *et al.*, 2010). In contrast to the above-mentioned studies reporting no direct impact of DCRs on crime (i.e., no increase), a recent study in Vancouver (adopting more advanced statistical methods) demonstrated a significant and lasting *decrease* in crimes in the district where the facility is located (Myer & Belisle, 2018). Furthermore, DCRs do not appear to lead to any significant disruptions in public order or safety in the neighbourhoods where they are located (Wood *et al.*, 2004c). In fact, as described above, findings of several studies suggest that (narrowly defined) disorder associated with public injecting has declined (Wood *et al.*, 2006b). Other evaluation studies have shown DCRs to have no adverse effects on drug use patterns in the broader community; following the facility's opening, no increased rates of initiation into IDU were seen, nor was there an increase in rates of relapse (Kerr *et al.*, 2006, 2007b). Relatedly, studies also indicate that concerns that DCRs delay entry into addiction treatment and detoxification services are not substantiated (Wood *et al.*, 2006d, 2007). In contrast to its well-documented benefits, such arguments opposing DCRs are not supported by scientific evidence.

### **3.6 Preliminary conclusion**

A substantial body of international research evidence has accumulated over the past three decades to support the effectiveness of DCRs in reducing the health and social harms associated with illicit drug use, and public injecting in particular. At the same time, an abundance of studies demonstrated that the feared negative consequences of opening a DCR (mirroring objections to NSPs and other harm reduction services in the past) are not borne out in experience; DCRs do not increase drug use in its vicinity, nor do they encourage young people to initiate drug use. Collectively, the scientific evidence derived from DCRs internationally support these facilities as part of a comprehensive local response to respond to drug-related harms that acknowledges public and individual health objectives.

#### **Realistic expectations are key**

Hedrich (2004) argues that, while evidence suggests that DCRs are effective in reaching their goals, it is important to set this in the wider context of problem drug use and of responses to it, and to be modest in claiming what DCRs can or cannot achieve—DCRs cannot solve problems they are not designed to address. More specifically, it would be unrealistic to expect that DCRs can prevent public

drug use, persuade all clients to reduce risky drug use or enter treatment, or solve wider problems of drug markets and drug dealing. Therefore, DCRs should rather be perceived as one component within a holistic response to the health needs of vulnerable people who use drugs in public places and other high-risk situations. Indeed, the measurable successes of DCRs do not eliminate the need for additional complementary services such as adequate treatment, mental health services, and community policing. Overall, expectations towards DCRs need to be realistic, as they cannot address all the key variables of drug-related harms; DCRs are not a panacea for *all* the harms associated with public drug use, but they comprise an important evidence-based component of a comprehensive drug strategy.

**Box 4. Evidence of effectiveness**

DCRs—although heterogeneous in design and operation—have demonstrated that they can produce beneficial effects, both for PWUD and for the community, particularly when they are part of a wider continuum of local interventions. Moreover, DCR use has been associated with reductions in overdose-related harms, syringe sharing and injection-related injuries, without increasing either the number of local PWUD or rates of relapse. DCRs also serve as important entry points to external drug treatment and other health and social services for PWUD. At the community level, the establishment of DCRs has contributed to improvements in public order through reductions in public drug use and publicly-discarded injection-related litter, and has not been associated with increases in drug-related crime. Collectively, the available evidence suggests that DCRs are effectively meeting their primary public health and order objectives and therefore supports their role within a continuum of services for PWUD.

**3.7 One size does not fit all: the necessity of local applicability**

As described above, studies show that DCRs can save lives and improve drug users’ health, while having no direct negative effects on the neighbourhood. These outcomes, however, are highly dependent on the local applicability of the facilities; their viability and effectiveness depends on local contexts and circumstances. Indeed, DCRs—and harm reduction strategies more generally—are in no way universal solutions that can be implemented in any given local context. In order to maximize their effectiveness, studies emphasize the importance of adequately tailoring these interventions to the specific setting and needs of the community, rather than implementing them as ‘one size fits all’ solutions (EMCDDA, 2015a; Marlatt & Witkiewitz, 2010; Parker *et al.*, 2012)—a tailored approach that equally applies to the more general community-level drug policy (EMCDDA, 2015a). As such, DCRs represent a local response based on local needs, closely linked to policy choices made by local stakeholders (EMCDDA, 2017c). DCRs’ design should thus be tailored to local setting in order to meet local needs and demand.

## **Design considerations and related barriers for access**

DCR utilisation—and hence its effectiveness—is influenced by the extent in which the facility is locally embedded. In other words, DCRs can only realise their full potential if those in need have access to the service. Access restrictions may limit the number of people who can benefit from a DCR's services in two general ways.

### **Location, accessibility, coverage and capacity**

First, the extent to which a DCR's goals is achieved largely depends on 'physical' aspects such as their accessibility, opening hours, and capacity required to satisfy the demand of its target group (Semaan *et al.*, 2011). *Location-wise*, DCRs may be situated in a centralized location, or rather decentralised (away from the city centre). Whereas having a DCR proximate to other services would increase the likelihood of PWUD using those services, this centralization option may also lead to a concentration of services in one specific area and thereby neglecting other neighbourhoods. Having a DCR centrally located (mostly in central neighbourhoods where PWUD congregate) would not only respond to the need for these services for PWUD in the area, but may also function as a public health response to a high volume of publicly discarded needles and syringes in certain neighbourhoods. On the other hand, whereas the decentralisation option has the advantage of geographically spreading services and destigmatizing specific areas, it may be less accessible for clients when located too far from central neighbourhoods or other services (Bardwell *et al.*, 2017). Rather than having a fixed DCR located in one neighbourhood, mobile units may make the services accessible to PWUD throughout the city (see Dietze *et al.*, 2012; McCann & Temenos, 2015)

Relatedly, (fixed) DCRs must be easily *accessible* to PWUD, irrespective of (de)centralization. For instance, evidence indicates that PWID are not generally willing to travel great distances to use a DCR (the intensity of drug withdrawal symptoms may influence whether they had time to travel to a facility; Bayoumi & Strike, 2012), and public transportation is often described as a barrier for many PWID (Petrar *et al.*, 2007). In this latter study, in addition to travel distance, the two most common reasons for PWID limiting use of the facility were limited hours of operation and waiting times.

In terms of *capacity and coverage*, it is important for DCRs to be adequately resourced to cover the local needs of PWID. Adequate capacity and coverage are important because pilot and under-resourced projects often cannot sufficiently control local epidemics, meet local needs, or provide the resources needed for DCR to meet their goals. For example, nuisance and neighbourhood conflicts (following a concentration of DCR clients in front of the facility) may be more likely when capacity or location of the facility does not meet local needs and waiting times are long. Waiting times can be problematic for clients who are experiencing symptoms of withdrawal. At the busiest times, clients in

the Vancouver DCR may have to wait 15–30 minutes for a booth to become available, and almost 10% of clients leave while waiting (Small *et al.*, 2011b). Only one in five clients would prefer to wait at the DCR than to inject outside sooner (Small *et al.*, 2011a). Thus, sufficient capacity is required to satisfy the demand of the target population. In order to guarantee sufficient flux, and consequently reduce waiting times, the majority of DCRs limit the amount of time clients can use drug consumption booths in one sitting (typically 30–45 minutes).

In addition, accessibility in terms of *hours of operation* is equally important, suggesting that these services be readily available when needed. Few DCRs are open 24 hours a day, which leaves clients with some hours during the day during which they must find another place to inject, or inject publically (Petrar *et al.*, 2007; Small *et al.*, 2011a). Extended opening hours in the evening can attract specific target populations into the DCRs, such as sex workers.

### **Admission criteria**

Second, it is important for DCRs to be low-threshold and low-barrier, but it is common for the facilities to establish eligibility criteria for use of services. Several *admission criteria* may limit access for several (minority) groups. For example, clients enrolled in OST are formally excluded from DCRs in Germany and Luxembourg (Schatz & Nougier, 2012). Elsewhere, considering the high prevalence of continued drug use among OST clients (Judson *et al.*, 2010; Senbanjo *et al.*, 2009), a pragmatic view is adopted that if clients enrolled in OST are going to use anyway, it is better if they do so in hygienic circumstances where there is also the opportunity for staff to engage with them.

Similarly, primarily to avoid attracting more drug users to the vicinity of the DCR, many Swiss and Dutch DCRs do not admit PWUD who are not resident in the local area (Schatz & Nougier, 2012). The downside of placing such a criterion is that it excludes non-local residents who may benefit from such a service, and vulnerable groups such as illegal immigrants and refugees. Other specific populations likely to be excluded include pregnant women, minors (or young people), novice injectors (i.e. individuals who intend to inject for the first time or who have only recently initiated injecting), and intoxicated clients.

As reported by Schäffer and colleagues (2014), the negative effects of admission criteria are illustrated by research in one German DCR. On 544 occasions, potential clients of the DCR were denied access for the following reasons: 150 times because clients were drunk or intoxicated; 109 times because people were in OST; four times because people were first-time or occasional users; two times because PWUD were under 18 years of age; and 250 times because they do not reside in the vicinity of the DCR. Analysis of 98 drug-related emergencies that happened in the vicinity of that DCR found a direct relationship between the reasons for excluding these potential clients and their exposure to risk

when they decided to use drugs but without the safety net provided by the DCR. Thus, as barriers to access are created by well-intentioned (and sometimes legal) regulations, such admission criteria may restrict access to a vulnerable group of PWUD who would significantly benefit from DCR usage. After all, restricting access for specific groups in need undermines the low-threshold underpinning of DCRs.

Lastly, as discussed above, restrictions on type of substance (e.g., heroin only) and route of administration (e.g., injecting only) may exclude vulnerable groups of drug users, for example crack cocaine smokers, whom could significantly benefit from DCR usage (Voon *et al.*, 2016).

**Local needs and barriers for access**

In short, several operational considerations (e.g., location, capacity, coverage, and admission criteria) may limit DCR accessibility and usage. If DCRs are to have an impact at community level, it is necessary to provide sufficient capacity relative to the estimated size of the target population, to locate rooms on sites that are easily accessible, and to ensure that opening hours are long enough to meet demand (Hedrich *et al.*, 2010). All in all, since DCRs are a local solution to a local problem, such services should respond to the needs of their target group.

**Box 5. The need to tailor a DCR to its local setting**

A DCR represents a local response based on local needs, closely linked to policy choices made by local stakeholders. Indeed, DCRs are no ‘one size fits all’ interventions that can be implemented in any given local context—DCR utilisation and its effectiveness relies on local applicability and the extent in which the DCR is locally embedded. Based on the available services, needs of the community, and drug use patterns, there are several essential operational issues to consider when implementing a DCR, such as its location, capacity, coverage, opening hours, and eligibility criteria (i.e., target group). Inadequately tuning such elements to the local setting may limit the number of people who can benefit from a DCR, and consequently undermine the success of the facility. A DCR should furthermore be embedded into the wider local policy framework as part of a network of services aiming to reduce individual and social harms arising from problem drug use. Taken together, DCRs can only realise their full potential if the service is part of a continuum of local services for PWUD, and all those in need have access to the DCR.

## 4. BELGIAN CONTEXT AND AIMS OF THE STUDY

In Belgium, no DCRs are currently provided to its drug using population, and very limited scientific information is available concerning this topic on national level. To date, only two studies focused on DCRs in Belgium. First, in 2004, a study regarding the desirability and the feasibility of a DCR in the city of Antwerp was carried out by Barendregt and Rodenburg (2004). A conclusion of this study was that participants (both drug users and professionals) felt the need for a DCR in Antwerp, especially for a specific group of drug users who were seriously marginalized. In contrast, inhabitants of Antwerp were opposed to a DCR. Next, even before such a DCR could be implemented, an adjustment of the federal legislation would be necessary, since providing a room for drug use is punishable to date (see CHAPTER 2). More recently, in 2014, a needs assessment was conducted in the city of Ghent focussing on harm reduction in general (Favril, Vander Laenen, & Decorte, 2015). By means of qualitative and quantitative methods, one of the local priorities identified in this study was the implementation of a DCR in Ghent. Despite the fact that both professionals and drug users perceived the implementation of such a facility as an important need within the local context, this was strongly associated with expected obstacles for implementation, especially political in nature, but also legal, financial and professional barriers are expected by professional actors. Both studies, however, only relate to a specific city, and should thus not be extrapolated to other Belgian cities.

In Liège, already before the pilot project of HAT called TADAM (Demaret *et al.*, 2011) which was operational from 2011–2013, the local authorities had been developing a Drug Strategic Plan since 2003, which emphasised the need for a DCR in Liège. In 2013, the mayor of the city of Liège introduced a proposal for amending the Drug Law of 1921. This proposal was filed jointly with the project for the delivery of diacetylmorphine-assisted treatment in the city, the so-called TADAM project. Following these steps, the local monitoring centre on drugs—the *Observatoire Liégeois des Drogues*—developed an inter-sectoral consultation on the topic of DCRs, with a view to establish the feasibility conditions for a DCR. Drug addiction health professionals, health coordinators, scientists, law and enforcement representatives, and local authorities were consulted. Issues addressed included the target audience, location, staff, tools and equipment, collaboration with other services, products allowed, injection practices, opening hours, and additional services offered. A report of the results of this consultation was drafted and disseminated.<sup>5</sup> However, the report has not been followed up so far.

Following a position statement by the *Vereniging voor Alcohol- en andere Drugproblemen* (VAD; Aertsen *et al.*, 2014), in which DCRs were advocated as a useful supplement to the existing range

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<sup>5</sup> Pôle stratégique Détresse Sévères – Plan de Prévention. (2014). Réflexion relative à la mise en place d'une salle de consommation à moindre risque à Liège [intern document].

of services for users of illicit drugs, the General Drugs Policy Cell<sup>6</sup> published a working paper in the end of 2016 (ACD, 2016) devoted to the topic of DCRs in Belgium. In the latter publication, the ACD/CGPD sought to investigate the feasibility and preconditions for the implementation of DCRs in Belgium, with specific attention to needs, and organisational, budgetary and legal aspects. One of the seven final conclusions was that “if one wishes to implement a DCR, a prior feasibility study is essential. In addition to the above-mentioned elements, the budget and legal aspects, including the issues regarding liability of the health care providers and the authorities in case of overdose, must be thoroughly examined” (p. 35). This research theme was included as a priority in the project call of the Belgian Science Policy Office (BELSPO) drug programme in 2016 and resulted in the current study.

Within this context, the current study intends to fill this knowledge gap on a national level, and aims to provide answers to the policy question of the (policy-level and legal) feasibility regarding one or more DCRs in Belgium. More specifically, we sought to conduct a feasibility study of DCRs in five major Belgian cities: Ghent, Antwerp, Brussels, Charleroi and Liège. This study should provide hands-on information on: (1) What are the legal implications of these facilities, explicitly analysing the (medical) accountability of the state and the care givers; and (2) What are the basic (pre)conditions and possible scenarios for the implementation of DCRs in the five selected Belgian cities. In addition to a thorough review of the scientific literature (CHAPTER 1), this study encompasses three phases. First, an in-depth analysis of the legal framework for DCRs is conducted, examining the compatibility of DCRs with the existing international and national legal framework (CHAPTER 2). Second, international data is examined to identify important organisational and operational considerations when establishing a DCR as well as possible models that a DCR could consider (CHAPTER 3). Third, a feasibility study is conducted by means of interviews (with key stakeholders) and focus groups (with PWUD) in the five Belgian cities (CHAPTER 4). Last, integrating all prior phases, recommendations for the Belgian context are formulated with regards to DCRs (CHAPTER 5).

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<sup>6</sup> Algemene Cel Drugsbeleid (ACD) or Cellule Générale de Politique Drogues (CGPD).



# CHAPTER II

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## LEGAL FRAMEWORK FOR IMPLEMENTATION

*Laurens van Puyenbroeck*

*Freya Vander Laenen*

*Louis Favril*

*Brice De Ruyver*



## CHAPTER 2

# LEGAL FRAMEWORK FOR IMPLEMENTATION

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### 1. AIMS AND OUTLINE

The legality of DCRs has been a matter of debate since their inception in the 1980s. The establishment of DCRs inevitably raises legal questions and concerns of a various nature. It is therefore key to carefully consider the compatibility of DCRs with the existing international and national legal framework, as well as to define the conditions and criteria to be taken into account in order to provide a sufficient level of legal protection for those actors involved. In what follows, a number of key issues will be analysed.

In the first part, the position of DCRs in respect of the international drug control treaties will be explored. This includes, in particular, an analysis of the legality of state-controlled public DCRs under the three relevant international drug control treaties and the relation with the International Narcotics Control Board (INCB). Further, the legal implementation of DCRs in other countries will be explored. The second part relates to the national perspective. Starting with an overview of the applicable (legal) provisions and some relevant initiatives, this part aims to identify the potential legal obstacles and will then consider the legal options and possible supporting measures for the establishment of DCRs in Belgium. Furthermore, the important issue of (medical) liability of the relevant actors (the DCR and its staff, the state, and the DCR users) will be analysed, for example in the case of an overdose. Both the criminal and civil accountability will be taken into account. Lastly, the third part presents conclusions and recommendations, thereby answering the fundamental question regarding the (legal) feasibility of establishing (a) DCR(s) in Belgium.

### 2. THE INTERNATIONAL PERSPECTIVE

#### 2.1 Brief overview

##### 2.1.1 United Nations

The UN Drug Conventions regime constitutes the core international legal framework concerning drug-related issues. This regime consists of The Single Convention on Narcotic Drugs, as amended by the 1972 Protocol (hereinafter “the 1961 Convention”), The 1971 Convention on Psychotropic Substances (hereinafter “the 1971 Convention”) and The 1988 United Nations Conventions against Illegal Traffic in Narcotic Drugs and Psychotropic Substances (hereinafter “the 1988 Convention”).

The Conventions have been established because of the need for states to develop an effective framework for international cooperation to control drugs. The Conventions are not self-executing. Because there is no sovereign international authority, international law relies on states themselves to apply this law. The so-called “executory” character of the Conventions imposes obligations on states, but they are not directly or immediately enforceable. It is important, however, to note that States have to remain true to the UN Conventions, as foreseen in Article 31 of the Vienna Convention on the Law of Treaties of 1969.<sup>7</sup> States have to respect the “object and purpose” of the Conventions, in essence, the development of universal standard norms to regulate the production, manufacture, transport, import, export, distribution, use and consumption of narcotic drugs and psychotropic substances. The 1961 Convention (accompanied by the 1971 Convention) and the 1988 Convention are key in order to assess the compatibility of DCRs with the international drug control system.

The *1961 Convention* was set up as a universal system to control the cultivation, production, manufacture, export, import, distribution of, trade in, *use and possession* of narcotic substances (opium poppy, coca leaf and cannabis).<sup>8</sup> Consequently, the Convention exercises control over more than one hundred narcotic drugs. From the beginning, the basic aim of the international drug control treaties has been *to limit the use of drugs to medical and scientific purposes only*. In order to streamline the control machinery, a multilateral authority within the United Nations was established, namely the International Narcotics Control Board (INCB). The INCB is responsible for the implementation of the Convention provisions. The INCB does not have the power to enforce the implementation of the Convention provisions, nor has it the power to punish Parties for non-compliance. This power remains under the domestic jurisdiction of each individual Party.<sup>9</sup>

The *1971 Convention* was established as the companion instrument of the 1961 Convention. It deals with psychotropic substances next to narcotics. Again, it establishes an international control machinery, entrusted to the INCB. The penal provisions, which are stipulated in Article 22, are similar to those of the 1961 Convention. Again, implementation of the Convention provisions remains under the jurisdiction of each state.<sup>10</sup>

The *1988 Convention* was designed specially to deal with the growing problem of international trafficking in illicit substances. Concerning penal provisions, the main focus of the Convention is the obligation on the states to establish as criminal offences: cultivation, production, manufacture, import, export, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage,

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<sup>7</sup> The Vienna Convention on the Law of Treaties, 23 May 1969.

<sup>8</sup> Article 2 of the 1961 Convention.

<sup>9</sup> Article 36 of the 1961 Convention.

<sup>10</sup> Article 22 of the 1971 Convention.

dispatch, transport, importation and exportation, *possession* or purchase of any narcotic drug or psychotropic substance contrary to the 1961 and 1971 provisions.<sup>11</sup>

The following international instruments are of further importance for the legal position of DCRs.

The UN's *1987 Comprehensive Multidisciplinary Outline* set out a number of drug demand strategies that were not translated into legal obligations in the 1988 convention.<sup>12</sup> The Outline targets support for prevention programmes, treatment programmes, the reduction of diseases and infections transmitted through drug-abusing habits and social reintegration

During the 20<sup>th</sup> Special Session in 1998, the UN General Assembly (UNGASS) adopted an important Resolution. Parties recognised the importance of a multidisciplinary approach towards the drug problem and demand reduction as an “indispensable pillar” to counter the world drug problem and committed themselves to having new or enhanced demand reduction strategies and programmes, in close cooperation with public health, social welfare and law enforcement authorities.<sup>13</sup> The General Assembly also adopted a Declaration on the Guiding Principles of Drug Demand Reduction.<sup>14</sup> This declaration called for a balanced approach between demand reduction and supply reduction. The latter Resolution eventually resulted in the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction. The approach to demand reduction includes both preventing the use of drugs and reducing the adverse consequences of drug abuse.<sup>15</sup>

Summarising, the discussed United Nations Conventions take a more prohibitionist approach to the drug problem, imposing at the same time some limitations to reform current drug policies. However, the UN's ‘soft law’ stresses the need for new demand reduction strategies and programmes (De Ruyver *et al.*, 2002).

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<sup>11</sup> Article 3 of the 1988 Convention.

<sup>12</sup> INCB, *Declaration of the International Conference on Drug Abuse and Illicit Trafficking and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control, United Nations*.

<sup>13</sup> United Nations, General Assembly, Political Declaration annexed to UNITED NATIONS, General Assembly Resolution A/RES/53/115, 1 February 1999 – International cooperation against the world drug problem.

<sup>14</sup> United Nations, General Assembly, Declaration on the Guiding Principles of Drug Demand Reduction, annexed to UNITED NATIONS, General Assembly Resolution A/RES/53/115.

<sup>15</sup> United Nations, General Assembly, Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction; annexed to UNITED NATIONS, General Assembly Resolution, A/RES/54/132, 2 February 2000 – on International cooperation against the world drug problem; UNITED NATIONS, Economic and Social Council E/CN.7/2001/3, 23 December 1999, Follow-up to the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drugs Demand Reduction, Report of the Executive Director.

### **2.1.2 European Union**

Since the mid-1980s, the European Community and the European Union have adopted important common measures for combating drug addiction and drug trafficking and for promoting international cooperation and to support the effort of the United Nations. The crucial mission statement within the European drug strategy is the development of a global, multidisciplinary and integrated approach. A key element within this approach is the reduction of drug-related health harms (De Ruyver *et al.*, 2002).

In the recent EU Action Plan on Drugs 2017-2020 (thus covering the remaining years of the existing EU Drugs Strategy in force until 2020), there is a stronger focus on risk and harm reduction measures, aimed at minimising the adverse health and social consequences of drug abuse. In the context of demand reduction, one of the proposed actions is to exchange best practices on risk and harm reduction measures, e.g., needle and syringe exchange programmes, *drug consumption rooms*, naloxone programmes, peer based interventions, outreach treatment programmes, hepatitis C treatment, pill testing, self-testing for HIV/AIDS, etc.<sup>16</sup>

## **2.2 Compatibility with the UN Drug Conventions**

### **2.2.1 Applicable provisions**

The implementation of DCRs leads to a number of questions regarding the compatibility with the UN Drug Conventions regime. In principle, DCRs tolerate drug use and thus could infringe upon the provisions of the international treaties concerning the use and possession of drugs. Moreover, the question can be raised whether such facilities could be considered as an inducement to use drugs. The primary consideration at hand concerns the question whether this form of risk reduction can be reconciled with the basic principle of medical purposes on the basis of the psychosocial preconditions and the medical support. Answering these questions requires a detailed analysis of the relevant provisions of the UN Drug Conventions, in particular regarding the use and possession of drugs. The relevant provisions are discussed below.

#### **The 1961 Convention**

##### ***Article 4: general obligations***

“The parties shall take such legislative and administrative measures as may be necessary: (c) subject to the provisions of this Convention, to limit exclusively to medical and scientific

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<sup>16</sup> EU Action Plan on Drugs 2017-2020, Official Journal, C215/21, Brussels, 5.07.2017.

purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.”

Commentary:<sup>17</sup> The objective of the international narcotics system is to limit exclusively to medical and scientific purposes the trade in and use of controlled drugs. From the beginning this has been a basic principle of the multilateral narcotics system, although all the treaties providing for it authorise some exceptions.

The term “medical purposes” has not been uniformly interpreted by Governments when applying the provisions of narcotics treaties containing it. Some have prohibited the consumption of narcotic drugs by all addicts excepting only when necessary to alleviate suffering during withdrawal treatment; a number of other countries have permitted consumption by persons whose addiction proves to be incurable of the minimum quantities required to prevent painful withdrawal symptoms and to enable them to lead a normal life.

The term “medical purposes” does not necessarily have exactly the same meaning at all times and under all circumstances. Its interpretation depends on the stage of medical science at the particular time in question.

### ***Article 33: possession of drugs***

“The Parties shall not permit the possession of drugs except under legal authority.”

Commentary:<sup>18</sup> Some Governments consider that they are not required to punish the unauthorised possession of drugs by addicts for their personal use, because the word “possession” as used in article 36, paragraph 1 (see further), covers only possession for distribution, and is not meant to include possession for personal use.

Whatever the position the Parties may take on this question of penal sanctions, it does not affect their obligation under article 33 not to permit the unauthorised possession of drugs for personal consumption, like any other possession of drugs without legal authority. If they choose not to impose penalties on the unauthorised possession for personal use, they still must use their best endeavours to prevent this possession by all those administrative controls of production, manufacture, trade and

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<sup>17</sup> United Nations, Commentary on the Single Convention on Narcotic Drugs 1961, United Nations Publication, New York, 1973, p. 110-111.

<sup>18</sup> United Nations, Commentary on the Single Convention on Narcotic Drugs 1961, United Nations Publication, New York, 1973, p. 402-403.

distribution which are required by the Single Convention, and whose basic objective is the prevention of the abuse of drugs and therefore also to prevent the *unauthorised* possession by addicts.

It is also submitted that Parties, which do not consider such possession to be an offence under article 36, and therefore are not required to apply article 37 regarding the seizure and confiscation of drugs, are nevertheless bound to confiscate the drugs found in the unauthorised possession of persons for personal consumption. This obligation appears to be implied in the provision of article 33 (in relation with article 4).

### **Article 36: penal provisions**

“1. (a) Subject to its constitutional limitations, each Party shall adopt such measures as will ensure that cultivation, production, manufacture, extraction preparation, *possession*, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention, and any other action which in the opinion of such Party may be contrary to the provisions of this Convention, shall be punishable offences when committed intentionally, and that serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.

(b) Notwithstanding the preceding subparagraph, when abusers of drugs have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration in conformity with paragraph 1 of article 38.

2. Nothing contained in this article shall affect the principle that the offences to which it refers shall be defined, prosecuted and punished in conformity with the domestic law of a Party.”

Commentary:<sup>19</sup> The “use” of drugs is not specifically listed in article 36, paragraph 1, among the actions which, subject to its constitutional limitations, a Party must treat as punishable offences. It appears that it is left to the discretion of each Party to decide whether it wishes to penalise the non-medical consumption of narcotic drugs by addicts, or whether it prefers to prevent such abuse solely by administrative and penal measures by which the production, manufacture and distribution of drugs must be controlled under the terms of the Single Convention.

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<sup>19</sup> United Nations, Commentary on the Single Convention on Narcotic Drugs 1961, United Nations Publication, New York, 1973, p. 111-112.



In addition to article 4, paragraph (c), the provisions of article 33 and of article 36, paragraph 1, deal with the possession of drugs. Under these provisions, Parties must take the required legislative and administrative measures to limit exclusively to medical and scientific purposes the possession of drugs,<sup>20</sup> must not permit the possession of drugs except under legal authority,<sup>21</sup> and subject to their constitutional limitations must make possession of drugs contrary to the provisions of the Single Convention a punishable offence.<sup>22</sup>

The question arises how far and in what way these provisions govern the possession of controlled drugs; do they apply without regard to whether the drugs are held for illegal distribution or only for personal consumption, or do they apply solely to the possession of drugs intended for distribution? Article 4, paragraph (c), undoubtedly refers to both kinds of possession; but whether that provision must be implemented by imposing penal sanctions on possession for personal consumption is a question which may be answered differently in different countries; according to the Official Commentary, there is sufficient support for the opinion of those who believe that only possession for distribution, and not that for personal consumption, is a punishable offence under article 36 of the Single Convention. Article 36 is still in that part of the Single Convention which deals with the illicit traffic.

***Article 37: seizure and confiscation***

“Any drugs, substances and equipment used in or intended for the commission of any of the offences, referred to in article 36, shall be liable to seizure and confiscation.”

***Article 38: measures against the abuse of drugs***

“The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their effort to these ends.”

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<sup>20</sup> Article 4, paragraph (c).

<sup>21</sup> Article 33.

<sup>22</sup> Article 36, para.1.

## The 1988 Convention

### **Article 3: offences and sanctions**

“1. Each Party shall adopt such measures as may be necessary to establish as criminal offences under its domestic law, when committed intentionally:

(a)(i) The production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation of any narcotic drug or any psychotropic substance contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.

(a)(iii) The possession or purchase of any narcotic drug or psychotropic substance for the purpose of any of the activities enumerated in (i) above.

(c)(iii) Publically inciting or inducing others, by any means, to commit any of the offences established in accordance with this article or to use narcotic drugs or psychotropic substances illicitly.

2. Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, *the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption* contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.

4. (d) The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, after-care, rehabilitation or social reintegration of the offender.”

Commentary:<sup>23</sup> Under the 1961 Convention, a party must, “subject to its constitutional limitations”, criminalise the cultivation, possession and purchase of drugs. A number of States have taken the view that “possession” in that paragraph does not include possession for personal consumption.

Two other provisions of the 1961 Convention are relevant: article 4, paragraph 1, under which parties “*shall take such legislative and administrative measures as may be necessary: ... (c) subject to the provision of this Convention, to limit exclusively to medical and scientific purposes the ... use and possession of drugs*”; and article 33, under which parties “*shall not permit the possession of drugs except under legal authority*” (an article which does not, however, require a penal sanction).

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<sup>23</sup> United Nations, Commentary on the United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances 1988, United Nations Publication, New York, p. 78.

#### **Article 14, paragraph 4: measures to eradicate illicit demand**

“The Parties shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic. These measures may be based, inter alia, on the recommendations of the United Nations, specialised agencies of the United Nations such as the World Health Organization, and other competent international organisations, and on the Comprehensive Multidisciplinary outline adopted by the International Conference on Drug Abuse and Illicit Trafficking, held in 1987...”

#### **2.2.2 Latitude within the UN Conventions**

In order to assess the compatibility of DCRs with the UN Drug Conventions framework, an assessment should be made of the latitude that is given to the Parties to develop a differentiated national drug policy, with specific attention to acts related to personal consumption. This latitude will be investigated on the following levels: the level of criminalisation of possession and use, the level of reaction and prosecution, and the level of harm reduction approaches.

##### **a. Criminalisation of possession and use**

The concepts “use” and “possession” are dealt with together, because neither the 1961 Convention, nor the 1971 and 1988 Convention require criminalisation of the consumption of drugs, in view of the fact that it is impossible to consume drugs without prior cultivation, purchase or possession (Krajewski, 1999). There is no formal obligation to criminalise the *use* of drugs within the UN Conventions. Regarding the question whether the *possession for personal consumption* should be criminalised, there are differing views. Based however on the drafting history and context of article 36, a solid case can be made for the view of those according to whom possession for personal use was never intended to be covered by article 36 of the 1961 Convention and therefore, Parties are not obliged to criminalise the possession for personal use.<sup>24</sup> Nevertheless, it is clear, based upon the principle of limiting drugs to medical and scientific purposes, the UN-Conventions require a *discouragement* of drug possession for personal use (De Ruyver, Vermeulen, & Owel, 2000).

In the 1998 Convention, Article 3, paragraph 2 clearly states that “the possession [...] for personal consumption” should be made a criminal offence. It is the first time “personal consumption” is explicitly added, which was not the case in the 1961 and the 1971 Convention. Article 3, paragraph

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<sup>24</sup> United Nations, Commentary on the Single Convention on Narcotic Drugs 1961, United Nations Publication, New York, 1973 (see above).

2 of the 1988 Convention constitutes the obligation of criminalising the possession for personal consumption. However, Article 3 of the 1988 Convention clearly distinguishes between “production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery [...], brokerage, dispatch, dispatch in transit, transport, importation or exportation” in paragraph 1; and “the possession, purchase or cultivation [...] for personal consumption” in paragraph 2.

Paragraph 1 has an absolute mandatory character, since it clearly states: “each Party shall adopt [...] to establish as criminal offences ...”. However, the establishment of criminal offences under paragraph 2 is “subject to [the] constitutional principles and the basic concepts of [its] legal system of the Parties concerned”, which leaves them a range of possibilities to differentiate their reaction towards possession for personal use.

#### **b. Reaction and prosecution**

*In general*, Article 36 of the 1961 Convention makes a distinction between “punishable offences” and “serious offences”, when it comes to sanctions. Firstly, Article 36 states that possession, cultivation, production, ... shall be a “punishable offence”. However, what this “punishable offence” should be, is subject to the “constitutional limitations” of the Parties. Secondly, “serious offences” shall be liable to “adequate punishment” particularly by imprisonment or other penalties of deprivation of liberty. Even this requirement leaves considerable room for implementation by the Parties. Firstly, the Convention does not stipulate what a “serious” offence is. The Parties can decide which offences are “serious”. Secondly, it is not stipulated what is to be considered as “adequate punishment”.

*In particular*, in relation to the offences for personal consumption, it becomes clear from the official commentary to the 1961 Convention that offences *for personal consumption* do *not* have to be treated as serious offences, since “possession of a small quantity of drugs for personal consumption may be held not to be a “serious” offence under Article 36.<sup>25</sup> Article 3 of the 1988 Convention clearly distinguishes between sanctions for “possession, purchase or cultivation”, “for personal consumption” and other criminal offences. Article 3, paragraph 4 (a), (b) and (c) establish the reactions towards the former. Article 3 paragraph 4 (d) establishes the sanctions for the latter. According to paragraph 4 (d) of Article 3, conviction or punishment is possible by the Parties; but there is in no way an obligation for a penal reaction, since “punishment” is not defined, and furthermore alternatives to punishment are possible.

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<sup>25</sup> United Nations, Commentary on the Single Convention on Narcotic Drugs 1961, United Nations Publication, New York, 1973, p. 112.

In general, the UN conventions leave room for a differentiated policy when it comes to the reaction towards the possession, purchase, cultivation, etc. of drugs. First, the Conventions recognise, implicitly and explicitly,<sup>26</sup> that defining and imposing sanctions is a matter within the domestic law of the Parties. Secondly, in the case of offences related to personal consumption, there is no obligation to convict or punish these offences. None of the Conventions impose an obligation to provide for imprisonment for possession for personal consumption (De Ruyver *et al.*, 2002).

In general, Article 36, paragraph 4 of the 1961 Convention, Article 22, paragraph 4 of the 1971 Convention and Article 3, paragraph 11 of the 1988 Convention, all stress that the offences “shall be [...] prosecuted [...] in conformity with the domestic law of a Party”. These provisions leave considerable room for the Parties to develop a prosecution policy by making use of the expediency principle by the public prosecutor. According to this principle, the prosecutor can use its discretionary powers to filter the incoming cases in such a way that stoppage can be avoided, by deciding whether to prosecute or not.

The use of the expediency principle does not conflict with the international Conventions, as long as the implementation of the Conventions is loyal. The latter would not be the case if the expediency principle would be systematically applied to activities that are qualified by the UN Conventions as “serious offences”.<sup>27</sup> Furthermore, it must be stated that governments are not allowed to invoke the expediency principle whenever they would like to systematically deviate from the international provisions (De Ruyver *et al.*, 2000).

Article 3, paragraph 6 of the 1988 Convention goes into the discretionary powers on the prosecution level. This provision limits the application of expediency on the prosecution level, since it should be “exercised to maximise the effectiveness of law enforcement measures in respect of those offences and with due regard to the need to deter the commission of such offences”. The rationale behind this paragraph is not the limitation of the expediency principle as such, but the need to secure these “situations in which the promise of reduced penalties may persuade an accused person to provide information implicating others”, which could have a great value in securing effective law

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<sup>26</sup> This principle is reaffirmed by Article 36, paragraphs 3 and 4 of the 1961 Convention, Article 22, paragraphs 2 and 4 of the 1971 Convention and Article 3, paragraph 11 of the 1988 Convention.

<sup>27</sup> For example, Article 3, paragraph 1 (a)(ii), in combination with paragraph 4 (a) of the 1988 Convention states that the cultivation of cannabis is a “serious criminal offence”. This means that the UN Conventions explicitly call for the fight against the production of cannabis.

enforcement.<sup>28</sup> This paragraph applies to all offences of Article 3 (and thus to drug use related offences as well), since it refers to “this Article”, and not to a paragraph within Article 3. However, it has been argued that the Parties’ discretionary legal powers are wider with respect to the prosecution of personal use offenders under Article 3, paragraph 2 as opposed to illicit drug trafficking offences under Article 3, paragraph 1.<sup>29</sup>

### c. Harm reduction approaches

As is clear from the overview above, there are two main themes running through the UN conventions: on the one hand, there is a strong emphasis on controlling the production, distribution and possession of drugs; on the other, there is a clear and repeated emphasis on the rehabilitation and integration of drug users and, indeed, on the general health and welfare of all people. Given the second aim, there is latitude within the conventions for the introduction of harm reduction measures that aim to improve the health of users and contribute to their welfare, rehabilitation and reintegration.

In 2002, the Legal Affairs Section of the United Nations Drug Control Program (currently the United Nations Office of Drugs and Crime; UNODC) produced an opinion for the INCB on the flexibility of the conventions with regard to harm reduction approaches.<sup>30</sup> The paper importantly notes that the treaties, also in their preambles, express their concern for the health and welfare of mankind, and for the health and social problems resulting from abuse. In the view of the UN’s legal experts, this might easily be construed as clear intent on the part of the treaties to combat drug abuse out of concern for its health and welfare consequences. The paper further states that, being this recent, *harm reduction* was not foreseen by any of the international drug control treaties. Therefore, there is no treaty-based definition for it and there are no specific treaty provisions that may be applied to the concept as such, at least not in general terms. A useful, albeit non-binding definition has been outlined by (at the time) UNDCP (now UNODC) in its publication *Demand reduction – a glossary of terms*, as follows:<sup>31</sup>

“Harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used particularly for policies or programmes that aim to reduce the

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<sup>28</sup> United Nations, Commentary on the United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances 1988, United Nations Publication, New York, p. 94.

<sup>29</sup> The basis for this argument is that the degree to which discretion should be curtailed in a particular case would be to weigh up the interest of the state in the prosecution of the particular individual against the interest of the supply of intelligence he or she offers to provide; See: N. BOISTER, *Penal Aspects of the UN Drug Conventions*, Kluwer Law International, The Hague/London/Boston, 2001, 172.

<sup>30</sup> UNDCP legal affairs section, decision 74/10, 30 September 2002.

<sup>31</sup> *Ibid.*

harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence”.

In its legal paper, UNDCP explicitly stated that it would support a balanced approach that would match supply reduction measures and prevention, treatment, and rehabilitation initiatives, with programmes aimed at reducing the overall health and social consequences and costs of drug abuse for both the individuals and their communities. According to the paper, this would be *fully consistent* not only with the Declaration on the Guiding Principles of Drug Demand Reduction (Resolution A/RES/S-20/4) of the General Assembly Special Session (further UNGASS 1998),<sup>32</sup> but also with stated position of the INCB. Moreover, this approach would also be in accord with the United Nations system’s position on *Preventing the Transmission of HIV among Drug Users, as approved in February 2001*.

Referring to Article 14, paragraph 4 of the 1988 Convention, the legal paper sees within the 1988 Convention a solid argument for the view that the human suffering associated with drug abuse can be alleviated through *harm reduction* policies.

The provisions in Article 14 authorise Parties to base their demand reduction measures on recommendations of, *inter alia*, the United Nations. General Assembly Resolution A/RES/S-20/4 5 (Declaration on the Guiding Principles of Drug Demand Reduction) would no doubt qualify as a United Nation’s recommendation. More recently, the United Nations General Assembly Resolution A/RES/S-30/1 of 19 April 2016 (‘Our joint commitment to effectively addressing and countering the world drug problem’ – further UNGASS 2016) should be seen as a further recommendation for the elaboration of demand reduction measures. The Resolution reaffirms the commitment to the goals and objectives of the three international drug control conventions, including concern about the health and welfare of humankind as well as the individual and public health-related, social and safety problems resulting from the abuse of narcotic drugs and psychotropic substances.

Importantly, the 2016 UN General Assembly Resolution explicitly promotes the use of the ‘technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users’ (WHO, UNODC, & UNAIDS, 2012). This technical guide provides countries with a

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<sup>32</sup> In this declaration, a number of principles are outlined that guide the formulation of the demand reduction component of national and international drug control strategies, in accordance with the principles of the Charter of the United Nations and international law, in particular, respect for the sovereignty and territorial integrity of States; human rights and fundamental freedoms and the principles of the Universal Declaration of Human Rights; and the principle of shared responsibility. According to these principles, demand reduction policies shall: “*aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse*”. The declaration further states that demand reduction programmes should “*cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse*”.

comprehensive package of interventions for the prevention, treatment and care of HIV infection among PWID. A number of interventions have not been included in the comprehensive package because of the relative lack of evidence of their effectiveness or other considerations. According to the WHO, this should not, however, rule out the delivery of additional interventions—as pilot programmes or full-scale interventions—where the local context requires them. The technical guide further states that, although the WHO “has not reviewed the evidence on the effectiveness of supervised drug consumption/injection facilities in preventing HIV infection, evaluations in high-income countries where these facilities have been implemented have reported reduced risk behaviours among attending clients” (p. 22).

It could easily be argued that the abovementioned United Nations Resolutions provide a clear mandate for the institution of harm reduction policies that, respecting cultural and gender differences, provide for a more supportive environment for drug users.

Although the General Assembly resolutions do not carry the legal weight of a treaty, and are in fact non-legally binding, they do reflect the evolution in the outlook of Parties on the drug abuse problem and the best means to cope with it. They also reflect a consensus of the international community on how to deal with drug abuse prevention and treatment.

Based on the aforementioned principles, the 2002 legal paper (UNDCP) includes an explicit review—and legal analysis—regarding a number of specific programmes, including DCRs, as regards to which the paper states:

[23] It might be claimed that this approach is incompatible with the obligations to prevent the abuse of drugs, derived from article 38 of the 1961 Convention and Article 20 of the 1971 Convention. It should not be forgotten, however, that the same provisions create an obligation to treat, rehabilitate and reintegrate drug addicts, whose implementation depends largely on the interpretation by the Parties of the terms in question. If, for example, the purpose of treatment is not only to cure a pathology, but also to reduce the suffering associated with it (like in severe pain management), then reducing IV drug abusers exposure to pathogen agents often associated with their abuse patterns (like those causing HIV-AIDS, or hepatitis B) *should perhaps be considered as treatment. In this light, even supplying a drug addict with the drug he depends on could be seen as a sort of rehabilitation and social reintegration*, assuming that once his drug requirements are taken care of, he will not need to involve himself in criminal activities to finance his dependence.



[24] Needless to say that, to be consistent with a comprehensive demand-reduction strategy, *any such approach would also require counselling and other health and welfare services, aimed at promoting healthier life-styles and, eventually, abstinence.*

[25] Encouraging addicts to use drug-injection rooms could arguably be construed as inciting to or inducing the illicit use of drugs, contrary to Article 3, paragraph 1 (c)(iii) of the 1988 Convention. Some might also see it as association with, aiding, abetting and facilitating the possession of drugs as foreseen in article 3, paragraph 1 (c)(iv) of the Convention.

[26] In this respect, *one should bear in mind the element of intent required in paragraph 1 of Article 3*, and recall the position of the Commentary on the 1988 Convention: “3.7 The various types of conduct listed in Article 3, paragraph 1, are required to be established as criminal offences only “when committed intentionally”, unintentional conduct is not included. It accords with the general principles of criminal law that the element of intention is required to be proved in respect of every factual element of the proscribed conduct. It will not be necessary to prove that the actor knew that the conduct was contrary to law...”

[27] *It would be difficult to assert that, in establishing drug-injection rooms, it is the intent of Parties to actually incite to or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs.*

[28] *On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug abusers, thereby reducing their risk of injection with grave transmittable diseases and, at least in some cases, reaching out to them with counselling and other therapeutic options. How insufficient this may look from a demand reduction point of view it would still fall far from the intent of committing an offence as foreseen in the 1988 Convention.*

### 2.2.3 Analysis

Based on the foregoing elements, several considerations can be made regarding the compatibility of DCRs with the United Nations Conventions.

Firstly, although there is no clear guidance in relation to the compatibility of DCRs with either of the UN Drug Conventions, it is key to assess the compatibility in view of one of the fundamental goals of the UN Drug Conventions, which is to preserve the health of mankind (see for example the first sentence of the Preamble to the 1961 Convention: “concerned with the health and welfare of mankind”). This explicit emphasis on the general health and welfare of people is essential in understanding the significance of the two general exceptions (medical and scientific purposes) to the main (prohibitionist) principle enshrined in article 4. When tackling the question regarding the compatibility of DCRs with the UN Drug Conventions, it is therefore important to stress that *the Conventions are health-oriented treaties*. Moreover, literal interpretations of the Conventions are difficult: there is inevitably, a considerable degree of ambiguity conferred by the three historical layers of the Conventions and the many paragraphs relating to the same issues (JRF, 2006). It can thus be concluded that the legal framework of the Conventions leaves room for flexible interpretation (for States to design and implement national drug policies according to their priorities and needs, as was recently acknowledged in UNGASS 2016).

Secondly, the 1961 Convention does not require a criminal punishment for the possession of drugs for personal use. Although governments are obliged to counter the trade in, use, and possession of drugs with legislative and administrative measures according to Article 4, subparagraph (c), of the 1961 Convention, this does not mean that Parties are obliged to penalise this sanctions. The obligation for penalisation only arises from Article 36, which enumerates the activities that require a punishment. Nevertheless, this latter Article does not contain an obligation to penalise the *use* of drugs. In addition, the required penalisation of drug possession does not necessarily refer to “possession for personal use”. Article 36 was historically set-up in order to penalise acts in relation to drug trafficking. In other words, international law requires a discouragement of drug possession for personal use, but does not impose a criminal section for this act as such (JRF, 2006). The same idea applies to the range of Article 37, which consequently does not require the seizure and confiscation of small amounts of drugs for personal use (De Ruyver *et al.*, 2000). Article 4, subparagraph (c), in relation to Article 33 of the 1961 Convention, on the contrary, does require a penalization and an arrangement for seizure and confiscation of “possession for personal use”. However, as regards DCRs, the possession for personal use (within the facility) can reasonably be seen as falling within the scope of the general exception of medical purposes enshrined in Article 4. As such, *the health-oriented goal of DCRs*—as an extreme,

though undisputable form of harm reduction—could provide parties with a justification for the non-seizure of the drugs intended for consumption in the state-controlled consumption rooms.

Thirdly, although Article 3, paragraph 2 of the 1988 Convention clearly obliges states to criminalise the possession of drugs for personal consumption, States are entitled to use the latitude given by the Drug Conventions in order to pursue its drug policy, in particular regarding the prosecution of such offences. Article 3, paragraph 2, explicitly states that Parties are obliged to establish drug possession for personal consumption as a criminal offence, “*subject to its constitutional principles and the basic concepts of its legal system*”. The international treaties do not infringe upon the principle of expediency (JRF, 2006). Therefore, when this principle exists in the countries’ criminal justice system—such as Belgium, the Netherlands and France—that principle may be applied when establishing DCRs in order to avoid violating international law.

## Summary

Taken together, an analysis of the international drug Conventions framework leads to the conclusion that, on the one hand, drug consumption facilities infringe upon certain provisions of the international Conventions concerning the use and possession of drugs; on the other hand, the United Nations Conventions do not impose a criminal settlement for drug possession for personal use as such and only require a discouragement of this act. Moreover, in establishing DCRs, it seems clear that in such cases the intention of governments is to provide healthier conditions for injecting drug abusers and, as such, governments cannot be seen as to actually incite or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs.

Although there are sufficient grounds for creating a national policy in which DCRs are not seen as necessitating the prosecution for related offences such as possession of drug for personal use, a *strict interpretation* of the drug Conventions could raise some doubts about the *loyal enforcement* of the UN-Conventions.

DCRs are without any doubt an extreme form of harm reduction and invoking the expediency principle in order to allow the creation of such facilities, does not give governments a *carte blanche* in order to deviate from the international provisions, which – according to the Vienna Convention on the Law of Treaties – should be applied in good faith, without the internal law being a possible justification for the failure to comply with a treaty.<sup>33</sup> Consequently, a loyal implementation of the UN Drug Conventions should take account of the specific criteria and preconditions that could make the DCRs qualifiable as an acceptable form of harm reduction, compatible with the UN Conventions regime.

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<sup>33</sup> Article 26 and 27, Vienna Convention on the Law of Treaties (1969)

As the UN's legal experts have indicated in its 2002 legal paper, for DCRs to be consistent with a comprehensive demand reduction strategy, it would be necessary to require counselling and other health and welfare services, aimed at promoting healthier life-styles, and, eventually abstinence. As such, it could be concluded that the establishment of DCRs *would not be incompatible per se* with the UN Drug Conventions *but that a loyal implementation of the Conventions' provisions would require a general harm reduction policy aimed at improving the health of users and contributing to their welfare, rehabilitation and reintegration*. As long as these goals are achieved, the Conventions do not seem to represent an obstacle to the establishment of DCRs.

### 2.3 The view of the INCB

The INCB is the main international institution responsible for the implementation of the Convention provisions. It is therefore key to thoroughly investigate its views on the issue of DCRs. In the annex to this report, a historic overview is given of the relevant parts of the INCB's annual reports. Based on this overview, the following part will show the striking evolution in the INCB's view as to the acceptability of DCRs. The main belief of the INCB has, for many years, been that DCRs are the contrary to the Conventions. The grounds for this view have varied somewhat over the years (see APPENDIX A):

- In the 1999 report the view expressed was that DCRs facilitate drug trafficking.
- In the report of 2000, the main reference was to DCRs breaching the principle that drugs should be used only for medical and scientific purposes.
- In 2002, there was concern about "aiding and abetting drug abuse (and possibly illicit drug trafficking)" (p. 70).
- In the 2003 report, there was a *more measured appraisal*, including the observation that the German DCRs "were perceived as a success by a large part of the local authorities and the local population". However, the report went on to state that there was little evidence that DCRs ensure that users underwent treatment or it decreased drug-related deaths. Moreover, in that they allowed the abuse of illicit drugs, they were seen as contrary to the Conventions (p. 78).
- The 2004 report recognised that the establishment of DCRs is a *contentious issue* and that some argue that there is a positive effect. However, the INCB reiterated that DCRs are against the central principle embodied in the international drug control treaties, namely that the use of drugs should be limited to medical and scientific purposes only.
- The 2005 report reiterated the INCB position that DCRs contravene "the major principle of the treaties".
- In the 2007 and 2008 reports, the INCB continued its request for governments to close DCRs.

- In 2009, the Board added to its objection a comment regarding the differing legal systems and legal traditions in the various states. The Board stressed the basic principles of international law defined in the provisions of Articles 26 and 27 of the Vienna Convention as well as the international drug control treaties.
- In 2012, the INCB reiterated its position, despite “taking note of the recent decision of the supreme court and the government’s views on the drug injection room in Vancouver” (p. 10). In this landmark ruling, the Supreme Court of Canada ordered the Minister of Health to grant an exemption to *Insite* (North-America’s first government controlled safe injecting facility) from the prohibition of possession of controlled substances.<sup>34</sup>
- A *remarkable evolution* in the wordings of the INCB is found in the 2014 report whereby, following the introduction of a legal framework for the establishment of DCRs in Canada, the Board indicated to “look forward to a continuing dialogue with governments that have permitted such drug consumption rooms” while reiterating its concern that such facilities “could be inconsistent with the provisions of the international Drug Control Conventions.”
- Finally, in the 2015 and 2016 reports, following the implementation of DCRs in France and Denmark, the concept of drug consumption facilities was no longer rejected as such but *replaced with an “expressed concern”* that, in order for the operation of such facilities to be consistent with the international drug Conventions, “certain conditions must be fulfilled” (chief among those conditions is that the ultimate objective of these measures is to reduce the adverse consequences of drug abuse to treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking). The INCB concluded in its 2016 report that “drug consumption rooms must be operated within a framework that offers treatment and rehabilitation services as well as social integration measures, either directly or by active referral for access and must not be a substitute for demand reduction programmes, in particular prevention and treatment activities” (p. 90-91).

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<sup>34</sup> In one of the key parts of its ruling, the Supreme Court stated: “The Minister’s failure to grant a s. 56 exemption to *Insite* engaged the claimants’ rights and contravened the principles of fundamental justice. The Minister of Health must be regarded as having made a decision whether to grant an exemption, since he considered the application before him and decided not to grant it. The Minister’s decision, but for the trial judge’s interim order, would have prevented injection drug users from accessing the health services offered by *Insite*, threatening their health and indeed their lives. It thus engages the claimants’ interests and constitutes a limit on their rights. Based on the information available to the Minister, this limit is not in accordance with the principles of fundamental justice. It is arbitrary regardless of which test for arbitrariness is used because it undermines the very purposes of the CDSA—the protection of health and public safety. It is also grossly disproportionate: during its eight years of operation, *Insite* has been proven to save lives with no discernible negative impact on the public safety and health objectives of Canada. The effect of denying the services of *Insite* to the population it serves and the correlative increase in the risk of death and disease to injection drug users is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics” (Supreme Court of Canada, *Canada (Attorney General) v. PHS Community Services Society*, 30.09.2011).

In sum, it can be stated that after a long period of objecting to the concept of DCRs, as being contrary to the Conventions, the INCB has recently shifted its viewpoint towards a more flexible approach. *This shift seems to be mainly inspired by the health and welfare of the users*, which—as seen above—is one of the main themes running through the UN Drug Conventions. Consequently, the INCB gives a particular focus to the way in which these facilities are operated, thereby stressing an integrated approach requiring a framework offering treatment, rehabilitation and reintegration.

**Box 6. The international perspective: UN and INCB**

The UN Drug Conventions of 1961, 1971 and 1988, to which Belgium is a signatory, contain sufficient flexibilities for the introduction of harm reduction within a balanced approach to drug use, including DCRs. An increasing number of countries which are signatories to the Conventions have introduced DCRs, with the implication that their operation is considered Convention-compliant. The establishment of DCRs is indeed not incompatible with the international drug control system, if a clear integrated model is foreseen when the DCR is included in a wider range of health, treatment and social integrated services, either directly within the facilities or by active referral for access to these services. If those preconditions are met, this form of harm reduction can be reconciled with the general principle of medical purposes as enshrined in the Conventions. Over the years, the INCB has shifted its viewpoint towards a more flexible approach. This shift seems to be mainly inspired by the health and welfare of PWUD, which is one of the main themes running through the UN Drug Conventions.

**2.4 Implementation abroad**

A number of European countries which are signatories to the Conventions have introduced DCRs, with the implication that they consider the operation of DCRs as being Convention-compliant. In practice, countries that are signatories to the Conventions interpret them within domestic legislation and it is this domestic legislation that determines questions of legality. This provides the primary reference point for consideration of whether or how DCRs might operate in a specific country (Hunt, 2008). Below, we highlight the legal implementation of DCRs in Belgium’s neighbouring countries (France, Germany, Luxembourg, and the Netherlands). Although not a neighbouring country, we also included Ireland since its situation is a very recent (and useful) example of the implementation of DCRs.

### 2.4.1 France

#### **Context and objectives**

The main objectives of the French drug policy are: to severely repress trafficking, to prohibit the use of narcotics, yet also to propose alternatives to the repression of use and to ensure free and anonymous care for users who seek treatment. The basic law is that of 31 December 1970. While this law has not been modified since then, ministerial directives have been issued to harmonise the practical application of law enforcement authorities and health related services. In particular, the Directive of 17 June 1999 concerning the traditional responses to drug addicts, recommends prosecutors to base their actions against drug using offenders on health related principles. This orientation constitutes one of the main issues of the French Action Plan on drugs adopted in 1999.

Harm reduction approaches in France have been developed by civil society organisations since the late 1980's and the HIV epidemic. In 1987, clean needles could be bought from pharmacies and two years later, Médecin du Monde de France was starting the first free and anonymous needle exchange programme. It was later institutionalised by the 2004 public health law that allowed for the creation of “Centres d'accueil et d'accompagnement à la réduction des risques pour les usagers des Drogues” (CAARUD), low-threshold centres that promote harm reduction, welcome and help drug users with social and health aspects.

The past years have witnessed a continued debate—and political hesitation—surrounding public acceptability of DCRs. There has been great reluctance to experiment with supervised DCRs, linked both to the public's fear of an increased precedence of drug users in the areas where such rooms should be set up, and the fear that such a measure could send out a message that drug use and injecting are acceptable practices. Finally, in January 2016, a new public health law was adopted, allowing the experimentation for six years of DCRs in cities that apply for it.

#### **Legal implementation**

The specific legal framework relating to the DCRs consists of:

- Article 43 of the “loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé”.
- Article L. 3411-8 of the “code de la santé publique (politique de réduction des risques et des dommages en direction des usagers de drogues)”.
- Article L. 3411-9 of the “code de la santé publique (prise en charge anonyme et gratuite)”.
- Article R. 3121-33-1 – R. 3121-33-4 of the “code de la santé publique (mission des centres d'accueil et d'accompagnement à la réduction des risques pour les usagers des drogues)”.

- The national repository of risk reduction foreseen in Article D. 3121-33 of the “code de la santé publique”.
- Article L. 311-7 of the “code de l’action sociale et des familles”.

The main legal provision regarding the establishment of DCRs in France is Article 43 of the above-mentioned new Health Law (of 26 January 2016). In essence, Article 43 allows for the establishment of DCRs within the framework of the so-called “centres d’accueil et d’accompagnement à la réduction des risques pour les usagers des drogues”, on a strictly experimental basis and for a maximum duration of six years starting from the opening of the first room. The DCR is defined as a place for risk reduction by means of supervised use, with respect to the specifications and conditions (“cahier des charges”) as defined on a national level by the minister of health. The law allows users (solely) to possess in the rooms the substances for their personal consumption on the spot under the conditions determined by the aforementioned national specifications, and under supervision of a multidisciplinary team.

The law explicitly states that those who possess drugs, merely for their personal consumption, inside a DCR cannot be prosecuted for illegal use and consumption (in Paris, an oral agreement between the local police and the DCR has determined the conditions in which the police will not intervene within the surrounding area; personal communication with Elizabeth Avril on 22 June 2017). Moreover, the law provides legal protection for the professional staff, by stating that no prosecution is possible for complicity to and facilitation of use of illegal drugs while intervening in a DCR according to their supervising role.

On the basis of Article 43, two ministerial decrees have been issued, recognising the establishment of DCRs in Paris and Strasbourg (ministerial decrees of 25 March 2016). The legal implementation of the DCR is outlined in detail in the aforementioned “national specifications and conditions” (cahier des charges) that were issued in the ministerial decree of 22 March 2016.<sup>35</sup> According to the “cahier des charges”, the general objectives of the DCRs are:

- To contribute to the reduction, among drug injecting users, of overdose, infections and other complications, linked to the consumption of drugs by providing secure injection conditions and sterile material.
- To contribute to the enrolment of the drug users in a process of risk reduction and treatment, and a new way of life, with the aim of combatting the addictions.
- To contribute to the cessation of drug use or substitution programmes.
- To contribute to an improved access of users to rights and social services.

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<sup>35</sup> Arrête du 22 mars 2016 portant approbation du cahier des charges national relatif à l’expérimentation d’espaces de réduction des risques par usage supervisé, autrement appelés “salle de consommation à moindre risque” (in particular the annex thereto).



- To reduce public nuisance.

The experimental project will take into account the realities and special needs of the territory on which it will be implemented. The choice of a location will depend on local data specifically relating to the number of injections, products, ways of consumption and user habits. It must be situated nearby the areas of consumption in order to be close to the users and to reduce the public nuisance where it is most tangible. The financing of the experiment is guaranteed (partly) by the state (ministry of social affairs and of health).

A national pilot committee is installed, composed by representatives of the different ministries involved (health, justice and interior). Its mission is to act as a liaison between the local pilot committees that will be put in place in order for the project to adapt fully to the population concerned, the national and local needs and the local options. A number of minimum rules are identified that need to be respected in all consumption rooms. These include, *inter alia*, the fact that the injecting is done by the user under supervision of a professional. If there is a need, the professional can give advice to the user on the conditions for a safe injection, without at any moment participating in injecting itself.

The national specifications and conditions require the establishment of two types of protocols: a protocol of assistance (protocol d'accompagnement) and of intervention (protocol d'intervention). The first is a document detailing the procedure to be followed by the user, from the initial access to the exit and needs to be elaborated before the opening of the DCR. The latter requires a written and detailed description of, *inter alia*, the hygienic rules, the situations that can justify a refusal or obligatory exit, the work modalities of the supervising staff, specifying that – within their supervising role – the staff should be able to judge the state of conscience of the users and to evaluate the degree of risk of consumption, as well as the conduct in a situation of emergency, specifically in case of discomfort or suspicion of overdose. Besides the protocols, a set of operating regulations are elaborated (conforming to Article L. 311-7 of the “code de l'action sociale et des familles”), defining—for the sake of the users—the rules that should be respected respectively by the professionals and users in order to guarantee the DCR to operate well.

Regarding the composition of the staff, the “national specifications and conditions” require the multidisciplinary team to meet the professional qualifications of the medico-social sector. Two assistants—of who at least one nurse, competent in emergencies linked to the use of drugs—are present at all times in the DCR. Former users, skilled in risk reduction, can assist the professional staff, in all spaces except the consumption space. They are not allowed to participate in the supervision as such.

## 2.4.2 Germany

### Context and objectives

The main law governing narcotics in Germany is the “Act to Regulate the Trade in Narcotics” (Betäubungsmittelgesetz) of 28 July 1998. It is the central drug law and has been amended several times. Prior to the introduction of official DCRs in Germany, the staff working in low-threshold facilities were faced with the contradiction of, on the one hand, providing sterile injecting equipment to increase safer use and, on the other, sending drug users back onto the street to use. Before the first official DCRs opened in 1994, a number of drug services in several cities (for example Bremen) had already been tolerating the on-site use of pre-obtained drugs since the mid-1980s. This practice could be seen as illegal and in 1993, the city of Frankfurt commissioned a legal review by a prosecuting attorney in order to check whether DCRs were in line with the narcotic law. The result of this preview was positive and led to the financial support of DCRs in Frankfurt and Hamburg. Legally, it was an interim solution, but nevertheless cities started to implement and finance DCRs. It took another seven years for DCRs to be approved by federal law (Lloyd *et al.*, 2017).

### Legal implementation

On 1 April 2000, the 3<sup>rd</sup> Amendment of the German Narcotics Law came into effect as a uniform federal framework regulation following an agreement between the German Parliament (Bundestag) and the Federal Council (Bundesrat). The newly created Section 10a of the Narcotics Law serves as a legal basis for the establishment of DCRs in Germany. Section 10a (on the Licence to operate a DCR) states:

*A licence of the competent highest Land authority shall be required by any person who wishes to operate a facility in the premises of which drug-addicted persons are afforded or granted an opportunity to use narcotic drugs that they bring with them and that have not been medically prescribed (drug consumption room). A licence may only be issued if the Land government has laid down the prerequisites for such issue in an ordinance according to subsection 2.*

*The Land governments are authorized to lay down, by means of an ordinance, the prerequisites for the issue of a licence pursuant to subsection 1. The provisions shall regulate, in particular, the following minimum standards for the security and control of the use of narcotic drugs in drug consumption rooms:*

- 1. Appropriate equipment of the premises that are to serve as drug consumption rooms;*
- 2. Arrangements to ensure the immediate provision of medical emergency care;*

3. *Medical counselling and assistance for the purpose of reducing the risks involved in the use of the narcotic drugs brought by drug-addicted persons;*
4. *Placement in follow-up and abstinence-oriented counselling and therapy services;*
5. *Measures to prevent criminal offences under this Act from being committed in drug consumption rooms, other than the possession of narcotic drugs pursuant to section 29 subsection 1 sentence 1 number 3 for personal use in small quantities;*
6. *Required forms of cooperation with the local authorities responsible for public order and safety to prevent, as far as possible, any criminal offences from being committed in the immediate surroundings of drug consumption rooms;*
7. *A precise definition of the group of persons entitled to use drug consumption rooms, especially with regard to their age, the kind of narcotic drugs they may bring with them and the consumption patterns that are tolerated; obvious first-time or occasional users are to be excluded from using these rooms;*
8. *Documentation and evaluation of the work done in the drug consumption rooms;*
9. *Permanent presence of a sufficient number of personally reliable staff whose professional training qualifies them to comply with the requirements specified in number 1–7*
10. *Appointment of a competent person who shall be responsible for compliance with the requirements specified in numbers 1–9, the obligations imposed by the authority issuing the licence, the orders issued by the monitoring authority (responsible person) and who is able to permanently meet the obligations incumbent on him;*

*A licence pursuant to subsection 1 shall not entitle the staff working in a drug consumption room to conduct assays of the narcotic drugs brought by drug-addicted persons or to provide active assistance in the actual use of these narcotic drugs.*

The law provides that an operating permission shall only be issued if the state (Lander) has passed an legislative act that includes limiting regulations. Consequently, the establishment of DCRs is dependent on the political will of the respective state government.

### **2.4.3 Luxembourg**

#### **Context and objectives**

The main drug law is that of 19 February 1973 regarding the sale of pharmaceutical substances and the fight against drug addiction (“loi du 19 février 1973 concernant la vente de substances

médicamenteuses et la lutte contre la toxicomanie”). This law regulates the production, use, possession, providing, sale and trafficking of controlled drugs. The latest amendment to the 1973 law dates from 2001. The law of 27 April 2001 has altered substantially the national legal framework concerning controlled drugs (“loi du 27 avril 2001 modifiant la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie”). The new amendment provides a legal basis for needle exchange as well as the creation of DCRs. The first DCR opened in the city of Luxembourg in 2005.

### **Legal implementation**

The law of 27 April 2001 modifies the text of Article 8 of the law of 19 February 1973 (stipulating punishments for a number of offences such as sale, transport, group usage and facilitating use of drugs). More in particular, the new Article 8 d) states: “ceux qui auront facilité à autrui l’usage, à titre onéreux ou à titre gratuit, de l’une ou l’autre substance..., soit en procurant à cet effet un local, soit par tout autre moyen, à l’exception des locaux et des moyens agréés par le Ministre de la Santé.” As such, Article 8 d) creates a legal basis for DCRs by stating that no penalties are foreseen for those who facilitate drug use of a third party within a defined place or by other means agreed by the ministry of health (the term “by other means” refers to the programmes for needle exchange or medically controlled heroin prescription).

Furthermore, the new Article 7.A.1. of the 1974 drug law (as modified by the law of 27 April 2001) states: “seront punis d’un emprisonnement de huit jours à six mois et d’une amende de 10.001,- à 10.000,- francs, ou de l’une de ces peines seulement, ceux qui auront, de manière illicite, en dehors de locaux spécialement agréés par le Ministre de la Santé, fait usage d’un ou plusieurs stupéfiants ou d’une ou de plusieurs substances... ou qui les auront, pour leur usage personnel, transportées, détenus ou acquis à titre onéreux ou à titre gratuit.” As such, Article 7.A.1. provides a legal guarantee for the users within a DCR that they do not commit a punishable offence for the use and possession of their drugs as consumed in the special rooms as designated by the minister of health. More specific legal provisions regarding the practical implementation of the DCRs are not provided (as is the case, for example, in France).

## **2.4.4 The Netherlands**

### **Context and objectives**

The main drug law in The Netherlands is the Opium Act (originally of 1919). The Act was fundamentally amended in 1976, determining the version currently in force. This amendment confirmed the

distinction between ‘hard’ and ‘soft’ drugs, suggested in a 1972 report by the government “Working Group on Narcotic Drugs”. Particularly, a risk scale was introduced based on medical, pharmacological, sociological and psychological data. The 1976 Opium Act thus distinguishes between drugs presenting unacceptable risks (unofficially ‘hard drugs’) and cannabis products (unofficially ‘soft drugs’).

The first DCRs were opened in Amsterdam in the 1970s as part of the then progressive low-threshold approach. In the middle of 1996, the city of Amsterdam further declared its support for DCRs on grounds of the nuisance problem in the city centre. In order to prevent the controllability problems of the past, the city issued a number of preconditions relating to the installation of DCRs. The city called for professional management, small-scale operations, stricter admission regulations (by means of an ID card system), integration with other relief facilities and cooperation arrangements with the police (de Jong & Weber, 1999).

Since 1996, the city of Rotterdam has also formally supported the development of DCRs in the framework of a policy, which aims to regulate the illegal drug market. DCRs are considered by the city as facilities that can reduce public nuisance and promote health among drug users. This policy has resulted in two new facilities, including a service for drug using street prostitutes. Besides, the city aims to promote “self-regulation” among drug dealing sites. When dealing sites fulfil a number of conditions and rules of good behaviour, dealing in drugs are given a low priority in the detection and prosecution policy of the police and the public prosecutor. Besides the facilities in Rotterdam and Amsterdam, DCRs have been installed in a number of other cities (de Jong & Weber, 1999).

At the beginning of 1996, the Minister of VWS (Health, Welfare and Sports) expressed his opinion on the so-called drug consumption rooms in the press. The findings of the report were that, provided a number of specific conditions were met, DCRs would or could be an important addition to existing dorms of drug relief. This conclusion was supported by the Inter-ministerial Committee on the reduction of nuisance, which, however, *advised the national government to take a backseat on this issue, as decision-making with regard to consumption rooms is considered the primary responsibility of local government* (de Jong & Weber, 1999).

### **Legal implementation**

As indicated above, no specific legal framework exists allowing for the establishment of DCRs or providing a strong legal guarantee against prosecution. The possession of drugs is generally considered a punishable offence according to Article 2 of the main drug law. This means, that for a long time, there was uncertainty with regard to the implications at the level of criminal law and particularly concerning the question whether DCRs are admissible under the terms of the Opium Act.

Meanwhile, this has been clarified to some extent by the prosecutorial guidelines of the Prosecutors-general's Office (of the Ministry of Justice) of 1996.<sup>36</sup> In these guidelines, the possession of drugs in DCRs is tolerated, provided the facilities fit into the policy of the local triangle committee (mayor, police and public prosecutor). The general principle underlying this policy of tolerance is the weighing of interests, whereby the interest of law enforcement makes room for a higher public interest (of public health and order). The guidelines therefore *call for a positive decision not to detect or prosecute*, despite the available capacity. A primary condition in this respect is that no drug is provided or dealt inside the DCR.

#### **2.4.5 Ireland**

##### **Context and objectives**

Although not a neighbouring country, the situation in Ireland is a useful (and recent) example of the implementation of DCRs. In May 2017, a specific Bill was published that allows for the establishment of supervised injecting facilities for the purposes of reducing harm to PWID. The Bill is a response to the recognised problem with street injecting in Ireland, particularly in Dublin centre, a practice which poses a significant health risk for the drug users and results in discarded needles which present a public health risk to others (Department of Health, Press Release, 7.2.2017).

When announcing the approval of the Bill, the Minister of Health said being “delighted to be bringing forward this important legislation that adopts a health-led approach to drugs-use by those in our society who have been marginalised as a result of their addictions” (Department of Health, Press Release, 7.2.2017). The Minister of State for Communities and the National Drugs Strategy added that the facilities will be “a safe harbour for chronic drug users, providing a controlled place for people to inject, but will be much more than that – a place to rest, have a chat and access the services people need” (Department of Health, Press Release, 7.2.2017). The Bill does not establish a location for a supervised injecting facility, but a pilot facility is planned for Dublin city centre.

##### **Legal implementation**

The Misuse of Drugs (Supervised Injecting Facilities) Act 2017 (published 16 May 2017) allows the Minister of Health to issue a licence, with conditions, to operate a supervised injecting facility. The relevant criteria for granting a licence include, inter alia, the suitability of the premises and the experience and expertise of the applicant. A licence shall remain in force for the time period specified

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<sup>36</sup> Richtlijnen opsporings-en strafvorderingsbeleid strafbare feiten Opiumwet, College van Procureur-generaal, 10 september 1996, nr. 187, p.12.

in the licence or until surrendered by the licence holder or suspended or revoked by the Minister. A licence holder, or the person in charge of a supervised injecting facility for the time being, may authorise a person, not being a person prescribed as being ineligible to be an authorised user, to be on the premises of a supervised injecting facility for the purpose of consuming drugs by injection (Article 7.1).

Regarding the liability of the facility or its staff, the Act stipulates that a licence holder or any person acting under the direction of the licence holder shall not be liable for any act done or omitted to be done in a supervised injecting facility, in relation to the provision of assistance or advice of, an authorised user and no person shall have a cause of action in respect of that act (Article 9).

The Act exempts authorised users from the offence of possession when in the facility, and with the permission of the licence holder. It further exempts licensed providers from the offence of permitting or tolerating the preparation, production or the possession of a controlled drug in the facility (Article 10). It should be noted that possession of controlled drugs continues to be an offence outside a supervised injecting facility and that possession for sale or supply remains an offence both inside and outside a supervised injecting facility.

The police, whether in uniform or not, or accompanied by such other persons as may be necessary, may at any time enter the premises of a supervised injecting facility without a warrant, and there make such inspection, examination, observation and enquiry deemed proper for the prevention or detection of drug offences, other than offences which according to Article 10 do not apply to an authorised user (Article 11).

## **2.5 Conclusion**

As to the question whether DCRs are compatible with the international legal framework on drug control, the following conclusions can be made. Although there is no clear guidance on the question of DCRs in the UN Drug Conventions, a legal analysis of the applicable provisions shows that none of the three Conventions would impede a government to proceed with the implementation of a DCR.

When tackling the question regarding the compatibility of DCRs with the UN Drug Conventions, it is important to stress that the Conventions are health-oriented treaties. The explicit emphasis on the general health and welfare of people in the UN Drug Conventions is essential in understanding the exception of ‘medical purposes’ to the main (prohibitionist) principle (as enshrined in article 4 of the 1961 Convention and the later treaties). Given the nature and (health-oriented) goal of DCRs, they can be seen as falling within the scope of this exception.

As for the prosecution of the related possession of drugs for personal use, the expediency principle would allow a government to establish a DCR in order to avoid violating international law.

Nevertheless, a loyal enforcement of the UN Drug Conventions would require a government to make the necessary legal arrangements in order for the interpretation of the UN Conventions to be made in good faith, in accordance with the specific context and in the light of the main objectives and purpose of the relevant Conventions provisions.

As such, a well-run DCR, within an *integrated* model including a range of health, treatment and social integration services, either directly or by active referral for access, would seem to be most Convention compliant. The extent to which DCRs might contribute towards meeting some of the Conventions' objectives concerning user welfare, rehabilitation and reintegration would depend on the extent to which other services were provided and referrals made. As long as the objectives of referral, rehabilitation and reintegration are met with, the INCB—in its recent reports—no (longer) seems to fundamentally object to the implementation of DCRs.

Although non-legally binding, the General Assembly resolution A/RES/S-20/4 (UNGASS 1998) as well as the recent General Assembly resolution A/RES/S-30/1 (UNGASS 2016), taken together with decision 74/10 on the flexibility of treaty provisions as regards harm reduction approaches (UNDCP 2002) provide an important addition regarding the interpretation and implementation of the UN Drug Conventions, providing a clear authorisation for Parties to implement DCRs without contravening the UN Drug Conventions. In the European context, the recent EU action plan 2017-2020, provides an explicit referral to DCRs as being a best practice on risk and harm reduction measures to be exchanged between member state.

In sum, based on the above-mentioned elements, it can be concluded that *the establishment of DCRs is not incompatible with the international drug control system if a clear integrated model is foreseen whereby the drug consumption facility is included in a wider range of health, treatment and social integrated services, either directly in the DCRs or by active referral for access to these services*. If those preconditions are met, this (extreme) form of harm reduction can be reconciled with the general principle of medical purposes as enshrined in the UN Drug Conventions. The example of other countries (including those neighbouring Belgium) shows that there is a growing commitment to tackle the health and social problems among drug users. This commitment has resulted in specific legislation (except for the Netherlands) allowing the establishment of supervised DCRs, either in the form of a pilot or on a permanent basis.



## 3. THE NATIONAL PERSPECTIVE

### 3.1 General principles of Belgian drug policy

#### 3.1.1 Brief overview

The basic law on drugs dates back to 24 February 1921.<sup>37</sup> The law is a framework law, further implemented by two main royal decrees of 31 December 1930<sup>38</sup> and 22 January 1998.<sup>39</sup> The Belgian drug legislation is the result of a loyal implementation of the international obligations as stipulated mainly by the UN Drug Conventions. Belgium has ratified the three UN Drug Conventions and, as a Party to these treaties, is bound by their content. As mentioned above, the UN Drug Conventions are of a prohibitionist nature, limiting the possession of drugs to medical and/or scientific purposes.

The laws of 4 April 2003 and 3 May 2003 (as well as the implementing ministerial decree of 16 May 2003) established a legal distinction between possession of cannabis for personal use and all other types of offences. The package of laws in 2003 further changed the title of the royal decree of 1930 to include the terms risk reduction and therapeutic advice, with the new chapter IIbis explaining this in detail. The title of the royal decree of 22 January 1998 was similarly modified with a new chapter IVbis to provide the explanations.

While the drug legislation mainly focuses on the repressive component—all penal provisions regarding drug regulations are included in the basic law of 1921 and the accompanying royal decrees—the Belgian (integrated) drug policy also has a preventive and treatment component (De Ruyver, Vander Laenen, & Eelen, 2012). The Federal Policy Paper on drugs of 2001, that was based on the recommendations by the Parliamentary Working Group on drugs of 1996/1997, was drafted to outline the national political priorities on drug policy. Besides focusing on prevention and treatment, one of the general principles underlying the criminal policy on drugs is the *ultimum remedium* principle, meaning that—at every level of the criminal justice system—a minimal intervention towards non-problematic drug use is aimed for (excluding the production of and trade in drugs).

#### 3.1.2 Harm reduction

In the last 20 years, the Belgian drug policy has given significant attention to harm reduction. The federal policy paper of 2001 explicitly states: “the development of harm reduction initiatives should

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<sup>37</sup> Law relating to the traffic in poisons, soporific and narcotic drugs, disinfectants and antiseptics, as revised by several subsequent laws.

<sup>38</sup> Royal decree 31 December 1930 on soporific and narcotic drugs and risk reduction and therapeutic advice, B.S. 10 January 1931.

<sup>39</sup> Royal decree 22 January 1998 on particular psychotropic substances and risk reduction and therapeutic advice, B.S. 14 January 1999.

be stimulated. Their goal is to minimise the negative consequences of excessive drug use. Attention should be given to substitution programmes, to medical and psychological assistance and to programmes for increasing social integration through employment and meaningful leisure activities. The fact that drug use goes hand in hand with individual and social problems should be taken into account: dealing with the addiction as such is only efficient when the underlying problems are also dealt with. In that sense, multidisciplinary is crucial".<sup>40</sup>

The continued focus on assistance to drug users, was confirmed in the Joint Declaration of the Inter-Ministerial Conference on Drugs, which in its policy document on a "global and integrated drug policy for Belgium" of 25 January 2010, stressed the need for an integral assistance strategy based on a health approach but also integrating other dimensions such as welfare and social inclusion. The declaration states the following forms of assistance that should be offered: drug-free treatment, withdrawal treatment, substitution treatment, harm reduction, reintegration and after-care.<sup>41</sup> The declaration further indicates the need for a co-operation between the additional authorities and drug treatment on the basis of mutual respect for their different finality.<sup>42</sup>

## **3.2 Relevant provisions and initiatives**

### **3.2.1 The basic drug legislation: Law of 24 February 1922**

*Article 3 paragraph 2:* "are punishable with the punishments provided in Article 2bis, and according to the distinction made therein those who, for payment or free of charge, facilitate the use by another person of the substances named in Article 2bis, paragraph 1, by supplying a room thereto or by any other means, or by inciting drug use".

*Article 9bis:* "unabated the competence of the traditional authorities and unabated the provisions of Article 134ter and quater on the new law on municipalities, the mayor can, after prior consultation with the traditional authorities, and when there are serious indications that, in a private but publically accessible place, illegal activities repeatedly occur in connection with the sale, delivery or the facilitation of the use of poisons, soporific, narcotic drugs, psychotropic substances, antiseptics,..., by which the public order and safety are threatened and after having heard the defence of those responsible, decide to close this place for a duration as determined (by the mayor) and for a maximum of 6 months (which can be extended once for the same period)".

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<sup>40</sup> Federal policy paper on drugs, 2001, p.12.

<sup>41</sup> The Joint Declaration of the Interministerial Conference on Drugs, on a global and integrated policy for Belgium, 25 January 2010, p.76.

<sup>42</sup> *Ibid.*

### 3.2.2 Ministerial and prosecutorial circulars

The prosecutorial policy regarding the possession of and trade in illegal drugs is determined by the body of Prosecutors-general, together with and under the authority of the minister of Justice. The current prosecutorial instructions are outlined in the Joint Circular of 21 December 2015 (COL 15/2015)<sup>43</sup>, of which a number of provisions are relevant in the context of DCRs.

As regards the determination (by the police) of drug offences, the Circular makes a distinction between the possession by an adult of a small amount of cannabis (no more than 3 gram or 1 plant), without indications of sale, aggravating circumstances or disruption of the public order on the one hand, and on the other hand *all other drug offences* regarding the possession of and trade in illegal drugs. The former type of offences are determined in principle by a so-called “vereenvoudigd proces-verbaal” (simplified police report). The latter are determined by a normal police report or by a so-called “A.P.O. proces-verbaal” (Autonomous Police Investigation report).<sup>44</sup> One of the main differences between both types of reports is the fact that in the first category, the police report is (normally) not transmitted to the prosecutor, meaning that (normally) no prosecution will be initiated.<sup>45</sup>

Regarding the seizure of the drugs that are found by the police, the Circular stipulates that *all substances* should be seized (on the basis of Article 35 of the Criminal Procedure Code) even if the offence was determined in a simplified police report. The Circular adds that “other goods or objects” are only seized if “this is necessary to reveal the truth or if they will be presumably confiscated”.<sup>46</sup> An exception is made for non-used syringes and/or needles. These will not be seized and will be given back immediately when the seizure “is not necessarily to reveal the truth”. In the case of a non-seizure, the Circular only requires that the police report mentions the discovery of these objects and gives a brief description.<sup>47</sup>

On the level of the prosecution, the Circular stipulates that, for offences regarding possession by an adult of illegal drugs (other than a limited amount of cannabis) for personal use, without aggravating circumstances, the prosecutor can, on the basis of the nature and gravity of the facts and taking into account the personality of the person involved, decide to *either* give no further consequence to the case, by means of a simple warning or by referral to a specialised service, *or* give a measure of probation, *or* terminate the prosecution by paying a sum, or the execution of certain

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<sup>43</sup> The Joint Declaration of the minister of Justice and the body of Prosecutors-general concerning the determination, legislation and the prosecutorial policy on the use of and trade in illegal drugs.

<sup>44</sup> The modalities and specifics of both the simplified police report and autonomous police investigation report are determined in the circular of the body of Prosecutors-general of 15 June 2005, as repeatedly revised (most recently on 9 February 2012), COL 8/2005

<sup>45</sup> COL 15/2015, nr. 5.2.1 and 5.2.2, p.13.

<sup>46</sup> COL 15/2015, nr. 5.3.1, p.13-14.

<sup>47</sup> COL 15/2015, nr. 5.3.1, p.15.

measures.<sup>48</sup> The Circular specifies that the prosecutor can issue more precise guidelines taking into account local circumstances or exceptional situations.<sup>49</sup> In this respect, reference can be made to the COL 8/2005 (Circular on the Autonomous Police Investigation and the Simplified Police Report),<sup>50</sup> which determines that the prosecutor has the discretion to decide that certain offences are added to the list of offences for which a simplified police report is recommended.<sup>51</sup>

### **3.2.3 Relevant harm reduction initiatives**

#### **a. Needle and syringe exchange**

The practice of exchange of syringes was given a legal basis in 1998. Article 3 paragraph 2, 2° of the 1921 Drug Law provides that there is no “facilitation of drug use” in the case of sale or handing over, even free of charge, injection material, disinfectants and sterile bandage.<sup>52</sup> The implementation of the legal exchange of syringes was done in the royal decree of 5 June 2000.<sup>53</sup>

Article 2 states the following: “the persons who are authorized to sell or make available, even free, the above mentioned materials are: either doctors; nurses, psychologists, paramedics and social workers, provided they are professionally linked to a specialised centre. A specialised centre is any structure, recognised or subsidised by the competent authority, that can prove to hold a practice regarding the therapeutic shelter and social assistance of drug users or regarding the prevention of transmittable diseases”.

The Articles 3–6 specify the conditions and specific criteria that the persons mentioned in Article 2 are obliged to respect. This include, inter alia, the fact that sterile injection material can only be made available free of charge in exchange for used injection material; the fact that making available or selling sterile injection material must be accompanied by providing written information regarding its safe use, the existence and indications of serological tests, the existing offer on additional social, psychological, medical and legal assistance; the circumstances wherein the acquired material should be conserved; the fact that a registry should be kept indicating on a daily basis: the quantity of acquired material, the quantity of sold or made available material, the quantity of used material that was recuperated, the identity of the suppliers, etc.

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<sup>48</sup> COL 15/2015, nr. 5.4.2, p. 19.

<sup>49</sup> COL 15/2015, nr. 5.4.2, p. 20.

<sup>50</sup> As repeatedly revised (most recently on 9 February 2012).

<sup>51</sup> See annex 3 of COL 8/2005.

<sup>52</sup> The law of 24 February 1921 was amended in this respect by the law of 17 November 1998. The same law amended the royal decree of 10 November 1967 (B.S. 23 December 1998).

<sup>53</sup> Royal decree in execution of Article 4, paragraph 2, 6° of the royal decree nr. 78 of 10 November 1967, concerning the practice of medicine, nursing, paramedic professions and medical commissions, B.S. 07/07/2000.

## **b. Heroin-assisted treatment**

The first heroin-assisted treatment (HAT) in Belgium began in the city of Liège in January 2011, in the form of an open-label randomised controlled trial, called *Treatment Assisted by DiacetylMorphine* (TADAM), comparing HAT with existing oral methadone treatments for 200 participants. The Federal Government funded two institutions to conduct the trial. A research team from the department of Psychiatry and Criminology of the University of Liège was requested to draw up the protocol and the assessment part, while on the basis of this protocol the city of Liège managed the treatment part. At the origin of TADAM was the claim of the city, sustained by methadone centres, that a new HAT could help some of the numerous heroin addicts who find no solution in methadone treatment, are in poor health condition and create open drug scenes (Demaret *et al.*, 2011).

The preparatory steps leading to the TADAM trial are of particular relevance to the possible implementation of DCRs in Belgium (e.g. in the form of a pilot, see further). At first, a *local consensus* was reached in the city of Liège on this new type of treatment. In 1998 and 1999, the mayor and the city council *concluded an accord* with the centres for methadone treatment, the medical authorities, the prosecutor and the university of Liège. Negotiations on the future of the project were then continued at the level of the federal government. In 2007, a final agreement was reached, leading to the establishment of the TADAM, as announced by the Ministers of Health and Justice and allocating a budget (mainly funded by the Minister of Health).

The Minister of Health issued *ministerial decrees* mandating the city of Liège to manage the establishment and operation of the centre for treatment by diacetylmorphine (DAM-centre). The University of Liège was requested to conduct a scientific evaluation of the project. Moreover, the university drafted a *protocol*, which formed the basis for the implementation of the DAM-centre, defining the conditions such as the target group, exclusion criteria, evaluation method, patient consent and privacy considerations.

## **3.3 Analysis**

### **3.3.1 Legal obstacles**

The establishment of a DCR in Belgium could face a number of potential legal obstacles.

***Facilitating or inciting drug use.*** The establishment of a DCR does not seem compatible with Article 3 paragraph 2 of the law of 22 February 1921, which makes it a punishable offence to make available a room in order to facilitate the use of illegal drugs. Consequently, the manager and occupiers of a DCR could face prosecution on the basis of Article 3, paragraph 2 of the law of 22 February 1921.

It could thus be stated that (the reach of) the law of 22 February 1921 would have to be modified in order to allow the establishment of a DCR.<sup>54</sup>

**Unlawful possession.** Clients that use a DCR programme would inevitably be in possession of whatever drugs they bring to the facility and would therefore be punishable since the possession of any illegal (controlled) drug is considered a criminal offence in the Belgian drug legislation.

**Supply of illegal drugs.** Any user who would share drugs with another user in a DCR would commit an offence and would be liable to criminal prosecution (if user A asks user B to inject him/her with heroin, then user B would be guilty of supplying drugs). Furthermore, managers and occupiers of DCRs would also be committing an offence if they were to knowingly permit or tolerate the supply or attempt of supply of a controlled drug.

**Paraphernalia.** Without specific legislation or regulation, workers in DCRs would be liable to criminal prosecution by providing certain paraphernalia to users (for example sterile cookers, razorblades, plastic film, aluminium foil or tourniquets). As such, the managers and staff of a DCR could be seen as facilitating drug use “by any other means”, as provided in Article 3 paragraph 2 of the law of 24 February 1921.

**Unlawful practice of medicine or nursing.** Given the fact that DCRs imply a certain amount of supervision on the injection of drugs by users, including advice on safe injection conditions as well as observations regarding the condition of the users, the staff should be fully aware of the provisions on the (un)lawful practice of medicine or nursing, as determined by the law of 10 May 2015 on health care professions, of which the violation can lead to criminal prosecution.

**Closure on the grounds of public safety and order.** On the basis of the current drug legislation (Article 9bis of the law of 24 February 1921), the administrative authorities (mayor) could make use of their discretionary competence to close a DCR on the grounds of public safety and order. Without specific regulation or agreement between the actors involved, this could prove a realistic obstacle for the implementation of DCRs in certain communities.

### **3.3.2 Legislative options**

The example of other countries illustrates that the implementation of DCRs is often preceded by a thorough (political) debate. The extreme nature of this form of harm reduction obviously fuels that debate. It is therefore recommendable for any study to take into account the (unpredictable) outcome of the political negotiations that will be held regarding this issue. In what follows, three legal options

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<sup>54</sup> This point of view was expressed in the “policy document on risk reduction consumption rooms of the General Department on Drug Policy (which includes the representatives of the federal government and the regional governments), October 2016, p. 26.

for implementing DCRs in Belgium are presented, whereby the feasibility of each option is determined by the time span for its implementation and the amount of political support.

**a. Establishment of DCRs by primary legislation**

A first option would be to provide an explicit exception to the principle embedded in Article 3 paragraph 2 of the law of 24 February 1921, thus explicitly creating a legal basis for the establishment of DCRs.<sup>55</sup> This option would imply a long-term implementation and would therefore require a considerable amount of political support. DCRs would thus be given a statutory basis as was done in 1998 in the case of needle and syringe exchange (see Article 3 paragraph 2, 2°), in combination with secondary legislation, where a royal decree would provide the conditions and modalities applicable in order to allow for the exception provided in the basic primary legislation (including the provision of paraphernalia to users).<sup>56</sup> In this respect, the question could be raised whether the competence for creating a legal framework lies exclusively at the federal level or could also be claimed by the regional level. In recent years (following the sixth reform of the Belgian state and government institutions) the responsibility for important aspects of the drug treatment policy have been transferred from the federal state to the regions. On the one hand, it could thus be argued that, with treatment as the primary aim, a regional decree could provide the legal framework for the implementation of a DCR. On the other hand, given the fact that the main legal issues arising from the establishment of DCRs relate to the criminal provisions embedded in the federal law of 1921, it could be argued that any regional legislative initiative in this respect would disproportionality infringe upon the federal competence. Given the room for interpretation, the issue of competence would have to be ultimately decided upon by the Belgian Constitutional Court.

**b. Establishment of DCRs by secondary legislation**

A second option would be to modify the reach of the law of 24 February 1921 (Article 3 paragraph 2) by secondary legislation (royal decree) in order to provide a sufficient degree of protection from prosecution under the basic law. This option would imply a mid-long-term implementation and would require a medium amount of political support. In this option, a well-elaborated royal decree could

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<sup>55</sup> As regards this option reference should be made to the legislative proposal of 16 September 2014, which provided the following amendment to Article 3 paragraph 2 of the law of 24 February 1921: “are not subject to the application of (the offence mentioned in paragraph 2) those who have facilitated another’s use, without inciting the person involved and with the purpose of preventing contagious diseases or, more in general, risk reduction connected to this use, of those substances mentioned in Article 2bis, in places under supervision and under the conditions as determined by the King as proposed by the minister competent for public health.”, see DOC 54-0259/001 (Chamber of Representatives, extraordinary session of 16 September 2014).

<sup>56</sup> A similar implementation was done in the case of syringe exchange (see the royal decree of 5 June 2000).

provide a legal basis for the establishment of DCRs and the provision of paraphernalia by staff in such rooms and, as such, restrict the application of Article 3 paragraph 2 of the law of 1921 in the sense that—under the specific preconditions and modalities as provided in the royal decree—DCRs could be recognised as a specific harm reduction measure aimed at promoting the health of the users, thus justifying an exception to the application of the offence as mentioned in Article 3 paragraph 2.

### **c. Establishment of a DCR as a scientific or medical experiment**

As a third option, a pilot could be set up in the form of a scientific or medical experiment—thus meeting the requirement of the UN Drug Conventions to combat drug abuse out of concern for its health and welfare consequences and to limit the use of drugs to scientific or medical purposes. This option would imply a short-term implementation and would require a limited amount of political support. Given the sensitive nature of DCRs and the possible political implications, it is strongly recommended for such a pilot to acquire a ministerial recognition or authorisation (e.g., by the Minister of Public Health). The above-mentioned implementation of TADAM as a *pilot project* could serve as a useful example in this respect—although its core characteristics should be distinguished from those of DCRs (see TABLE 2).

With regard to this third option, it should be noted that—although there is no legal obstacle for creating such a (soft) legal framework—its *feasibility and sustainability are hugely dependent on the full support of (at least the local) prosecutorial authorities*. Moreover, there is a risk of legal action to be undertaken against such a ministerial decision (of recognising the pilot project) on the grounds that this recognition is deemed incompatible with the federal norm established in the Law of 24 February 1921 (although, should legal action be undertaken against the ministerial decision, there are strong legal arguments for ruling against this legal action in view of the basic health-oriented goal of DCRs and its compatibility with the UN Drug Conventions as discussed above).

### **3.3.3 Supporting options**

Irrespective of which of the above-mentioned options would be followed, it is highly recommendable to complement these with additional measures in order to guarantee a more solid and effective implementation.

#### **a. Specific prosecutorial guidelines**

As outlined above, on the basis of the current prosecutorial guidelines, users carrying illegal drugs in or out of a DCR, would possibly face judicial measures (such as probation, the payment of a sum for settling the case, etc.). On the basis of COL 15/2015 the police would normally be obliged to determine



the offence of possession by means of an official police report (either a normal police report or a report qualifying as an autonomous police investigation). Such report would have to be sent to the prosecutor, making the user potentially liable for criminal prosecution.

An amendment to these prosecutorial guidelines should therefore be considered, either (1) by providing a tolerance for drug possession for personal use in (the perimeter of) a DCR (which would of course require a well-functioning system of (for example by means of / registration of the users), or (2) by extending the specific regulation for the non-problematic possession of a certain amount of cannabis to other illicit drugs, in which case a simplified police report should be drafted, which would normally not be sent to the prosecutor (see COL 15/2015, nr. 5.2.1.). Furthermore an additional exception should be provided regarding the seizure of the substances in case of possession for personal use in a DCR and regarding the paraphernalia carried by the user. At present, only syringes and/or needles are explicitly mentioned as an exception to the general principle of seizure in case of offences of possession for personal use, even when the procedure of a simplified police report is followed.

The above mentioned options—either to tolerate the possession for personal use inside or within the perimeter of a DCR, or to extend the current list of offences for which a simplified police report is used to include possession for personal use in (or within the perimeter of) a DCR—call for a further analysis of their legal feasibility. Under the current drug legislation, unlawful possession of any type of controlled substance is considered a criminal offence, meaning that, at present, the possession for personal use of substances both inside and outside of a DCR would have to be dealt with by law enforcement authorities. This results in a number of questions, in particular regarding the responsibility of police officer, as well as to the proper functioning of a DCR, since an overly active police intervention could undermine the effectiveness of a DCR.

Regarding the first option (tolerating the possession linked to users of a DCR) it is clear that there is *no specific legal basis* for applying such “tolerance” in a general way. This could raise questions as regards to the legal uncertainty, both for the users and for the local police officers operating in the area of a DCR. However, there is no reason why—given the exceptional nature and (health-oriented) goal of a DCR—specific agreements on a local level could not be reached, establishing a *de facto* non-intervention towards those users linked to the DCR (by means of a registration system), as long as certain rules are followed. If such an option would be preferred, a well-elaborated set of rules either at a national level (by means of general guidelines of the body of the Prosecutors-general), either at local level (by specific guidelines of the local prosecutor,<sup>57</sup> or even oral agreements between the DCR

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<sup>57</sup> In this respect, the current prosecutorial guidelines on drug-related offences, already allow for specific guidelines to be issued by the local prosecutor (taking into account for example local circumstances). See COL 15/2015, 5.4.2.

management and the local police, as is the case for instance in Paris) could therefore be drafted in order for them to be applied as generally as possible.

As regards the compatibility of such prosecutorial guidelines with the obligation of the police to report on any offence of which they have knowledge,<sup>58</sup> the following clarifications should be made. The apparent contradiction between on the one hand the basic obligation for police to report an offence to the prosecutor and, on the other hand, a general guideline that would entail a policy of tolerance towards possession of certain illegal substances for personal use in a DCR, is not—or at least less—present in case of an *autonomous police intervention*, which in the Belgian criminal procedure takes the form of either the autonomous police investigation (“ambtshalve politioneel onderzoek”) or the simplified police report (“vereenvoudigd proces-verbaal”).

Article 28bis, paragraph 1, 3° Criminal Procedure Code (CPC) is the basic legal provision governing the autonomous police intervention. According to this Article, the prosecutor, who has sole responsibility, leads the investigation. According to Article 28bis, paragraph 3, in fine CPC, the prosecutor guarantees the lawfulness of the evidence and its loyal gathering. According to Article 26 CPC, the prosecutor can issue general guidelines necessarily for exercising the tasks of traditional police. Besides those cases where the police acts on demand of the prosecutor, Article 28ter §2 CPC allows police to act on their own initiative, after which they are obliged to inform the prosecutor within a certain period of time and in the way determined by the prosecutor (in the form of guidelines). As mentioned before, Article 29 CPC (as well as Articles 15-1 and 40 of the law on the police statute) provides a principal obligation for police officers that gain knowledge of an offence, to immediately report to the prosecutor. The Court of Cassation has, however, ruled that Article 29 CPC nor any other legal provision, or an essential rule of criminal procedure, impedes a police officer, which gains knowledge of an offence while on duty, to begin and continue his detection, without reporting to the prosecutor in advance and immediately.<sup>59</sup>

As a result, the general responsibility of the prosecutor does not impede police officers to act autonomously within the general framework determined by the prosecutorial guidelines regarding this autonomous investigation (see COL 8/2005). The main application of this autonomous intervention is the aforementioned “autonomous police investigation”. At present, the prosecutorial policy on drug offences already recognises the autonomy of the police with regard to offences of possession for personal use (with no aggravating circumstances) of illegal substances (other than a small amount of cannabis). For such offences, the police will carry out a simplified investigation, after which the report will be sent to the prosecutor who will then determine the consequence.

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<sup>58</sup> Article 29 criminal procedure code (CPC) and Articles 15-1° and 40 of the law of 5 August 1992 on the police statute.

<sup>59</sup> Cass. 25 April 1989, as confirmed in the case law of 23 March, 6 and 7 July 1999 and 22 August 2001.

The second option (extend the current list of offences for which a simplified police report is used to include possession for personal use in a DCR) can be seen as a specific modality of the autonomous police intervention as described above. The so-called simplified police report (“vereenvoudigd proces-verbaal”) is a specific form of autonomous police intervention, which is defined as a registration by computerised means of the most important material elements of offences that are considered ‘relatively less serious’.<sup>60</sup> The limited list of offences with regard to which this procedure is applicable, is determined in an annex to the COL 8/2005 (annex 3). The simplified police report contains the reference number of the investigation (the so-called “notitienummer”), the place and date of the facts, the nature of the facts, the identity of the complainer or declarant, the damage, the modus operandi, the identity of the offender(s) and witness(es) and, in summary, their version of the facts. This means that the persons involved give an actual statement, although this is not registered extensively. The simplified police reports are in principle not sent to the prosecutor, unless it is requested or unless new elements are found which necessitate the drafting of a normal police report. Every month the police services draft a list of the simplified police reports that were registered in the previous month and send this list to the prosecutor.<sup>61</sup>

In sum, taking into account the foregoing elements, and with the aim of maximising the (legal) certainty —both for the users and the police—the most obvious option would seem to be the issuing of guidelines demanding the (local) police not to intervene towards those users in and outside (within a well-defined perimeter) the DCR, if certain conditions are met (e.g., no public nuisance or aggravating circumstances). As long as the police would follow these guidelines, their (autonomous) decision not to intervene in the particular circumstances, would not be incompatible with the current legal principles regarding their professional responsibility. Moreover, if specific prosecutorial guidelines would not be feasible, local agreements between the competent authorities and the DCR (even on an oral basis) could provide a sufficient basis for the DCR to operate. If the option of non-intervention is not desirable, it should be considered to *at least* extend the system of a simplified police report for the possession of the substances *outside* of the DCR for those users who can be linked to the specific DCR (by means of a registration system). Such an option would of course require an intense collaboration between the police and the DCR in order to identify the users illegible for such an alternative police registration (e.g. by means of an ID-card) and would further require a workable definition of the perimeter in which the police would be asked to intervene in this alternative way. Moreover, this last option would necessarily have to be combined with certain measures to guarantee a *de facto*

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<sup>60</sup> COL 8/2005, p.19.

<sup>61</sup> COL 8/2005, p.19-23.

*tolerance within* the facility. This would again require well-elaborated local agreements between the prosecutor, the police and the DCR stipulating the specific conditions and the practical implementation of such an agreement.

#### **b. Cooperation protocol**

Given the sensitive nature of DCRs and its delicate implementation into local communities, it is of the utmost importance to strive towards a cooperation protocol or accord between the relevant actors. This accord would ideally be established between the management of the DCR, the administrative authorities (mayor), the judicial authorities (prosecutor-police) and the treatment services (including medical institutions). The accord may prove essential in the successful establishment of a DCR in a local community, by containing agreements on the following issues:

- The in-house rules of the DCR, including, in particular, a strict prohibition of sharing of or trade in drugs as well as the avoidance of public nuisance;
- Specific agreements on referral of users towards the most appropriate agencies or institutions with the basic aim of providing for a balanced treatment and social (re)integration;
- Specific rules on supervision and action by the police, for example focusing on the question on the perimeter in which the police would refrain from action towards users (and which ideally would be determined locally, on a case by case basis);
- The mutual respect for treatment services and law enforcement authorities acknowledging their different finality and guaranteeing, for example, the professional secrecy;
- Specific and regular consultation with the local community, represented by ordinary citizens;
- Specific regulations on the medical supervision of the DCR by medical staff, specially trained for dealing with medical emergencies relating to drug use.

#### **3.3.4 The case for an integrated model**

In order to increase the legal sustainability of the DCR-concept in the Belgian context, a strong case should be made for an integrated model when implementing the DCR. As discussed above, the UNODC and the INCB have indicated that, for DCRs to be recognised as an acceptable harm reduction measure and thus being compatible with the UN drug conventions regime, DCRs should be ‘integrated’ to the maximum extent possible. This integration should be done at two levels. First, it requires a recognition of and respect for the local community in which the DCR would be embedded, since taking account of the local circumstances will be key to the success and acceptance of a DCR on the local level. Second, the integration must work at an organisational level, meaning that the DCR model would include a range of health, treatment and social integration services.

### 3.4 Civil liability aspects

The concern about drug-related deaths is one of the main factors in the debate about the added value of DCRs. By providing safety-related rules, supervision of the injecting process and medically trained staff, the evidence shows that overdose deaths can be prevented. The same goes for non-fatal overdoses, which are frequently associated with serious health implications for users and drawing on ambulance and hospitals resources. Nevertheless, given the delicate nature of the activities within the DCRs, emergencies and damage cases connected to the use of drugs, in particular the occurrence of overdose is a realistic risk. The large majority of reported emergencies within DCRs are overdoses relating to heroin. The most frequent way in which heroin overdose causes immediate death is through respiratory depression, often in combination with other drugs, particularly alcohol (JRF, 2006). DCRs can therefore prevent deaths through aiding user's breathing and administering Naloxone. Because of the fact that medical emergencies are a realistic scenario in DCRs, due attention should be paid to the question of the responsibility and the liability of people and/or institutions connected to the DCR. In what follows, the various and most likely damage claims will be dealt with, together with the relevant criteria for dealing with such claims and possible measures to minimise the risk, although it will, of course, never be possible to exclude the possibility of a claim all together.

Given the fact that overdose or other serious injury cases may occur within the setting of a DCR, a first possible claim could be based on the general principles of civil liability of those concerned. Take for example the situation where a user would—in violation of the house rules—directly inject another user with heroin, resulting in the death of the latter. In that case, the injector may be guilty of manslaughter. Moreover, a person may also be liable for manslaughter if they assisted another in the injection process. This could potentially lead to a charge of DCRs' employees to be charged with manslaughter if they would act in circumstances that constitute assisting another in an unlawful injection process and death from heroin intoxication results. Besides criminal prosecution, the family of the deceased could mount a civil action, for example, if there were evidence of negligence. In the same sense, those running DCRs could be subject to civil liability, if things would go wrong, for example, if a user died or if a member of staff was injured in negligent circumstances. A civil claim could be successful, if there were evidence that the management of the DCR did not meet health and safety requirements and did not succeed in protecting their employees from injury. On similar grounds, a civil claim directed towards the local government, on whose territory the DCR operates, would be feasible if there were evidence that the responsible authorities did not meet the necessary requirements regarding supervision and control of the DCR and its activities, resulting in damage to users or third parties such as inhabitants from the neighbourhood, etc. Therefore, it is important in the context of this feasibility study to go into these various types of civil damage claims.

### **3.4.1 The drug consumption room and its staff**

#### **a. General principles**

A damage case resulting in injury or death of a user could lead to a claim of a third party (or even the user) towards the DCR and/or its staff members (or, depending on the circumstances, a claim of the staff towards the DCR). Such a claim would be subject to the general principles regarding civil liability (Tort). The basic criterion in this respect is the *general cautionary norm*. According to this criterion, the concrete behaviour of those held responsible, will be checked against a (reference) norm, the so-called *bonus pater familias* norm—meaning the behaviour of a normal, careful and forward-looking person (Vansweevelt & Weyts, 2009). This reference norm is an abstract and objective criterion, which is interpreted in a reasonable way.

In order for the claimant to be compensated, he or she would be required to deliver proof of the *error*, the *damage* as well as the *causality* between them (see Article 1382 Civil Code). The error criterion will be judged according to the factual circumstances of the concrete case. It is important in this respect to note that, in considering whether the general cautionary norm is respected, the *professional competence* of those concerned will be taken into account. The damaging behaviour of a person will be checked against the normal, forward-looking and careful behaviour of those belonging to the same professional category. Consequently, specific obligations are imposed by the jurisprudence depending on the type of profession (for example the obligation to provide information in case of a doctor).

#### **b. Victim responsibility**

In Belgian Tort law, it is generally accepted that a victim should be held responsible for the damage when the person concerned has knowingly and willingly subjected himself to a dangerous situation and as such is deemed to have accepted its risks (Vansweevelt & Weyts, 2009). Whenever there is evidence that the victim has acted carelessly, the risk taken by the victim can be taken into account. Given the inherent risk connected to drug use—even within the setting of DCR—it could be expected that any claim of the victim or its relatives, would be met by a defence according to this principle, especially if there is evidence that the user has not respected the house rules or has used the drugs carelessly.

#### **c. Liability for appointees**

Since a DCR would frequently work with certain appointees, it should be added that this could lead to a specific form of claim directed towards the DCR, based on the principle of Article 1384, 3°, Civil Code.

According to this principle, a harmful act by appointees can lead to liability of those who appointed them, if three conditions are met. Firstly, a bound of subordination needs to be proven, meaning that a person has the factual possibility to supervise another person's act. Secondly, the appointee must have made an error that has damaged a third party (for the criterion against which the act will be checked; see above). Thirdly, the harmful act must have taken place in connection to the service of the appointee (Vansweevelt & Weyts, 2009, p. 399). An exception should be made to the foregoing principle for those who are considered employees. On the grounds of Article 18 of the Labour Law, employees that commit a harmful act damaging a third party (or its employer) while performing their duty according to the contract, can only be held liable for fraud, grave error and frequently occurring minor errors (Vansweevelt & Weyts, 2009, p. 426).

#### **d. Possible measures**

In order to provide a maximum protection against the various civil claims as mentioned above, a central aim of the DCR must be to guarantee circumstances that would make it difficult—or even impossible—for a claimant to prove that the negligent behaviour of the management of the DCR or its staff, are a sufficient ground to conclude to their civil liability. The DCR should therefore take all measures to provide clean injecting equipment, a clean environment in which to inject, a clear code of conduct and some clinical supervision of the injecting process. House rules and regulations, such as the prohibition of the sharing of injection equipment and injecting in the neck, should be instituted and controlled through the supervision of the consumption process. DCRs should thus be monitored (independently) on a regular basis, guaranteeing a regular observation of their operation, the process of supervision and the enforcement of house rules.

More in particular, the house rules would need to take due account of certain basic rules, such as a detailed and continuous *education* of the users about all possible ways to prevent damage, as well as carefully defining and limiting the level and nature of help offered to injectors by staff (including the provision of paraphernalia). The rules would also need to carefully govern the safe disposal of needles, to prevent injury to staff or users, and the acts that should be taken if users leave behind suspected drugs. Moreover, clear written procedures would need to be set out for responding to overdose incidents. A possible measure in this respect could be the signing of a *contract* between the DCR and the users, which should be drafted in such a way as to stress the responsibility of the users and to minimise the risk of the DCR and its staff toward possible future claims.

Finally, in order to prevent any of the non-medical staff to be prosecuted on the grounds of unlawful practice of a (legally protected) health care profession, it is essential to ensure that a doctor or nurse *exclusively* performs any of the following acts:<sup>62</sup>

- Acts seen as the practise of medicine (to be performed exclusively by doctors):<sup>63</sup>
  - o The sale and offering, even free of charge, of medicines;
  - o Giving information and advice on medicines, including the proper use;
  - o Personalised assistance of patients who use their own medicines;
- Acts seen as the practise of nursing:<sup>64</sup>
  - o Observing, recognising and determining the health status, either on psychological, physical or social level;
  - o Informing and advising patients and their family;
  - o Continuously assisting, performing and helping to perform those acts, by which the nurse aims for the preservation, improvement and recovery of the health of healthy and ill persons and groups;
  - o Being able to take urgent life-saving measures independently and being able to act in cases of crisis or disasters.

### **3.4.2 The local government**

A civil claim may also be directed towards the local administrative authorities, based on the general principle in Belgian Tort law (Article 1382 Civil Code). It is generally excepted that an error of the executing branch can lead to its civil liability, whereby the criterion against which this error should be checked is similar to what is described above (the general cautionary norm). Consequently, the behaviour of the authorities will be checked against the (objective and abstract) behaviour of a normal and careful authority. The same principles and possible measures to be taken for providing a guarantee against such claims as mentioned above, are applicable in this respect. As a result, a claimant would have to deliver substantial proof of the fact that a government *has failed manifestly* in its duties towards a proper functioning of a DCR. Although this means that the burden of proof would be quite high for a claimant, when establishing a DCR, the local government authorities should pay due attention to their supervising role, meaning that a robust set of rules should be agreed between the local government and DCR.

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<sup>62</sup> See Articles 3-5 and 45-46 of the Law of 10 May 2015 on health care professions, B.S. 18.06.2015.

<sup>63</sup> Article 5/1, 1°, 8° and 10°.

<sup>64</sup> Article 46, paragraph 1, 1°, a), d), e) and f).



### 3.5 Criminal negligence

According to Belgian criminal law, every citizen has a duty—based on a general and moral solidarity requirement—to come to aid of those who are in grave danger (“schuldig verzuim”, Article 422bis Criminal Code). In case of a drug-related overdose occurring in a DCR, there is a realistic possibility that either the staff or the fellow users could be prosecuted on this ground. Therefore, in drafting the house rules and in training the component staff, every person concerned should be made aware of the general principles regarding this particular offence.

Criminal negligence (as described in Article 422bis Criminal Code) requires four constitutive elements (De Nauw, 2010). Firstly, the victim has to be in grave danger. This requires a situation where the individual is threatened in his personal integrity without having to be in mortal danger. The danger has to be serious, constant, real and factual. It is important to know that the obligation to provide help still exists for those who are dying, even when there is little or non-existing hope to save the person<sup>65</sup>. Only when the person has deceased, for example as result of a drug overdose, the obligation is deemed to stop<sup>66</sup>. It is irrespective who is the cause of the danger (the victim, a third party, circumstances independent of the person or the perpetrator of the criminal negligence himself). Secondly, the person who refuses to lend assistance, has either determined the situation himself or has been described the situation by others who call upon his help. It is therefore required that the person knows about the danger, before he can be expected to come to assistance. According to the jurisprudence, any person in great danger should be helped, without taking account of the possible degree of effectiveness of the requested help.<sup>67</sup> There is no criminal negligence when the defendant has immediately tried to help, even if the help was not successful, effective or even clumsy.<sup>68</sup> Thirdly, a moral element is required. The offence of criminal negligence does not require a special purpose. It suffices that the person knowingly and willingly has failed to lend assistance. Jurisprudence will take account of factual circumstances to assume that the defendant should have realised that the consequences for the victim were serious. Fourthly, the defendant was able to help without grave danger for himself or others. The law does not define the concept of grave danger, so that will be considered taking into account all factual circumstances.

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<sup>65</sup> Brussel 20 april 1966, *J. T.* 1966, 406.

<sup>66</sup> Corr. Brussel 11 april 2003, *J. T.* 2003, 585.

<sup>67</sup> Cass. 9 november 1964, *Pas.* 1965, I, 242.

<sup>68</sup> Antwerpen 27 mei 1981, *R.W.* 1983-1984, 1899; Corr. Gent 30 september 1988, *T.G.R.* 1988, 179; Luik 25 juni 1968, *Jur. Liège*, 1986, 674.

### 3.6 Medical liability

DCRs vary in the level of medical supervision that they provide. Some have nursing staff and/or a doctor present at all times, allowing immediate and early response to overdose incidents, by having available a fully equipped emergency room and staff on-site able to administer Naloxone. Other DCRs have doctor and/or nurses working with them. In these cases, there is variation in their ability to provide on-site intervention in emergencies and, in some cases, a greater reliance on ambulance call-outs to treat overdose cases (JRF, 2006). Depending on which model would be implemented when establishing a DCR—either providing a continuous medical supervision and presence of a doctor, or working with a doctor who is required to supervise in a more general way—it is important to take into account some general principles regarding the liability of the doctors, and/or medical staff (Vansweevelt, 1997).

The general principle applicable in this respect is the aforementioned general cautionary norm (Article 1382 Civil Code). Consequently, the same criterion and relevant elements are applicable as those described above. Additionally, some specific requirements are bestowed upon medical professionals. For example, whenever a doctor is confronted with a case, he is required to take all necessary measures to make a correct diagnose. This requires a thorough examination of the patient, often requiring the doctor to perform a *physical* examination and not merely dealing with the case by telephone. In case of an overdose, there can be therefore no doubt that, given the urgent character of the situation, the doctor is required to immediately perform a physical examination of the patient. Furthermore, from the moment that the doctor has examined the patient, he is considered to be the doctor in charge, meaning that he has the obligation to follow-up the condition of the patient until the moment when another doctor in charge would take over (for example when the patient is taken to the emergency service of a hospital).

Doctors and medical staff should be particularly aware of the specific requirements bestowed upon them in the context of the aforementioned offence of criminal negligence. As described above, one of the constitutive elements is that there is a general obligation to help a person when one knows about the danger. This can prove delicate in the case of doctors, who are requested by telephone to help a patient that is not known to them. It has frequently been ruled that doctors have the professional obligation to get a clear image of the situation whenever their assistance is requested. Doctors are professionally required to lend effective assistance or to take all necessary measures in order to allow the treatment of the patient (De Nauw, 2010, p. 232). As is the case for police officers, the moral element applicable in the context of criminal negligence is interpreted more strictly depending of their profession (Herbots & Put, 2013).

### **Box 7. The Belgian framework**

A reason why a solid legal framework is essential stems from the fact that the implementation of DCRs in Belgium would lead to a number of legal questions, particularly related to their ‘facilitating’ effect, the ‘illegal possession’ by service users, and ‘public safety and order’ concerns. It is therefore required that the implementation strategy deals with these legal issues in order to provide a maximum level of legal protection for a (management of the) DCR, its staff, and the service users. Three options for legally implementing DCRs in Belgium are identified, whereby the feasibility of each option is determined by the time span for implementation and the amount of political support. In any of the foregoing options, it is necessary to complement the implementation with an amendment to the prosecutorial guidelines on drug-related offences. Furthermore, it is important to take a broad range of measures in order to effectively minimise the risk of (civil and criminal) liability, thus offering a sufficient level of protection for the staff, the service users, and the local government.

## **4. CONCLUSIONS AND RECOMMENDATIONS**

The establishment of DCRs leads to a number of legal questions. The research and the example of neighbouring countries have led to the following conclusions and recommendations.

### **4.1 The international perspective**

Although there is no clear guidance on the concept of DCRs in the UN Drug Conventions, an analysis of the relevant texts leads to the conclusion that *the Conventions do not form a legal obstacle for the implementation of DCRs*. The *explicit emphasis on the general health and welfare of people* (including the rehabilitation and integration of PWUD) in the UN Drug Conventions is essential in understanding the significance of the exceptions (‘medical and scientific purposes’) to the main (prohibitionist) principle as enshrined in article 4 of the 1961 Convention and the later treaties. When tackling the question regarding the compatibility of DCRs with the UN Drug Conventions, it is therefore important to stress that the Conventions are health-oriented treaties. Given this, there is latitude within the conventions for the introduction of harm reduction measures that aim to improve the health of users and contribute to their welfare, rehabilitation and reintegration. *As long as their implementation aims to reduce the adverse consequences of problematic drug use, this (extreme) form of harm reduction can be reconciled with the general principle of medical purposes as enshrined in the Drug Conventions.*

In 2002, the UN’s legal experts concluded that it seems clear that, in establishing DCRs, it is the intention of governments to provide healthier conditions for PWUD. When implementing DCRs, a Government could use the expediency principle in order not to prosecute the related possession of illegal drugs for personal use. The Government should however, in implementing and/or supporting DCRs, strive towards a loyal enforcement of the Conventions in good faith.

Recommendation 1: any debate on the implementation of DCRs should take account of the health-oriented nature of the UN Drug Conventions as well the international legal framework on harm reduction (such as the UN Resolutions UNGASS 1998 and UNGASS 2016 as well as the EU Action Plan on Drugs 2017-20).

A historic analysis of the INCB’s view towards DCRs shows a (recent) shift from a principal objection to a more pragmatic approach. Increasingly, the INCB’s primary concern is the way in which these facilities are implemented, stressing the need for an integrated approach.

Recommendation 2: in order for DCRs to be most compliant with the UN Drug Conventions, as supervised by the INCB, their implementation should be done—to the maximum extent—along an integrated model, offering treatment, health, social integration services primarily aimed at the welfare, rehabilitation, reintegration and referral of the users.

## 4.2 The national perspective

Belgian Drug Policy is already to a large extent based on the principles that form the underlying incentives of DCRs, such as the *ultimum remedium* principle and a multidisciplinary approach aimed at harm reduction as part of an integral assistance strategy based on a *health improving perspective*. The implementation of DCRs in Belgium would lead to a number of legal questions, particularly related to their ‘facilitating’ effect, the ‘illegal possession’ by users and ‘public safety and order’ concerns. It is therefore required that any implementation strategy deals with these legal issues in order to provide a maximum level of legal protection for the (management of the) DCR, its staff and the users. Three options for legally implementing DCRs in Belgium have been found, whereby the feasibility of each option is determined by the time span for its implementation and the amount of political support.

***A first option would be to provide an explicit exception to the principle embedded in Article 3 paragraph 2 of the law of 24 February 1921, thus creating an explicit legal basis for DCR to operate.***

This option would imply a long-term implementation and would therefore require a considerable amount of political support.

Recommendation 3: if a statutory protection/recognition would be opted for, the legislative implementation of France would provide a good example of the way in which primary legislation (allowing for the establishment of the DCR and providing protection to clients and staff in the law of 24 February 1921) can be combined with secondary legislation (stipulating the preconditions and criteria in order for a DCR to be legally protected in a Royal Decree). The ten minimum criteria as introduced in the German legislation could also be a useful inspiration in this respect.

If statutory protection by means of primary legislation would not be possible—or while awaiting the legislative process—***a second option to establish DCRs could be to modify the reach of Article 3, § 2 of the law of 24 February 1921 by means of a royal decree***, on the grounds that these facilities would act as a specific harm reduction measure aimed at protecting the health of the users, justifying an exception to the application of the offence as mentioned in Article 3, paragraph 2 (a) and, as such, providing a significant degree of protection from prosecution under the basic law. This option would imply a mid-long-term implementation and would require a medium amount of political support.

***As a third possible option, the implementation of DCRs could be considered—without prior legislative changes—in the form of a (temporary) scientific or medical experiment (pilot)***. This pilot would not only be in accordance with the general aim of the UN Drug Conventions—to limit the use of drugs to scientific or medical purposes—but would also meet the recommendations of the UNGASS resolutions (of 1998 and 2016) and the recommendation of the WHO in its 2012 technical guide to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Possibly, such an initiative could seek ministerial authorisation (e.g. by the Minister of Health). This option would imply a short-term implementation and would require a limited amount of political support.

In any of the foregoing options, ***it is deemed necessary to complement the implementation with an amendment to the prosecutorial guidelines on drug-related offences*** (see COL 15/2015) in order for the users to be freely able to possess a small amount of illicit drugs for personal use in the facility. There are basically two options in this respect. Firstly, a general instruction at the national (by guidelines of the Minister of Justice and/or the Body of Prosecutors-general) or local (by specific guidelines of the Prosecutor) level demanding local law enforcement authorities not to intervene in (i.e. to tolerate) those situations where it is established that the person concerned is merely in

possession for personal use in (the perimeter of) the DCR (to be considered according to a set of criteria and/or indications). In the absence of such general instructions, local (and even oral) agreements between the DCR management and the local law enforcement authorities (especially the local police) could be concluded. Secondly, the extension of the ‘simplified police registration’ method, for those found in possession of a small amount of illegal substances (other than cannabis) for personal use in the perimeter of the DCR, thus, in principle, avoiding prosecution.

Recommendation 4: the prosecutorial policy and subsequent agreements on (non- or soft) police intervention should include a clear definition of and/or criteria on the ‘perimeter’ in which no or an alternative action would be taken (in and outside the facility), as well as specific preconditions such as the absence of indications regarding sale or other aggravating circumstances as well as public nuisance.

Recommendation 5: the foregoing options would require a full cooperation between DCRs and the local law enforcement authorities, e.g. by guaranteeing a clear procedure of registration of users.

Recommendation 6: any change in the prosecutorial guidelines would also have to take account of the need to provide (new) rules on the seizure of the (illicit) drugs for personal use in the DCR, as well as the relevant paraphernalia (additional to those already excluded from seizure according to COL 15/2015).

**A cooperation protocol or accord between the relevant actors** should be made for each location where a DCR would be established. This would include the management of the DCR, the administrative authorities (mayor), the law enforcement authorities (prosecutor and police) and the relevant treatment services (including medical institutions).

Even when legal initiatives would be taken to protect the DCR, its staff and the users from prosecution for drug-related offences, the risk for damage claims resulting from drug-related deaths or serious health damage is real. **A number of measures could, however, be taken to minimise the risk and to provide a sufficient level of protection** against (civil) claims against DCRs, its staff, the users and the local (administrative) government.

Recommendation 7: the DCR should provide clean injecting equipment and other relevant paraphernalia, a clean environment in which to inject, a clear code of conduct and some clinical supervision of the injecting/administration process. House rules and regulations, such as the

prohibition of the sharing of injection equipment and injecting in the neck, should be instituted and controlled through the supervision of the injecting/administration process. DCRs should be evaluated (independently) on a regular basis, guaranteeing a regular observation of their operation, the process of supervision and the enforcement of house rules. More in particular, the house rules should need to take due account of certain basic rules, such as a detailed and continuous informing of the users about all possible ways to prevent damage, as well as carefully defining and limiting the level and nature of help offered to injectors/users by staff (including the provision of paraphernalia). The rules would also need to carefully govern the safe disposal of needles, to prevent injury to staff or users, and the acts that should be taken if users leave behind suspected drugs. Moreover, clear procedures would need to be set out for responding to overdose incidents. Finally, a contract between the DCR and the users could be drafted in such a way as to stress the responsibility of the users and to minimise the risk of the DCR and its staff toward possible future claims.

Recommendation 8: an essential measure should be to strictly limit the nature of intervention by the (medical) staff when supervising the injection/administration by users. Any form of active assistance during the injecting/administration should be ruled out, in order to avoid (criminal and/or civil) liability, thereby taking into account the relevant provisions of the law of 10 May 2015 on health professions.

Recommendation 9: it should be considered to agree on specific rules between the local administrative bodies and the DCR, with the aim of minimising the risk for a damage claim against the local government.

Recommendation 10: specific training should be provided to the staff working in or with the DCR, raising awareness on the specific criteria regarding (medical) liability, in particular regarding accusations of criminal negligence.





# CHAPTER III

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## **OPERATIONAL AND ORGANISATIONAL CONSIDERATIONS**

*Louis Favril*

*Freya Vander Laenen*



## CHAPTER 3

# OPERATIONAL AND ORGANISATIONAL CONSIDERATIONS

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### 1. AIMS AND METHODOLOGY

Existing DCRs worldwide share a number of common features and core operational elements, yet they also differ greatly in terms of many aspects of design, operations and programme delivery policies. For example, while facilities like the Sydney or Vancouver DCR have a mainly ‘medicalized’ design and focus on actual drug consumption, many of the European facilities are designed more broadly as social and health services in which supervised drug consumption constitutes just one among many interventions provided (Fischer & Allard, 2007). Therefore, an important decision when establishing a DCR is whether to focus on services that are related to drug use or to also include a variety of services that address a broader range of health and social needs. Decisions about which services to offer will also depend on the availability of services offered by other programmes, whether a DCR is integrated into another service or is affiliated with other health facilities, and the local context. Design considerations include days and hours of operation and the number of spaces for clients to inject drugs or for smoking or other non-inhalation routes of drug use. Another consideration is whether a DCR should accommodate both supervised injection and smoking and, if so, whether and how these types of drug use should be separated. In this chapter, we focus on two key research questions for considering how a DCR might be implemented:

1. What are the important design considerations when establishing a DCR?
2. What are the possible models that a DCR could consider?

In order to answer these research questions, we first reviewed the international literature focusing on practical, operational and organisational issues (e.g., design, service provision, rules, and referrals). This review was conducted as a basis for considering potential models of service delivery for DCRs. The review primarily draws on organisational overviews of DCRs worldwide (Belackova *et al.*, 2017; Hedrich, 2004; Hunt, 2006c; Kimber, Dolan, & Wodak, 2005; Schatz & Nougier, 2012; Woods, 2014) as well as country-level reports focussing on operation and service delivery (Havinga & van der Poel, 2011; Schäffer & Stöver, 2011). This was supplemented by additional information from the internet (e.g., the *International Network of Drug Consumption Rooms*) and grey literature. Secondly, on-site visits and interviews with local DCR managers were conducted in Paris (1), Frankfurt (2), Amsterdam (2), and Luxembourg (1).

## 2. CROSS-NATIONAL OVERVIEW

To our knowledge, only two studies have been carried out across European countries, mapping the organisational and practical aspects of operating DCRs. These surveys, however, do not differentiate findings by country. In 1999–2000, a first survey was conducted in 15 European DCRs (the Netherlands, Germany, Spain and Switzerland) by Kimber and colleagues (2005). More recently, an update was conducted by Woods (2014), providing an organisational overview based on a survey among managers of 39 DCRs located in six European countries (Denmark, Germany, Luxembourg, Norway, Spain and Switzerland). The latter report did not include Dutch DCRs, but integrated results from an earlier survey covering 30 DCRs in the Netherlands (Havinga & van der Poel, 2011). In 2016, a survey was conducted by the *International Network of Drug Consumption Rooms* (Belackova *et al.*, 2017), mapping various organisational characteristics of DCRs worldwide. This recent report included 51 responses from DCR representatives of the (at that time) 92 operating facilities in Australia, Canada, Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland. Over half of all DCRs were represented (55%), and all countries where at least one DCR operated at the time of the survey were represented. Below, in order to provide a cross-national overview of DCRs operating worldwide, findings from this latter study are briefly summarized. Unless otherwise specified, data relate to this survey; wherever deemed useful and necessary, results are supplemented by the report of Woods (2014).

### 2.1 Goals and objectives

No details regarding objectives were included in the survey by Belackova *et al.* (2017). In the European survey by Woods (2014), the vast majority (91.2%) solely named ‘health damage reduction’ as the most important goal of the DCR. Two respondents considered both nuisance reduction and health damage reduction to be their primary goals, and only one out of 34 responded its primary goal to be ‘keeping those who do not fit in the streetscape off the streets’. To the question on what the primary motivation for the foundation of the DCR was, 63.6% of respondents cited improving the health status of the target group. Contrastingly, 27.3% said that the reduction of public disorder was their primary motive.

### 2.2 Location and DCR model

In the worldwide survey, the majority of DCRs are located in the centre of town (74%), and/or near a major travel hub (54%) as well as within the boundaries of an established street-based drug scene (48%). A large proportion of them were co-located (integrated) with other services used by DCR clients (57%). Only a minority of DCRs were a stand-alone programme (30%), operated a mobile service (20%), or were situated on the periphery of a city/town (13%).

## 2.3 Operation and funding

The majority of the DCRs in the survey were operated by a not-for profit organisation (67%), followed by local, regional or national government (40%); additional 4% were operated under a contract with a government. A rather small proportion of DCRs in the survey were operated by a private entity (7%) and only one programme was operated by a charity or religious organisation. There were no primarily peer-driven DCRs in the survey. Irrespective of the service operator, the majority of DCRs were funded from a local (municipal) government budget (71%), followed by a state/regional government (36%) and, lastly, national government (13%). Nine per cent received (additional) funding from a charity or religious organisation or through social or drug service subsidies (4%). Proportions of co-financing (the total percentage surpasses 100%) were not reported.

No specific numbers of funding and budget were available in any survey. In 1999–2000, the median annual budget of fifteen DCRs across Europa was €440,650 (oscillating between €164,300 and €859,268), and funding was sourced predominantly from local and State governments (Kimber *et al.*, 2005). Other cost data on European services are not publically available to our knowledge (see BOX 8).

## 2.4 Capacity and throughput

From the DCRs that answered a set of questions on service provision, all except one provided spaces for injecting ( $n = 42$ ), the majority also had spaces for smoking ( $n = 31$ ), and about half had spaces for sniffing ( $n = 22$ ). Of the 34 services in the sample who allowed for at least two different means of drug administration (injecting combined with sniffing and/or smoking), 20 of them (58%) had separate spots for each and four services made it explicit that they had them placed in separate rooms. The mean number of spaces for safe and hygienic drug consumption in the DCRs was 6 spaces per each means of administration (injecting: 1–23; smoking: 1–40; inhaling: 1–16). Approximately 72 visits were made each day at a DCR to inject (1–296), 51 visits to smoke (3–260) and 12 visits to snort/inhale (1–60).

Similarly, the survey by Woods (2014) shows that most DCRs throughout Europe offer places for intravenous drug use as well as for smoking/inhaling substances. On average, DCRs offer between 7 and 8 intravenous drug use places and between 6 and 7 drug-smoking places. The amount of drug-smoking places on offer ranges from 2 to 14, with seven locations (21.2%) offering no smoking facilities at all. The number of daily visitors varied widely—between 20 and 400—with six of the facilities catering for more than 200 clients a day. These findings are consistent with the earlier survey by Kimber and colleagues (2005), reporting that, in fifteen European DCRs, the number of places for injecting ranged from 3–12; six centres also provided places for smoking (with a range of 3–6 places); and the median number of average visits per day was 100 and ranged from 25 to 400 per day.

### Box 8. Cost estimates from DCRs in Canada and Australia

Cost data are typically not provided for European DCRs, and only Australian and Canadian specialised facilities provide detailed cost data. According to Health Canada (2008), the annual operating cost of the *Insite* service (a stand-alone facility) is estimated to be \$3,000,000 (including the cost of the syringe exchange programme) or \$14.00 per client visit, and similar numbers are reported for 2015.<sup>69</sup> The cost per individual who used *Insite* for IDU was, on a yearly basis, \$1,380. Financial cost evaluation of current operation of Sydney's Medically Supervised Injecting Centre (MSIC) shows that the set-up costs of the (stand-alone) facility were \$1,334,041; the operating costs for the first year were \$1,995,784; and budgeted costs for 12 months were \$2,420,214. In the initial year of operation, the cost was \$63.01 per client visit and assuming increased uptake and efficiency, it is estimated that the cost per client visit will drop to \$37.23 in the second year of operation (MSIC, 2003). More details on initial set-up costs, set-up costs since opening, and operating costs in the first year for the Sydney DCR are provided in the final evaluation report (MSIC, 2003).

According to Andresen and Boyd (2010), the \$3,000,000 annual operating cost of *Insite* is 'all-inclusive'; this cost estimate includes such services as addiction counselling and case management, the provision of primary healthcare, public health screening (immunisations and diagnostics), addiction and housing services, education, and peer counselling. Instead, the annual operational cost of the DCR-portion of *Insite* amounts to \$1.5 million; a figure they used in their cost-benefit and cost-effectiveness analysis because it only considers the operational costs of the DCR portion of *Insite* (Andresen & Boyd, 2010). In their cost-benefit analysis of a potential DCR in San Francisco, Irwin and colleagues (2017a) found that a single DCR in San Francisco with 13 injection booths (the same as Vancouver's *Insite*) would cost an estimated \$2.6 million per year to operate, which includes \$2.4 million in operating costs and \$220,000 in annualized upfront costs.<sup>70</sup> The same authors made a similar calculation for the city of Baltimore in the United States (Irwin *et al.*, 2017b), where their estimate of the total annual cost was \$1.79 million, including \$1.62 million in operating costs and \$170,000 in annualized upfront costs.

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<sup>69</sup> According to Vancouver Coastal Health, the operating budget of the *Insite* service in 2015 was \$2,938,665 with 263,713 visits to the site by 6,532 unique individuals in that year.

<sup>70</sup> These calculations were computed based on *Insite* in Vancouver: a facility occupying roughly 1,000 square feet, provides 13 booths for clients, and operates 18 hours a day. *Insite* serves about 1,700 unique individuals per month, who perform roughly 220,000 injections per year. More details of calculations can be found in Irwin *et al.* (2017a).

## 2.5 Admission criteria and intake procedure

The majority of DCRs worldwide pertained to a minimum age (87%), to having an established drug dependence or drug use (67%) and to previous experience in IDU (20%). In about half of the DCRs, the use of the service was limited to a specific drug (49%) and/or to the residents of a specific area (27%). While most facilities worldwide allow access to clients on an anonymous basis, about one-third of DCRs require their clients to present with a national ID (31%); i.e., a non-anonymous identification. Other, less common criteria included being homeless ( $n = 2$ ), no pregnancy ( $n = 3$ ) or no current medication-assisted treatment like OST ( $n = 3$ ).

The clients often had to undergo an entry interview (62%) or a registration survey (56%) and in some services, to sign a “terms of use” document *upon their first visit* (56%). In addition, several other criteria applied to *each DRC visit*—most notably, these were clients having their own drugs (89%). In some DCRs, using the service required that people came with a specific drug (36%) and/or that they had an ID or a unique identifying number at each entry (24%). Restrictions on using the DCR at each time included not being intoxicated (24%) or not being pregnant (13%).

Similar findings are reported in the European survey by Woods (2014), in which most of the European DCRs (87.9%) hold an entry interview with new visitors to the facility who are screened for eligibility. In TABLE 4, additional admission criteria from this survey are presented. Most of the European DCRs do not work with a card system; just 5 out of 32 respondents (15.6%) reported working with one. All respondents said to adhere to a minimum age for visitors of the DCR. A minimum age of 18 years was the threshold reported by 90.6% of the DCRs.

**Table 4.** Common admission criteria in European DCRs (Woods, 2014).

DCR admission criteria	EU facilities (excl. NL), %
In possession of drugs before entering	72.7
Signing of contract	69.7
Not being in OST	45.5
Signing of disclaimer	27.3
Registered with the municipality	24.2
Residing in the vicinity of the DCR	15.2
Poor physical and mental condition	15.2
Homeless	6.1
Registered as a client with the managing institution	6.1
Registered as a client of a local facility	6.1
Having caused public nuisance	6.1

Relatedly, 13 out of 32 respondents (40.6%) in the European survey (Woods, 2014) stated that there were target groups they would like to reach but currently do not. Generally speaking, these groups include young PWUD, those who use a different substance, those with alternative routes or methods of use, and migrants or non-locals. In Germany, several DCRs mentioned they would also like to reach drug users who are in substitution treatment; however, German federal state regulations prohibit this.

## **2.6 Registration**

A variety of data about clients was collected at DCRs when the clients first attended (only two of the 45 DCRs who answered this question said they did not collect any data). This was mostly age (93%) and gender (91%); 78% of DCRs collected name or initials that served for unique client identification. Two thirds collected data about accommodation status and some asked about the place of residence (7%). Data on the history of injecting (51%) and length of injecting (40%), on treatment history (47%) and on other substance use (9%) were collected. Health-related data including blood-borne disease status was collected to a limited extent (7%) alongside with a range of other characteristics (18%),

In the European survey (Woods, 2014), 87.9% of the DCRs register some sort of data on visitors. This tends to be basic information such as the date and frequency of visiting, and often including details on the substance the visitor is using. Some record this anonymously, while others also register personal details. Moreover, all but one Danish facility note down the details of the daily affairs (such as visitors' need for help, or a conflict between visitors).

## **2.7 Hours of operation**

Data concerning hours of operation are only provided by the European survey (Woods, 2014). All of the facilities are open during weekdays (with just one German DCR being closed on Wednesdays). On Saturday 60.6% of the DCRs are open, and on Sunday 63.6% of the facilities open their doors. Around a third of the facilities report being closed on the weekend, and those that do open maintain slightly shorter opening times. Individually, opening hours differ significantly, with some opening in the morning hours, whereas others open as of noon and focus more on evening hours. In cities where there are two or more DCRs (e.g., Amsterdam and Frankfurt), opening hours are complemented to one another in order to provide an opening span on city-level as broad as possible. The average duration of opening hours varies from day to day, with the longest average on Mondays (8.6 hours) and the shortest on Sunday (7.6 hours). The duration also varies greatly between facilities, with one German DCR being open for 20 hours per day during weekdays, and one Swiss facility being open for 3 hours and 35 minutes on five of the seven days that it opens.



## 2.8 Referrals to DCRs

TABLE 5 illustrates which parties are involved in the guidance of clients towards the DCR (Woods, 2014). The police and addiction treatment facilities are the most involved players when it comes to referring new clients to DCRs (73%). This is followed by shelters (67%) and outreach workers (58%). Neighbours (24%) are the least involved when it comes to guiding clients to a DCR. The category ‘other’ includes: municipal and state authorities, (governmental) health services, local and regional governmental officials, doctors, and local health authorities.

**Table 5.** Referrals to DCRs (Woods, 2014).

Parties involved in the guidance of clients towards the DCR	EU facilities (excl. NL), %
Police	73
Addiction services	73
Shelters	67
Outreach workers	58
Mental health services	55
DCR visitors	52
Neighbours	24
Others	27

## 2.9 House rules and regulations

In order to ensure safety of clients and staff, DCRs establish a code of conduct or “house rules” that outline the rights and responsibilities of clients as well as staff. Basic rules (e.g., no violence, no dealing) apply in most DCRs. Moreover, in the large majority of services, sale of drugs was prohibited (96%), as was drug sharing (60%). Injecting other people was not allowed in most DCRs (64%); 80% of DCR representatives said staff were not allowed to inject the clients. In some DCRs, injecting in certain parts of the body was prohibited (29%), such as neck or groin. Time limits often applied to each visit (58%) and at times the number of visits per day was limited (7%). Finally, use of alcohol was prohibited in most services (76%), and the use of tobacco was banned in about half (49%). This latter finding echoes results from Woods (2014), where in 75.8% of the DCRs alcohol is prohibited, and in 39.4% tobacco is prohibited. The main reason provided for alcohol prohibition is to reduce violence and drug use risks. As for tobacco the most common reason to prohibit it is state legislation protecting the health of non-smokers. The facilities that do allow tobacco smoking primarily permit it in separate smoking areas.

Furthermore, findings from Woods (2014) indicate that the majority of European DCRs operate a maximum duration policy that visitors are allowed to stay in the smoking (87.1%) or injecting room (69.7%). In both rooms the average maximum lies just above 30 minutes, with an actual range of 15 to 90 minutes. The main reason stated for this time limit is to allow as many users as possible into the DCR. Most facilities have to deal with queues, so to keep the DCR accessible to all and adhere to their objective to reduce public drug use, a set time limit is utilised. It is with this same objective in mind that all but one facility allows their visitors to access facilities as often as they want. The only DCR reporting a maximum amount of times that visitors can access facilities per day also claims to do so because of a shortage in personnel.

### **Parties involved in the formulation of house rules**

When asked which parties are involved in the establishment of house rules, 90.6% responded that the DCR staff was involved in this process, often in collaboration with the staff of the parent organisation; 56.3% involved only the latter (Woods, 2014). This European survey also indicates that 18.8% involved the police in the process, but merely 6.3% involved their visitors. No DCR involved the neighbourhood.

### **Presentation of rules to the visitors**

Once the house rules have been established, 90.6% of the DCRs communicate the house rules during the intake interview, while also having them printed out (e.g. as a poster) in the living room and/or consumption room (Woods, 2014). The few DCRs that do not present the house rules during an intake interview communicate them through posters. One Danish DCR reported imparting the rules verbally.

### **Consequences of breaking the rules**

When visitors break the rules, all but two European facilities (one in Denmark and one in Germany) adhered to sanction regulations (Woods, 2014). This also includes facilities in the Netherlands (Havinga & van der Poel, 2011). The most identified causes of sanctions are violence or drug dealing, and the most used sanction is suspension from the facility for varying amounts of time. While some facilities suspend for a lifetime in very severe situations (e.g. Germany), the DCRs in Copenhagen, Denmark, are known to use a model with very high tolerance, where it is impossible to get suspended for a longer period of time. Similar results are found in the worldwide survey by Belackova and colleagues (2017): when clients did not adhere to the house rules, the most severe sanction in many DCRs has been a temporary ban (53%), although a permanent ban was option in others (40%). In some of the surveyed services, there was no ban (8%).

## 2.10 Services on location and referral

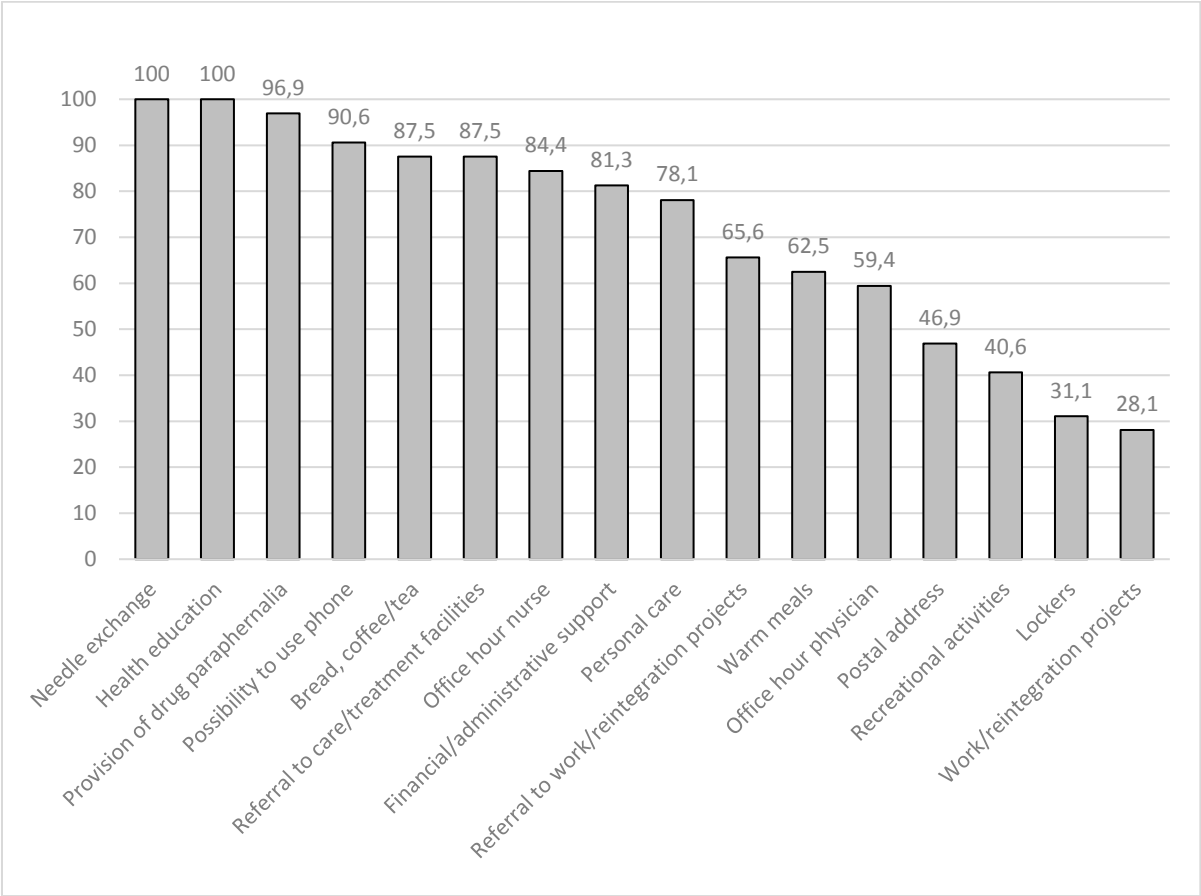
Based on the worldwide survey (Belackova *et al.*, 2017), out-patient counselling (46%), mental health care (44%), hepatitis B vaccination (41%), legal counselling (39%), and take-home naloxone (37%) were provided on-site in about two thirds of all DCRs. In about a quarter of DCRs, OST was available on-site (24%) and in some, short term ( $n = 5$ ) or long-term ( $n = 4$ ) abstinence treatment were available. Beyond the health and social services listed above, an array of support was provided on-site. Almost all DCRs in the survey provided referrals to treatment and distributed clean paraphernalia for take-away (94%); also, clients could use a phone and get coffee or tea (91%). In the majority of DCRs, personal care was available (shower, washing clothes; 76%) and so was support with financial and administrative affairs (74%). More than half of all DCRs provided meals (61%) and recreational activities (57%). In some DCRs, work and reintegration projects were available to clients (41%); clients could sometimes use lockers (26%). Among the “other” services provided on-site, a minority of DCR representatives mentioned medical and GP services ( $n = 3$ ), provision of clothing/wardrobe ( $n = 2$ ), as well as sleeping facilities, overnight shelters and housing collocated with the DCR ( $n = 4$ ).

On location, all of the respondents in the European survey (Woods, 2014) reported providing needle exchange, with 96.9% providing drug paraphernalia. In terms of medical care and education, health education is offered to clients by all of reporting facilities, 59.4% have an office hour physician, and 84.4% have an office hour nurse. As illustrated in FIGURE 2, ‘health status improving services’ are offered, along with several other services such as basic food and personal care facilities, practical support, and referral to or on location work and recreational activities.

Furthermore, the survey by Woods (2014) indicates that approximately nine in ten DCRs (87.5%) refer clients to other care and/or treatment facilities. Moreover, when asked whether or not the respondent thought that ‘clients have greater use of other services and entry to treatment as a result of using the DCR’ all respondents said their visitors had greater access to at least one form of service or treatment.

Besides improved access to primary health services, the majority of DCRs also facilitate access and use of social, mental health care, drug treatment and work reintegration services. Most of these factors contribute to the improved health status of clients, but DCRs also cover a more social function. This social function includes the improvement of social status and/or inclusion through work integration, housing support and socialisation (Woods, 2014).

**Figure 2.** Service range at 32 DCR in Europe, excluding the Netherlands (Woods, 2014).



**2.11 Staff (training)**

The most common staffing model is a team of trained health care workers such as (psychiatric) nurses and social workers or psychologists in order to provide a psycho-medical-social approach. The broad social support offered to visitors of DCRs is illustrated by the fact that 96.8% of the European facilities have at least one (full-time or part-time) social worker on location (Woods, 2014). Worldwide, most DCRs participating in the 2016 survey employed nurses (80%) and/or social workers (78%). Other front-line professions that were employed in DCRs were health educator/rescue workers (35%), paid peer-workers (24%), a psychologist (13%), case managers (11%) and students or trainees (11%). Over half employed a director or programme manager (57%). Less than half had a doctor/clinician on-site (46%), and some employed a psychiatrist (17%). About one third of DCRs employed administrative staff (35%) or security personnel (33%). A minority of DCRs employed unpaid peers (*n* = 3) or researchers (*n* = 3).

Besides a variation in functions, there is also a great variety in the number of staff members working for each facility, ranging between 8 and 71 in European DCRs (Woods, 2014). Note that these variances are not only due to the differences in capacity and visitors per day, but those with the

greatest numbers of staff primarily work with part-time employees. More detailed information can be found in the more recent worldwide survey, reporting that the mean number of *paid employees on an average day of DCR operation* was 7.4 (range: 1–26). Based on these numbers, no conclusions can be inferred concerning the client-staff ratio.

All but one European DCR (in Germany) have a structural offer of staff development training. Different trainings offered to DCR employees include basic course on first aid for drug related incidents (96.7%), infectious diseases (73.3%), basic course on drugs and addiction (60%), providing information services (50%), and motivational interviewing (50.0%).

## **2.12 Peer involvement**

As mentioned above, only 6% of European facilities involved clients in the establishment of their house rules (Woods, 2014). In this same survey, peer involvement was found to be equally low regarding other aspects of the DCR: formulation of DCR's goals in dialogue with visitors of your facility (38%), involvement of DCR visitors in the establishment of the services on offer (31%), and employment of (former) drug users (25%). Different forms of organised visitors' participation are the involvement of visitors in decisions regarding the organisation and internal affairs (12.1%), deployment of visitors for management and functioning of the DCRS (21.2%), and organising visitor meetings (36.4%). The most common reason reported why there is currently lacking a form of organised visitor's participation is that it does not fit in the organisational structure (40%). At the time of assessment, 13% stated to be "working on it". Similarly, in the worldwide survey (Belackova *et al.*, 2017), in majority of the services, clients did not participate in the management of the service (63%); however there were regular meetings with DCR representatives in about a quarter of services (26%) and one in 10 had clients take part in the DCR management (9%).

### 3. COUNTRY-LEVEL ANALYSIS

The above summary provides a recent and general overview of European DCRs' operational aspects. A country-specific analysis, however, is lacking. Therefore, the current section provides a more in-depth analysis focussing on Belgium's four neighbouring countries: the Netherlands, Germany, Luxembourg and France. The sources of information consisted of overview documents (only available for Germany and the Netherlands), supplemented by on-site visits and interviews with DCR managers in Frankfurt, Amsterdam, Paris and Luxembourg. For each of the four countries, a case study of one DCR that was visited by members of the research team will be discussed in depth.

#### 3.1 The Netherlands

The first DCR in the Netherlands was established in 1994. In February 2017, there were 31 DCRs located in 25 cities country-wide (EMCDDA, 2017c). The most recent organisational overview of Dutch DCRs dates from 2011, surveying 30 of 37 DCRs operative at that time (Havinga & van der Poel, 2011). Thus, since the report was published, the number of Dutch DCRs slightly decreased at national level (N=31 in February 2017).

The majority of DCR managers claimed the primary rationale for *founding* a DCR was nuisance reduction, and only one-third responded with 'a safe place to use for the drug users'. As a goal, nuisance reduction appears to be more prominent in the Netherlands than in other countries (Woods, 2014). Of all 30 surveyed DCRs, 25 (83.3%) were integrated facilities, and the remaining five were specialised DCRs. Indeed, most DCRs are incorporated in existing low-threshold services.

Most facilities in the Netherlands have both smoking and injecting rooms. There are only three smoking-only and two injecting-only facilities in the Netherlands. On average, the 30 surveyed DCRs have 15–16 spaces (ranging from 2 to 50 slots) where visitors can inject and/or smoke. The average number of visitors per day was 22 (2–60) in integrated facilities and 24 (17–30) in stand-alone facilities. Throughout the week, Dutch facilities were open 8 hours a day on average, ranging between 3 and 15 hours per day. Over three quarters of DCRs are open every day. The large majority of DCRs operate a maximum duration policy that visitors are allowed to stay, ranging from 20–120 minutes.

In terms of admission criteria (see TABLE 6), 90% of Dutch respondents indicated maintaining a minimum age limit (18, 21 or 23 years). On average, six criteria apply per DCR, ranging from 1–9 criteria for admission per DCR. In specialised facilities, 'having caused public nuisance' is more explicitly an admission criterion compared to integrated DCRs.

**Table 6.** Admission criteria of 30 DCRs in the Netherlands (Havinga & van der Poel, 2011).

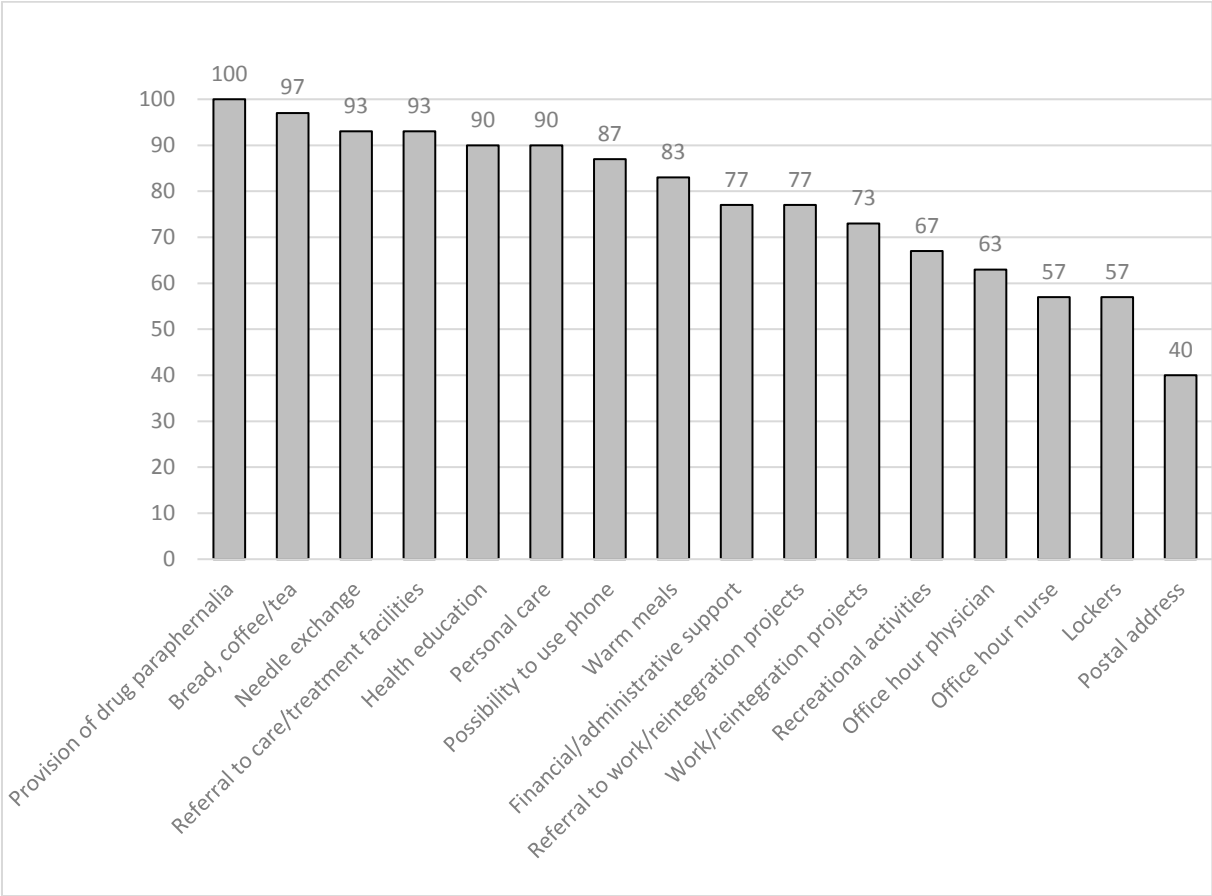
DCR admission criteria	The Netherlands (%)
Minimum age	90
Registered with the municipality	70
Signing of contract (declaration of agreement with house rules)	67
Registered as a client with the managing institution	67
In possession of drugs before entering	53
Homeless	43
Having caused public nuisance	40
Registered as a client of a local facility	37
Tuberculosis check	23
Signing of disclaimer (declaration of liability)	20
Residing in the vicinity of the DCR	20
Poor physical and mental condition	17
Known to police	13

The majority of services serve a limited target group of ‘chronic addicts’ from a specific local area; the service user must register with the municipality or local drugs agency and be a legal resident of the Netherlands. One DCR is reserved for people who originate from outside of the Netherlands.

Once on location, the facilities have rules for controlling the social climate, including the prohibition of aggression and a ban on the sale of drugs. There are also rules for safe use, such as a ban on injecting into certain parts of the body (e.g., neck) and the prohibition of sharing paraphernalia. In 40% of all Dutch DCRs, visitors are actively involved in the formulation and establishment of these house rules.

More generally, more than 75% of all facilities in the Netherlands offered some kind of participation to its visitors. In comparison, visitors’ participation in European facilities on average (6.3%) proves to be quite low compared to the Netherlands. Other forms of visitors’ organised participation in Dutch DCRs are: organising visitor meetings (57%), engaging visitors in determining services (47%), meetings with visitor representatives (40%), involvement of visitors in decisions regarding the organisation and internal affairs (27%), and deployment of visitors for management and functioning of the DCRS (17%).

**Figure 3.** Services provided in 30 DCRs in the Netherlands (Havinga & van der Poel, 2011).



Most Dutch facilities are run by regional drug services, offering a wide range of services from low-threshold harm reduction measures to reintegration projects. Often they are incorporated in existing low-threshold services (for instance for homeless people) that provide medical care, counselling, food, laundry and shower. On location, all DCRs provide drug paraphernalia, and 93% provide needle exchange. Health education is offered to drug users by 90% of reporting facilities, 63% have an office hour physician, and 57% have an office hour nurse. Alongside, several other services such as basic food and personal care facilities, practical support, and referral to or on location work and recreational activities are provided (cf. FIGURE 3). Reintegration focus is far more common in the Netherlands than in other European countries, and is considered to be a typical trait of the Dutch model (Woods, 2014).

Half (53.3%) of the Dutch DCRs had at least one nurse, and 73.3% had at least one social worker among its staff members. Furthermore, supervision and/or security staff may be part of the team. The large majority of DCRs had a mix of the abovementioned disciplines. More than a third employed (former) drug users.



### **Case study: AMOC in Amsterdam (Regenboog Groep)**

Situated in the centre of Amsterdam, AMOC (*Amsterdams Oecumenisch Centrum*) was founded in the eighties, mainly for German drug users. Nowadays it is a low-threshold facility with a specific range of care facilities specifically targeted at a group of group of foreign nationals; they often have no official status in the Netherlands, no rights, and therefore cannot access regular social and health services. During the day, they are given shelter at the drop-in centre on the ground floor. The capacity of the centre is around sixty people. Clients are not limited to PWUD—although they often use drugs, are homeless or have no insurance in Holland. Located in the basement, AMOC provides showers for clients, as well as a limited overnight shelter for homeless people and a round-the-clock shelter for crisis situations. Additionally, AMOC provides a DCR integrated in the facility since 1998, located at the first floor with a capacity for 18 users.

Before they are granted access to the consumption are, PWUD have an intake interview on the first visit with the coordinator (see APPENDIX B). During this intake, eligibility criteria are checked. If the user is granted access to the consumption room, s/he will have to sign a contract, which briefly reflects the rules and corresponding sanctions of the facility (see APPENDIX C). The contract also sets out some conditions that the clients have to adhere to; for example, it is forbidden to deal drugs in the DCR.

The DCR is open 7/7, from 10h to 17.30h on Mondays to Friday, and 12–19.30h in weekends. The average number of weekly hours of operation was 53 in 2016. The total number of unique visitors to the DCR was 65 throughout 2016, with an average number of daily DCR visitors of 12. There is one room for consumption without a separation based on route of drug administration: injecting, smoking, inhaling, and snorting may occur at the same time in the same room. There is no time limit in the DCR.

Cost data were not available upon request.

## **3.2 Germany**

In Germany, in 2017, there are 24 DCRs operating in 15 cities (EMCDDA, 2017c); the first *official* DCR being opened in 1994. While Hamburg now operates five and Frankfurt four DCRs, many other cities have to manage with fewer facilities. Two consumption rooms are operated in Berlin, and the other cities are limited to one DCR each. In addition, in both Berlin and Cologne operates a mobile DCR. In 2011, an overview of German DCRs was published (Schäffer & Stöver, 2011), which will be summarized below, focusing on operational and organisational aspects. The number of DCRs included in the review remained equal compared to the situation to date.

German policy toward DCRs can be described as low-threshold and acceptance-orientated facilities. German DCRs were not established for the sole purpose of offering a place to consume drugs,

but rather, were integrated into already existing low-threshold service facilities. This policy of providing DCRs where services already exist emphasizes that the DCR is in addition to a broad range of services (Zurhold *et al.*, 2003). Consequently, all DCRs in Germany are integrated in existing (harm reduction) facilities. The opening hours (3.5–12 hours), as well the number of available consumption spaces (3–20 spaces), are based on the local demand. DCR staff is usually composed of doctors, nurses and educators, supported by qualified student assistants. 41.2% of all German DCRs offer some sort of participation to its visitors.

The right to use a DCR is regulated by the German Narcotics Law. The superordinate federal level mandates that “obvious first-time and occasional consumers” must be excluded. Additional groups of persons who are to be excluded from using DCRs are defined in the legal regulation of the states (Schäffer & Stöver, 2011). Woods (2014), surveying 17 DCRs in Germany, reported that all German facilities adhere to a minimum age for visitors of the DCR. Three facilities have a minimum age of 16 (2) or 17 (1) years; minimum age of 18 years was the threshold reported by the remaining DCRs. Additionally, the most common admission criteria were being in possession of drugs before entering (88%), not being in OST (82%), and signing of contract (76%). Other, less widely adopted criteria were: signing of disclaimer (4/17), registered with the municipality (3/17), residing in the vicinity of the DCR (3/17), poor physical and mental condition (3/17), being homeless (2/17), registered as a client of a local facility (2/17), having caused public nuisance (2/17), and registered as a client with the managing institution (1/17).

In contrast to the Netherlands, limited facilities for smoking have been added to DCRs in Germany. However, a room has been opened specifically for crack users in Frankfurt and for heroin smokers in Hamburg (Hedrich *et al.*, 2010).

### **Case study: Niddastraße in Frankfurt (Integrative Drogenhilfe e.V.)**

Located near the central train station, the DCR Niddastraße (run by the NGO Integrative Drogenhilfe e.V.) was established in May 1995 containing 12 injection seats. The DCR is founded on three main principles: (1) health care, by providing a hygienic environment, first aid in case of an overdose, and needle exchange; (2) connecting the clients to other facilities, including detoxification, OST, drug advice centres, and medical treatment; and (3) compensation of the public problems in the city.

The DCR is integrated in a wide network of cooperation services, including other drug services, drug substitution outpatient departments, street corner work, the Public Health Department, social assistance office, and youth welfare. In 2015, the whole building was fully reconstructed. Finalized in 2016, an extra smoking room with four places was opened, and the DCR now worked across two floors. On the ground floor, besides a counter and needle exchange service, a waiting area and resting room

for 40 people is located. On the first floor, 12 places for IDU (in one room) and four places for inhaling use (in another room) are located. Both consumer rooms are overseen by a single observation desk.

Important inclusion criteria include minimum 18 years of age, already a drug user, and not on OST. All new clients are provided an intake conversation, where information is gathered concerning the client's drug use in the past 30 days, what kind of treatments they have done, living- and work situation, medical status (HIV and HCV). Clients have to show their ID card for a one-time only registration procedure. When meeting the abovementioned criteria, clients have to sign a usage agreement including the rules of the DCR (see APPENDIX D). With regard to these house rules, the following points are strictly forbidden of the DCR: (1) deal drugs, share drugs, pack and ration drugs, offer drugs; (2) walking around with open needles; (3) violence and sexism, both to staff and other clients; and (4) possess more than one unit of drugs/just the amount to consume.

The DCR's opening hours are: 17–23h on Mondays, and 11–23h from Tuesday to Sundays. These are adjusted to the opening hours of the other DCRs in Frankfurt. In 2015, there were 11,008 registered clients in the DCR (compared to 10,686 in 2014), accounting for 63,139 registered injections. In 2016, there were 181.426 consumptions in all four DCRs located in Frankfurt (4.705 unique clients); 40.4% of which took place in the Niddastraße (Stöver & Förster, 2017). In 2015, 123 emergency cases (overdoses) occurred inside the DCR, of which 72 required ambulance intervention. However, none of these cases resulted in death. Annually, there are 300–400 referrals to detoxification services.

The facility employs a total of seven social workers and circa 35 students from different disciplines. There are two shifts per day (11–17h and 17–23h), and for each shift, eight persons are employed with minimum one social worker in the late shift. No specific medical staff is employed (such as nurses), but all staff is obligated to take courses in first aid, motivational Interviewing, de-escalation training, and dealing with traumatized people. Annual operational costs (excluding the rent of the building) are estimated to be €1.25 million, largely owing to personnel costs, funded by both the city of Frankfurt and the state of Hessen.

A special cooperation includes police. In Frankfurt, there is a special police unit responsible for all drug helping institutions in the main station area. In case of problems, (too crowded in front of the door, shooting in public, dealing, etc.), DCR staff can call a special telephone number linked to this unit. The police staff of this unit drops by once a day, to check if everything runs smoothly. To possess one unit of drugs is allowed in the DCR; however, in front of the facility, possession remains forbidden, which proves to be a problem in the case of policemen which are not familiar with the cooperation between the DCR and police. Therefore, every two weeks, a meeting with the DCR manager takes place in the police headquarters. Such a cooperation is a legal obligation to work together with the police to reduce impairments in the area of the DCR. All in all, according to DCR staff, a trusting relationship currently exists between the managers of the DCR and the responsible police officers.

### 3.3 Luxembourg

There is only one DCR in Luxembourg, located in its capital, which opened its doors in July 2005. The facility was established 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, at that time, already managing a low-threshold centre for people dependent on drugs in the City of Luxembourg (Schatz & Nougier, 2012). This centre, called *Abrigado*, now runs three different services: a low threshold drop-in centre (the *Kontakt Café*), a night shelter with 42 beds (since December 2003), and since July 2005, a DCR with a capacity of 7 injection tables. The DCR is thus integrated into a low-threshold centre for drug users. In early 2012, *Abrigado* moved into a new facility which now provides a room (consisting of six places) where drugs can be smoked or inhaled under supervision, in addition to the already existing spaces for intravenous consumption (expanding the number of injection tables to eight). *Abrigado* also participates in the national needle and syringe exchange programme.

There are a number of criteria to be fulfilled for clients to have access to the DCR. Admission criteria are: 18 years and over, already drug dependent, in possession of drugs before entering, and not intoxicated. Luxembourg excludes people in opioid substitution treatment from using DCRs, and there is no organised visitor participation in this DCR (Woods, 2014). After an intake interview (APPENDIX E), all clients must sign a ‘terms of use’ contract when they first arrive at the DCR (APPENDIX F).

Up to 2016, a total of 1,7175 clients had signed the facility’s mandatory user contract (15% of which were females). More than 57,000 passages (including multiple counts) were recorded in the consumption room during the year 2016, with an average of 159 (141 in 2015) consumptions per day, and a total of 67,083 (56,178 in 2015) consumptions. Until the end of 2016, 112 new contracts were signed by DCR clients. The forms of consumption are as follows: 57% intravenous consumption, 41% smoking of heroin and 2% sniffing. The ability to snort or smoke drugs should help clients change from a high-risk form of consumption (intravenous use) to a less hazardous and less unhealthy form. During the year 2015, the *Abrigado* team took care of 29 (20 in 2015) overdoses with loss of consciousness and 40 (59 in 2015) overdoses without loss of consciousness. The ambulance was called 38 times and the police on two occasions (CNDS, 2017).

In 2016, the DCR was open for 361 days. The DCR and the drop-in centre share the same opening hours. Both are opened Saturday, Sunday, Monday and Tuesday from 12:00 to 19:00; from 12:30 to 16:00 on Wednesdays, and Thursday and Friday from 9:00 to 16:00. Two staff members are permanently present in the DCR. They are assisted by the six employees of the drop-in centre. 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.

Since the beginning of the DCR in 2005, the facility is monitored and developed by a group of key stakeholders (decision makers from the Ministry of Health, Ministry of justice, Prosecutor, Police, city council, Customs Administration and various other partners). This group meets every two months, where the DCR managers should give an account of the activities of Abridado (statistics and situation analyses). This steering group is, according to the DCR manager, one of the important factors of success. In 2016, personnel costs amounted to €2,148,300 and operation costs to €417,306 (totalling to €2.5M), funded primarily by the Ministry of Health (in addition to the City of Luxembourg). A second supervised DCR is planned in the southern part of the country for 2018.

### **3.4 France**

Thirty years after the opening of the first DCR in Switzerland, France has become the 10<sup>th</sup> country to open a DCR, on October 17<sup>th</sup>, 2016. The first one has opened in Paris and is handled by the health and social structure *Gaïa-Paris* (Avril, 2017) and a second one has opened November 7<sup>th</sup> 2016 in Strasbourg, handled by the *Ithaque* association (Kreiss, 2017). Both DCRs are located in public hospitals, even though they have a separate entrance and are only administered by the health and social structures in charge. Being located in a hospital has also allowed the facility to develop more relationships with certain services of the hospital and a protocol has been set up in case of a vital emergency. The Paris and the Strasbourg DCR are very similar in design and operation, given the fact that both DCRs are based on the same model. Below, we will discuss the Paris model more elaborately.

#### **Case study: Paris (Gaïa)**

The first in-hospital facility in the world opened in Paris' Lariboisière Hospital in October 2016. The hospital is located near a busy train station where there is a high rate of drug use. Although embedded within the hospital (but with a separate entrance), the DCR can be categorized as a 'specialised' DCR, exclusively intended for PWUD. The facility (400 m<sup>2</sup>) consists of a waiting room, a consumption room, and a resting area after drug consumption. The team in Paris (with 6 FTE's) is composed of doctors, nurses, social workers and security personnel. Peer workers will also join the team, and will be staffing the welcoming area and the resting area. Their inclusion and participation to the functioning of the DCR is essential for Gaïa. The DCR is open 7/7 days from 1:30 pm to 8:30 pm. The consumption room consists of one injection room with 12 booths, and one inhalation room with 4 booths, supervised by medical staff. The DCR is able to welcome around 400 consumptions (circa 150 unique clients) per day.

In addition to the supervised consumption of drugs, other services include: social, medical, psychiatric support; sterile equipment for personal use (NSP); social, nursing and medical consultations; primary care: tips and education for safer drug use; hepatitis and HIV screening. Referrals can be made to substitution treatment (Avril, 2017).

At first visit, potential clients must complete an intake interview, which includes an assessment and basic registration, as well as an explication of house rules linked to the signature of a contract. These operating rules include: (1) only PWID over 18 years old; (2) 20 minutes for each consumption (however, there is no time limit in the resting area); and (3) no restriction on products allowed. When entering the DCR, clients give their first name and date of birth at intake, and show the substances they want to consume. They are then provided a numbered ticket—only one consumption is permitted each time. An oral agreement between the local police and the DCR has determined the conditions in which the police will not intervene within the surrounding area. The DCR in Paris has a budget of €1 million per year, which is covered entirely by the national social security system (Cook, 2017).

In view of its recent opening, little data is available to date. From October 2016 to August 2017, there were about 200 visits/day and 799 users (669 in May) were included in the DCR programme (87% male), responsible for 53,582 consumptions and 38,058 injections (Avril, 2017). Half of all clients live in Paris, and 45% outside of Paris. 42.6% inject Skenan (morphine sulphate), 43% use crack (20% IDU), 12.4% an OST substance (methadone, buprenorphine), 1.2% heroin, and 0.8% cocaine. There were 509 medical/nurses consultations for 220 unique clients, 610 social consultations for 188 different users, 40 rapid tests for HIV and 31 rapid tests for HCV. 17 emergencies occurred so far due to an overdose.

The French National Institute of Health and Medical Research (INSERM) is in charge of carrying out a scientific evaluation of the DCR in Paris, but also the one in Strasbourg. The DCR project will be evaluated using a cohort study—the Cosinus Cohort—in four cities, two with (Paris and Strasbourg) and two without (Bordeaux and Marseille) DCRs. The study will look at the impact of DCRs on HIV and HCV risk practices and other drug-related harms. Another part of the evaluation is dedicated to the social acceptability of DCRs among PWUD, neighbourhood inhabitants, health care professionals, and public safety professionals. The final results of the evaluation will be delivered to the French Parliament six months before the end of the experiment and will be determinant for the future of DCRs in France.

## 4. SUMMARY

DCR models around the world fall along a continuum, ranging from the clinical model of Sydney's DCR, which is very rule-bound, procedural, hierarchical, and administered by highly trained professionals, to the consumption rooms in the Netherlands, which are administered 'by users and for users' (Semaan *et al.*, 2011). This chapter sought to summarize the main features of existing DCRs worldwide, and in Belgium's four neighbouring countries more specifically, in order to allow consideration of the way in which models of delivery elsewhere might apply to the Belgian setting. The organisational overview by Woods (2014) and Belackova and colleagues (2017), as well as the country-specific analysis, illustrate that DCRs worldwide share a number of common features and core operational elements, but also differ widely in terms of design, organisation, operations and programme delivery.

European DCRs offer on average seven places for supervised injection (ranging between one and 13 slots) and four places for smoking/inhaling. Over half of the facilities provide the service on a daily basis, opening on average for eight hours a day (a minority of them during night hours). The number of daily visitors varied widely (between 20 and 400), with six of the 33 facilities catering for more than 200 clients a day. Practically all facilities adhere to a minimum age for visitors, and 'being in possession of drugs before entering' (72.7%) and 'signing a contract' (69.7%) were two admission criteria widely carried in Europe and in all countries. Most in-house regulations (e.g., prohibition of drug dealing and aggression) and practices seem primarily directed at maintaining a safe environment and ensuring outreach and harm reduction to as many drug users as possible. Furthermore, European facilities deliver a wide range of auxiliary services. In addition to providing clean injecting equipment, all of the facilities reportedly offered needle exchange as well as health education advice to clients, while 60–70% of facilities offer access to primary health care by a nurse or physician. Besides in-house health care, a very important aspect of DCRs is the potential for referral to other services. Conversely, addiction treatment facilities and the police were identified as the main sources of referral to the DCR. Facilities are typically staffed by social workers and with medically trained personnel; several employ doctors and ex-users.





# CHAPTER IV

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## FEASIBILITY IN BELGIUM: A QUALITATIVE ANALYSIS

*Louis Favril*

*Pierre Smith*

*Jessica De Maeyer*

*Freya Vander Laenen*

*Pablo Nicaise*



## CHAPTER 4

# FEASIBILITY IN BELGIUM: A QUALITATIVE ANALYSIS

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### 1. AIMS

Locations and operating procedures vary by country and by city, depending on consumption patterns and local drug scenes. Therefore, a faulty assumption would be to suppose that a DCR project similar to that in Germany, France, the Netherlands or Luxembourg would be well-suited for Belgium, given the different local contexts. In many respects, ‘copy-pasting’ such a model would probably be poorly suited to local needs and likely to forego opportunities than a model specifically tailored to the Belgian setting, or even the local context of specific cities in Belgium. Therefore, we sought to examine the local feasibility of DCRs in five Belgian cities. Here we focus on two main questions for considering how a DCR might be implemented in Belgium: (1) What are the possible models that a DCR could consider; and (2) What are important operational and organisational considerations when establishing a DCR? In order to answer these research questions, we conducted a feasibility study on DCRs in five Belgian cities: Ghent, Antwerp, Brussels, Liège, and Charleroi. The study was overseen by a advisory committee composed of stakeholders from various sectors, and they were selected based on their expertise and interest in community responses to illicit drug use.

### 2. METHODOLOGY

The principal goal was to examine the feasibility of different scenarios as well as the conditions for the implementation of these DCRs. Due to time constraints, five Belgian cities were selected, based on the size of the city and the drug problems at city-level (EMCDDA, 2015a): Ghent, Antwerp, Brussels, Liège, and Charleroi. In each city, interviews with key stakeholders were conducted. Additionally, one focus group was organised in each of the cities with PWUD defined as a potential target group for a hypothetical DCR.

#### 2.1 Interviews

The main consideration for the stakeholder interview component was to capture a comprehensive and diverse variety of perspectives from different areas of stakeholders; each of them hold key information

necessary for a locally informed assessment of the feasibility and specific considerations necessary for a possible DCR initiative (Fischer & Allard, 2007). Hence, in line with a comprehensive and integrated approach to drug policy, the sample for each of the five cities was a diverse and a representative group of stakeholders. To ensure that the diversity of the professional actors is covered, professionals were recruited from a range of relevant sectors, including law enforcement, criminal justice system, policy development, (mental) health care, social welfare, drug treatment services, outreach, harm reduction services. Selection of specific respondents occurred by purposive sampling (mostly one respondent per sector per city) in dialogue with the respective local drug coordinator. The interview guide (APPENDIX G) was based on prior feasibility research in Canada (Bardwell *et al.*, 2017; Bayoumi & Strike, 2012), which was obtained after personally contacting the researchers, and adapted to the Belgian setting. Between July and September 2017, a total of 46 one-to-one, semi-structured interviews were conducted with a diversity of professional stakeholders from five cities to identify essential preconditions, possible DCR models and delivery options, organisational and operational considerations (e.g., opening hours, staff, services). Using the same interview guide, the interviews in Ghent ( $n = 9$ ) and Antwerp ( $n = 8$ ) were conducted by a Dutch-speaking researcher (LF); those in Brussels ( $n = 11$ ), Charleroi ( $n = 8$ ) and Liège ( $n = 10$ ) were conducted by a French-speaking researcher (PS). Participants provided verbal informed consent and the interviews were audio recorded with permission. With 3,117 minutes of interview for 46 professional stakeholders in total, average duration was 68 minutes (range 39–140). Each interview was assigned an individual number to ensure anonymity.

## 2.2 Focus groups

The perspectives of PWUD are particularly important in DCR implementation research because of the nuanced descriptions they are able to provide about drug-using practices and environments (Bayoumi & Strike, 2012; Watson *et al.*, 2013). Therefore, engagement of the target group was ensured by means of several focus groups. Focus groups have shown to be an effective research method in vulnerable populations such as PWUD (Favril *et al.*, 2015; Vander Laenen, 2016) and was chosen as an appropriate data collection format for drug user informants in order to make these participants feel as comfortable as possible for the purpose of the data collection exercise. One focus group was planned in each city. PWUD were recruited using a targeted sampling procedures, via local low-threshold (harm reduction) services (e.g., MSOC/MASS) and street corner work, who were asked to recruit 8–12 respondents who could be “potential clients of a DCR might this be implemented” in their particular city. Such a rather vague instruction ensured a heterogeneous composition (e.g., duration of drug use, homelessness, age, gender, involvement in drug treatment, etc.) of the sample, in order to explore a wide range of perspectives. A topic list was based on the interview guide (see above). A total of 62 PWUD participated

in the five focus groups (15 in both Brussels and Charleroi, 14 in Ghent, 12 in Antwerp, and 6 in Liège). Average duration was 57 minutes (range 49–61). All PWUD participating in the focus groups read and signed an informed consent, and were compensated €15 for their involvement in the study.

### **2.3 Analysis**

For both interviews and focus groups, qualitative data were appropriately analysed (Decorte, 2016). In order to improve interrater-reliability, transcripts were initially examined by two researchers (LF and PS) in order to identify primary coding categories as well as the range of themes present in each category. Subsequent coding and thematic analyses were done using NVivo 11 software. Inductive and deductive methods were used, which involved the use of a priori categories, and emergent categories from the dataset. Based on the interview and focus group guide and emerging themes, a final coding structure was developed. Results are clarified using quotes from the interviews and focus groups.

## **3. RESULTS**

Below, results from the interviews with professional stakeholders, and focus groups with PWUD, will be discussed for each city separately. Since the results for several variables (e.g., opening hours, house rules, and evaluation) were highly similar across cities (and not city-specific), these will be discussed together at the end of this section.

### **3.1 Ghent**

#### **Goals**

Health goals are a central aspect of a DCR in Ghent. Providing the possibility to consume drugs in a safe manner within a supervised setting is deemed the most important goal according to the stakeholders in Ghent. Secondly, many stakeholders feel that another benefit of a DCR would be the opportunity to connect drug users with other health and social services: they are perceived as good strategies to reach and maintain contact with a hard-to-reach group of PWUD, and consequently promote the health of service users by facilitating access to other services (both medical and psychosocial), whether delivered on-site or through referrals.

*“To connect with people who are not yet reached by existing services; the threshold for some people who use drugs is still too high, and these hard-to-reach users may come to such a drug consumption room. And if there’s, besides using their drugs in a safe and controlled setting, additionally the opportunity to have a conversation or make use of social or medical services... For this group, such support would be extremely useful.” (IV9)*

Less emphasised is the reduction of public nuisance, which, according to the local stakeholders, is not perceived as problematic in the context of Ghent. Although needles/syringes are still found in public spaces, this is rather limited. This nuisance-dimension in Ghent has been greatly reduced by projects such as NSP, dropboxes and needle/syringe patrols, according to the interviewees (including some of the law enforcement stakeholders). In short, a DCR in Ghent would be a good intervention mainly to reduce health risks for a specific group of PWUD.

### **Target group and admission criteria**

In Ghent, stakeholders are quasi unanimous that the target group of a DCR is a well-defined and rather small group of PWUD. A DCR should target long-term drug users, mostly street-involved or homeless individuals, irrespective of type of (hard) drugs. Although most stakeholders acknowledge the fact that, ideally, there should be no differentiation based on administration route (i.e., injecting, inhaling and smoking), the majority of them state that PWID are the primary target group of a DCR, since IDU is associated with the highest health risks. Thus, if choices should be made (due to financial reasons), the DCR should focus on injecting drug use (since their need is perceived as higher), rather than smoking.

*“Not exclusively injecting, but evidentially also people who problematically use drugs in another way should be able to use the facility. But the need for this latter group may not be that high I think; the main risks are still related to intravenous use.” (IV7)*

*“It highly depends on how you will apply your funds. Injecting drug users are by far the high-risk, high-need population. I can imagine that a drug consumption room... if choices have to be made, then I would opt for this vulnerable group. But ideally, it does not have to be limitative nor exclusive. Not necessarily injecting, but then you will have to provide separate inhalation rooms, I think.” (IV9)*

Respondents state that the duration of drug use, rather than individuals’ chronological age, should be considered as an inclusion criterion. However, the vast majority of stakeholders in Ghent are convinced

a DCR should only be accessible for adults; i.e. PWUD aged 18 years and over. Adopting this cut-off arises from the fear to expose minors to long-term drug users, and the fact that treatment is a more feasible option for this younger segment of PWUD rather than DCR-usage. A minority of stakeholders however is convinced that a DCR should be accessible for minors too. Although these respondents are aware of moral and legal barriers, they state that a threshold of 18 years is arbitrary and people aged 16 or 17 years, who would benefit from a DCR (and meet other inclusion criteria), should equally be gained access to the facility. The advantage of allowing minors to a DCR is that their problematic drug use is not denied, and that the service provides opportunities to connect these young people with other (age-specific) services through in-depth assessment and follow-up. Opinions regarding a cut-off age of 18+ were mixed among law enforcement stakeholders.

Stakeholders' opinions are divided concerning the local residency criterion. Some respondents suggest that adopting such a criterion is necessary in order to preserve the small-scale nature of the DCR, and to avoid a 'honeypot' effect of PWUD from nearby cities. Others justify the choice for this criterion that the target population will be dependent on the subsidising body or institution: *"if the DCR is financed at city-level, it would be more difficult to allow access to people outside of Ghent, and to sell it to a broader region, let alone at a provincial level"* (IV7). When funding would be limited, choices will have to be made, and the DCR in Ghent will then primarily have to serve its local population of drug users. Others, on the other hand, state that the downside of placing such a criterion is that it excludes non-local residents, and vulnerable groups such as illegal immigrants and refugees, who may benefit from a DCR; particularly since this latter group appears to be insufficiently reached: *"they [illegal immigrants and refugees] comprise a rather large group of problematic drugs users in Ghent, who don't have official documents nor any contact with existing drug treatment services. For this specific population, DCRs would especially be desirable"* (IV5). Again, opinions regarding this local residency criterion were mixed among law enforcement stakeholders.

With regard to individuals enrolled in OST, stakeholders are convinced they should be able to use the facility, given the high rates of continued drug use among OST-clients. As stated by one stakeholder, *"Don't exclude them, otherwise we'll miss a substantial subgroup of clients who could benefit from such a facility. This would be an ideological choice, rather than an evidence-based one"* (IV7). Other specific populations comprise intoxicated clients and pregnant women. Overall, rather than excluding such at-risk groups from the facility, interviewees believe this would provide a window of opportunity for DCR staff to engage with these vulnerable groups of PWUD. Conversely, denying them access to the facility would possibly lead to drug consumption in unsafe and unhygienic circumstances. These groups are considered to be high-risk and need special considerations and related procedures.

*“A reason all the more to ensure that there is a maximum of support, in any form. The last thing you should do is leave them to the greatest degree of insecurity and uncertainty.” (IV7)*

*“It’s really a grey zone. In my opinion, the majority of clients will have already used some sort of substance, whether alcohol or illicit drugs, who are going to use anyway, so it’s better to let them do so in safe conditions. To rigorously decline intoxicated clients is difficult... In essence, it’s about people providing an alternative to using in unsafe circumstances, and to monitor their safety. Hence, we should not automatically decline these high-risk cases; specialised medical staff will have to assess these situations case-by-case.” (IV8)*

In sum, admission criteria as proposed by stakeholders in Ghent comprise long-term drug use, age  $\geq 18$  years, and (for some) being a local resident. Overall, a DCR should maintain its low-threshold nature, without a plethora of admission criteria and conditions, in order to reach as many as potential clients as possible: *“Don’t work exclusively; if one should not meet one of the criteria, the person will have to go back to the park next door to use his drugs... That does not seem a good practice, nor healthy to me. We should avoid exclusion criteria as much as possible, without going to an open door policy. Otherwise, you’ll lose your target group” (IV15).*

## **Location**

The vast majority of interviewees state that, if deemed necessary, one single facility would initially be sufficient in Ghent. This finding is consistent with stakeholders’ views that the target group in Ghent is rather small in absolute numbers. Some professionals say that, over time, expansion to multiple sites is an option worthy of consideration; each site specifically tailored to the needs of different subgroups (defined by, for example, sex, type of drugs or route of administration).

Location-wise, opinions of stakeholders in Ghent favour the geographical implementation of a DCR in a centralized area, for example the city centre or near the rail station (St. Pieters), for several reasons. First, locating a DCR in a centralized area of Ghent would benefit its accessibility for the target group. By not having a DCR centrally located, there would be additional barriers for PWUD, such as travel distance, with the risk of people not using the facility. In this respect, only one stakeholder suggested a mobile unit, rather than having a fixed DCR located in one neighbourhood, to increase accessibility PWUD throughout the city, especially those who would not be able to go to the centre. There were however some concerns about having a DCR centrally located, for example in a specific area where there is a pre-existing offer of other health and social services. Additionally implementing a DCR in such an area could, according to some interviewees, lead to a concentration of services and



thus an overburden of a certain area. On the other hand, other key stakeholders suggested that having a DCR close to other services would facilitate referrals from and to the DCR, and would increase the likelihood of clients in using those services.

*“A central location, in the proximity of other services. There is no point in putting a consumption room outside the centre where no one is going... The experience of the MSOC has clearly shown this—accessibility is an important criterion.” (IV15)*

According to these professionals, locating a DCR at the border of the city would hinder its accessibility and consequently impede the objective of reaching a particular group of PWUD. In contrast, some (including law enforcement) favoured a more decentralization perspective; more specifically a location proximate to areas where drug use occurs more frequently. It should however be noted that the distinction between the centre and the border of the city was not always that clear (such as the ‘19de-eeuwse gordel’ of Ghent), even for stakeholders. Those advocating the implementation of a DCR at the periphery of the city, in areas where PWUD congregate, state that this would have the advantage of bringing the DCR close to the place where they use drugs. Decentralisation was also seen as a way to reach PWUD living in neighbourhoods outside the city centre.

*“The fact that we still keep finding discarded syringes in these specific areas is either of people who have no home or shelter and can only use but publicly, or of people who do have their own place in Ghent where they could use, but prefer to do so in public, close to where they bought their drugs. For both groups, a consumption room not located close to these areas will be too far for them. It appears that their need to use is pressing at that time, in that neighbourhood. Might we locate a consumption room outside such problematic areas, I think we’ll fail to reach an important segment of users.” (IV8)*

This was echoed by PWUD in the focus group. Location-wise, PWUD favoured locations where “most buy their drugs” like neighbourhoods as *Rabot* and *Brugse Poort*. In terms of accessibility, they stated that the distance from these drug scenes to the facility should be kept to a minimum: “Nobody will, the moment they scored their dope, walk for several kilometres to a consumption room to use it. It’s ‘buying and using’. They won’t take a bus...”.

In contrast, according to professionals, locating a DCR in one of these specific areas where drug use congregates may, besides the neglect of other neighbourhoods in Ghent, further stigmatize the area: “It wouldn’t be opportune at all to ‘hide’ a facility in a neighbourhood that’s already impoverished [...]”

*Rather than locating a facility in such a specific neighbourhood or district that is known for its drug problem, the centralized option would be a better solution in Ghent, preferably linked to an existing organisation” (IV7).*

### **Organisation and integration**

All stakeholders in Ghent said that a DCR should be partnered with existing local agencies that serve PWUD. The vast majority of stakeholders quote the Medisch Sociaal Opvangcentrum<sup>71</sup> (MSOC) as an appropriate partner, given their expertise, medical approach, and experience and familiarity with the target group of DCRs. More specifically, most interviewees favour a *physical* integration of a DCR within the current MSOC building for several reasons. First, the MSOC has a long-standing expertise with the target group and is medically-oriented in its approach, which resonates with health-oriented goals formulated by interviewees in Ghent. Economically, such an integrated model also allows sharing of resources—besides staff, also premises, NSP, and other supplies. Such a DCR will cost less to set up and run, whereas a specialised DCR would be more expensive due to rental costs of a building and starting a programme from scratch. A DCR embedded within an existing organisation (in casu MSOC) has some additional advantages, including the availability of auxiliary services, the possibility for direct on-site referrals, and the internal flow of staff (between the DCR and general MSOC operations).

*“Starting up a consumption facility from scratch, out of the blue, will not be easy, wherever its location. Also with regard to the neighbourhood. Integrating such a facility within an existing organisation such as the MSOC might be the most sensible option. [...] Particularly concerning organisational aspects: expertise, financially, in-house referrals and staff flow.” (IV7)*

Nonetheless, according to those stakeholders favourable of a DCR embedded within the MSOC, such an option also has some significant caveats, the most significant one being mixing different groups of PWUD in one single facility. For instance, might the MSOC start with a DCR, both active drug users (DCR clients) and more stabilised or ex-users (e.g., people being dispensed OST in the facility) would be able to access the facility, albeit with a different purpose. For instance, this may complicate an abstinence-oriented trajectory of some OST-clients not using the consumption room, who additionally do not want to be identified with the subgroup of DCR-clients: *“A lot of people are struggling to come to the MSOC, once they are more stabilized, when they want to distance themselves from these ‘junks’, so they say themselves. It would be a mistake to see them as one homogeneous group, and not to take this heterogeneity into account” (IV7).* Therefore, might a DCR be integrated within the MSOC, it would be

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<sup>71</sup> Medisch Sociaal Opvangcentrum (MSOC) or Maison d’Accueil Socio-Sanitaire (MASS).

imperative to physically separate the consumption room from the other areas within the same building, for example by means of a different entrance.

*“Physically integrated within the MSOC, but rather as a ‘living-apart-together’ relationship. Like a side entrance so people coming for their methadone do not have to go through the same door as people who come to use the DCR. Otherwise, I think this wouldn’t be beneficial for the former group’s process; perhaps towards abstinence.” (IV9)*

Partly because of this reason, two stakeholders prefer and propose a different DCR model in which the MSOC is still responsible for the exploitation of the DCR, but as a stand-alone (i.e., physically separate) facility. Their justification for this ‘antenna’ model (a separate building rather than integrating the DCR into an existing organisation) is to separate active and stabilized drug users (see above), and to provide a facility with the core purpose of drug consumption. Moreover, a specialised facility may lower the threshold due to its exclusive focus on drug consumption since DCR-clients may avoid a facility that is integrated within existing harm reduction or treatment services: *“the advantage is that, as a user, you are free to go to the DCR without being confronted with any sort of care or treatment context”* (IV3). Nevertheless, stakeholders emphasize that a stand-alone DCR should have partnerships with other local agencies to improve access to additional services and referrals.

Last, four interviewees—including all law enforcement stakeholders—advocate the option of a DCR embedded within a local hospital. Analogous with the “Paris model”, as cited by these interviewees, such an integration may have several important advantages, such as security, informal social control with regard to drug dealers, presence and expertise of a multidisciplinary team who is already present at the hospital (such as an emergency doctor), its medical context, and the possibility for referrals.

## **Services**

With regard to whether a DCR should include multiple services or solely supervised consumption, most stakeholders stress the importance of providing a myriad of additional—although voluntary—services to DCR clients. In addition to overdose prevention, NSP and information on safe IDU (endorsed by all respondents irrespective of their opinion on the provision of extra services), the most common services considered important for a potential DCR in Ghent included mental health care, nursing care (such as wound care), low-threshold drug treatment services, and social services (such as OCMW/CPAS). Most see a consumption room as one part of a holistic service for PWUD, rather than a facility solely focused on drug consumption.

*“For some, harm reduction can be a springboard to additional care services. As caregivers, we shouldn’t lower our goals by merely providing a place to use drugs, because then you might seize valuable opportunities for these individuals. It shouldn’t be conditional; some users won’t be open to it, but they at least have the possibility.” (IV3)*

*“If it’s only a place where you go to make a shot, then I miss something. Social interaction with care services, however rudimentary these may be, is still very important. A broad framework for these people in Ghent is necessary.” (IV7)*

*“A drug user should be able to use in a safe context, and in that way providing sufficient care and guidance for these clients, thus creating a context in which we can maximize opportunities for further care. Not merely drug use, but equally possibilities for... Not necessarily mandatory, but we should at least create the possibility for further assistance and care. We have little ambition to organise a ‘syringe exchange with a consumption room’ without further services. If we might implement a consumption room, we should go beyond this, and see how we can assist drug users at a certain time in their trajectory of addiction.” (IV15)*

Stakeholders, including law enforcement, note that the advantages of offering multiple services in one single setting—whether integrated or not—included reduced barriers to health and social services and increased continuity of care for PWUD. On the other hand, such services should be demand-oriented rather than conditional, according to some of these stakeholders. Too much focus on psychosocial or medical care would create a barrier for individuals who are, at that specific time, merely interested in the consumption of their drugs. Similarly, advocates of a stand-alone facility stress that although a DCR should be embedded within a network of local organisations serving PWUD, additional services provided on-site should be kept to a minimum in order to preserve the low-threshold nature of the DCR. Alternatively, according to these actors, staff should be vigilant for clients’ demands for further care, and these demands should be addressed through referrals to health, welfare, and social services, preferably in the vicinity of the DCR. Another reason for focusing solely on supervised consumption was avoiding duplicating services in the local community.

*“You shouldn’t create similar services that already exist in Ghent, because, I think, you can just as well refer those people to these services. You should avoid overlap; it would be absurd to install identical services on two separate locations, especially given the limited resources. But I*

*am convinced that, to ensure a close link between services, staff should be present in the DCR to ensure in such referrals.” (IV3)*

In a similar vein, though a majority of interviewees acknowledge the importance of additional services at a voluntary basis, professionals from Ghent were mixed in their opinions regarding the provision of day care, purposeful activity or a drop-in centre. They fear that such a drop-in centre would duplicate existing services, which are, according to their views, sufficiently available in Ghent at present:

*“Should there be no such services available in Ghent, I’d say, okay, if you would start a DCR, make sure it’s integrated and a lot of auxiliary services are provided within. But the fact that a lot of initiatives are currently up and running at different locations, I think it’s logical that we would not to install another drop-in centre, or something similar.” (IV8)*

In the focus group, overall, PWUD advocate a rather clinical operationalization of a DCR; *“you shouldn’t make it too cosy, too comfortable”*. In a similar vein, respondents were more in favour of a stand-alone facility compared to an integrated DCR in which more services and activities are provided: in Ghent, *“there are already enough solutions for that”*. Taken together, for the PWUD included in the focus group, a DCR in Ghent should primarily focus on drug consumption, whether smoking or injecting. Nonetheless, several other services were spontaneously mentioned by participants that should be available; especially NSP and the possibility for drug testing was perceived as an important addition to the DCR.

## **Staff**

As mentioned above, DCRs that are physically integrated into existing facilities (such as a MSOC or a hospital) have the advantage of a range of staff and auxiliary services already available in the facility. With regard to staff, the presence of a physician specialised in the field of addictions is deemed a large advantage of an embedded DCR; not only because of expertise and experience, but also with regard to the cost of a medical doctor (MD). Moreover, most stakeholders do not think that a MD should be permanently present at the DCR, although s/he should be on call (contactable) during opening hours. When implemented in the context of a MSOC or hospital, there is no need to additionally staff the DCR with a MD. Irrespective of the specific model, stakeholders from Ghent stress the importance of nurses to be present in the DCR, which is in keeping with the medical and health-oriented focus as discussed by most of the respondents. Some stakeholders specify the need for psychiatric nurses, given the high comorbidity of mental health problems among the group of PWUD.

*“A starting point is clearly nursing services, but we should certainly not forget the social aspect, such as drug-related services and support.” (IV2)*

In addition to medical staff (nurses and/or a MD), social workers and related professions are frequently cited by stakeholders as essential personnel within a DCR. According to the interviewees, they are able to provide services extending a medical focus, as well as in referrals. Overall, both nurses and social workers are deemed imperative in the context of a DCR in Ghent; a multidisciplinary, socio-medical framework is considered to be the most effective by local stakeholders. Only those advocating a stand-alone facility express the need to additionally employ security staff in the DCR. In contrast, according to the stakeholders, specific security personnel would be ‘overshooting’ in case the DCR is embedded within an existing organisation, such as a hospital or MSOC. Lastly, irrespective of the proposed model, most professionals state that involving the target group would be a welcome addition for the operation of a DCR. Participation of clients is especially perceived as desirable with regard to the formulation of house rules and responsibility towards the daily functioning of the facility. Employing former PWUD as staff was deemed a beneficial option by some of the professionals, however, they cited several issues, for example the difficulty for an ex-drug user being constantly exposed to active drug use.

Aligned with a proposed ‘clinical DCR’ in the focus group, medical staff was perceived as essential by PWUD. Supervision by medical personnel, for example nurses, was important with regard to safety in case of emergencies, such as overdoses. Furthermore, according to PWUD, ‘social staff’ (e.g., a street corner worker) should be *“present in the background”*. In case DCR clients would have questions, they should be able to address these concerns to social workers. However, respondents emphasized the demand-driven nature of such help and/or referrals. Furthermore, it was important that interactions with staff *“shouldn’t always relate to dope”*.

### **Law enforcement**

Every participant was convinced that clear agreements with law enforcement, and police in particular, are key in a successful operation of a DCR. Many stakeholders expressed that it is of utmost importance that police is involved in all aspects of the planning and implementation process (cf. *infra*) given the specificity of a DCR—the issue of drug possession of clients.

Several stakeholders propose that a ‘bubble zone’ (perimeter) should be installed where police should tolerate the possession of drug use. In this regard, many mention the absolute need for a clear legal framework. Stakeholders state that this perimeter is not absolute, and exclusively relates to the

possession of a small amount of drugs of users. Although acknowledging the need for a certain zone in which police should not have an ongoing visible presence—since this would nullify the low-threshold nature of the DCR, and deter (potential) clients from using the facility—professionals emphasize the difficulty of repression towards dealers in the direct vicinity of the facility when such a perimeter is to be inducted. Furthermore, the ‘tolerance policy’ does not constitute a silver bullet or free pass for DCR clients who are searched for by the police for offences other than drug possession near the DCR.

*“It is especially important for police [...] that agreements are made, that they don’t organise [drug] controls in the street where the facility is located. In concrete terms, I however doubt that this will ever be written down in a corps-wide directive... I think it will rather be some kind of ‘modus vivendi’ or an unwritten rule, that police will adopt a certain radius. But again, if the persons who use the drug consumption room are caught elsewhere, or during another control, the excuse of ‘I’m heading to the consumption room’ does not hold of course. It’s no free pass. It will be necessary to meet with the local security council—with the chief of police, the mayor and public prosecutor to find feasible ways to deal with such issues. Because, if police sees something, they have to register it. But if they don’t actively look, they won’t find it off course.”*  
(IV9)

Besides the need for clear-cut agreements towards the possession of illicit drugs, stakeholders also (1) express the role of police to provide support for a DCR by responding to calls dealing with emergencies, and (2) believe that police should encourage people who were engaging in public drug use to go to an DCR (e.g., play the role of a referral agent) instead of arresting them. According to interviewees, there currently are good agreements with local police for other low-threshold facilities working with PWUD, such as MSOC.

*“There’s already a good cooperation in Ghent between the Public Prosecutor, police and health services about similar issues, and I would always opt for a protocol—a protocol in which it is agreed on what information is shared and what not, the specific way of cooperation, is police allowed to enter the facility, and so on... That there are clear and written agreements on such matters, preferably in advance [of opening].”* (IV15)

Similarly, in the focus group, a main concern of PWUD related to law enforcement. Respondents were fearful about police patrolling in the vicinity of the facility. The need for solid and clear-cut agreements with police were a central aspect in respondents’ accounts; they should have some ‘guarantee’ for not

being arrested solely based on their visit to the DCR. More generally, respondents said that a DCR should primarily be a place where they can consume drugs in a safe and peaceful environment.

### **Responsibility and funding**

With regards to responsibility, most mention the local level since *“a consumption room is a local story”* (IV2). Specifically, both the municipal office for social affairs and welfare (*schepen van welzijn*) and the major should be responsible. Some mention a collaboration between the Flemish government and the local level. In terms of funding, the majority of stakeholders favour the Flemish government (the administration Welfare, Public Health and Family) given their competence for drug-related matters, as well as the health-oriented focus of DCRs and thus a health initiative.



## 3.2 Antwerp

### Goals

According to stakeholders, the main goals to implement a DCR in Antwerp are to improve safety and health of PWUD; reduce drug-related morbidity and mortality; and increase access to harm reduction services. Furthermore, many stakeholders feel that a DCR would be an important point of contact for service providers to build relationships with DCR clients, especially with those who are not regularly accessing health or social services. Secondary, improving public safety and reducing public nuisance (e.g., discarded needles, syringes and other paraphernalia) are posited as important goals. In general, stakeholders were in agreement that safety of PWUD and their health should be the most prominent concern. Likewise, in the focus group in Antwerp, PWUD stressed that a DCR should, above all, provide a safe and peaceful environment for drug consumption. A safe and peaceful space would, according to the PWUD, primarily result from the provision of sterile equipment, medical staff being present to oversee the consumption (and intervene in case of an overdose), and the insurance that police is not present. The desire to use safely and quietly was a central theme in the narratives of PWUD.

### Target group and admission criteria

In terms of the type of drugs or the methods of drug use, the large majority of stakeholders in Antwerp believe that a DCR should be accessible to anyone with an active addiction, regardless of the type of drug or whether the drug was used by injection or inhalation. Most stakeholders preferred DCRs that permit both supervised injection and supervised smoking within the same facility; albeit physically separated from each other. Some stakeholders, on the other hand, want a possible DCR programme to be open to injection only.

*“Long-time drug use, whether its injecting or freebasing. Although injecting use is particularly associated with nuisance, you shouldn’t make any distinction. The main feature is being long in use, regardless of its way of administration. Everything, but in case we should make choices for budgetary reasons, I think we should primarily focus on intravenous use, because of the risk and nuisance. But, ideally, not exclusively.” (IV14)*

For most stakeholders in Antwerp, the idea of people < 18 years of age being allowed access to the DCR generated discomfort due to legal, moral and professional reasons. Concerning the latter, most interviewees were convinced that there are still other (preventive) strategies to approach this vulnerable population of PWUD; many felt that that there is still opportunity to prevent youth from

becoming adults who use drugs, and young people should instead be referred to some sort of a drug treatment program. Further minimum age restrictions for DCR access were not specified; duration (and seriousness) of drug use prevails over chronological age.

According to the stakeholders, setting too much inclusion criteria would undermine the low-threshold nature of the DCR and would consequently contradict its goal to reach and connect with a vulnerable group of PWUD in Antwerp. Especially the exclusion of individuals enrolled in OST and non-homeless PWUD was not deemed feasible by the vast majority of local stakeholders (including law enforcement).

*“Suppose you’re a parent with children at home and you don’t want to confront them with your drug use. Then, I think it’s a wise choice to go to the drug consumption room, to use. If you will only allow homeless drug users, you’ll completely undermine your goal of such a room.” (IV4)*

Regarding a local residency requirement, opinions were more mixed. Some state that inclusion should be *“all or nothing”* (IV11), thus including PWUD regardless of local residency, whereas others (including some stakeholders from law enforcement) lean towards the admittance of only local residents (broadly defined as an explicit and durable link with the city) because of a feared ‘honeypot’ effect whereby a DCR could attract drug users to the area, increase local nuisance and rates of crime, and contribute to a negative image of the city. Irrespective of the question whether a DCR should be region-bound, most acknowledge the fact that illegal immigrants and refugees should be able to access the facility since this group constitutes a particularly vulnerable population of PWUD, insufficiently reached by current drug-related services.

*“Certainly the group of people without papers, migrants and refugees, and itinerant users who strand in the city of Antwerp. And, of course, local people who use drugs. So in general, people who are designated to the public space at a given moment because of their lack of stable housing.” (IV13)*

Taken together, it was often noted that safety is a primary goal of DCRs and that goal should be equally applied to anyone who wants to use the facility, regardless of type/method of drug (use), current OST, or homelessness. Intoxicated individuals and pregnant women presenting at the DCR are considered vulnerable subgroups warranting additional procedures and follow-up by staff. Though the importance of a low-threshold facility was emphasized by nearly all participants, two criteria (aged 18 and older, and local residency requirement) were receiving considerable support by stakeholders.

*“If they’ll make the choice to install a consumption room, why should you burden it with many criteria? Besides, conditions that you’ll need to check, leading to conflict situations in the sense that ‘he is granted access and I am not’. [...] By not adopting a pragmatic point of view, you will refer some users to illegal and unhygienic circumstances, with all its subsequent risks. (IV13)*

PWUD in the focus group strongly preferred a DCR that would allow both smoking and injecting or inhaling within the same facility. However, a physical separation of smoking from injecting was strongly advocated as this option would segregate clients experiencing different highs, and reduce exposure to different modes of substance administration, especially IDU for non-injectors. Furthermore, regarding the target group, respondents in the focus group were clear that homelessness, enrolled in OST, and local residency were no feasible eligibility criteria; a DCR should be accessible for everyone who uses ‘hard’ drugs and feels the need to use in a secure environment. An exclusion criterion that was deemed necessary included < 18 years of age. PWUD thought that an intake interview at first visit was a good way to gain insight in the person’s drug use, physical conditions, and age.

### **Location**

Location-wise, stakeholders are convinced a DCR should be implemented in one or more specific areas in Antwerp, rather than prioritizing a more general central location. More specifically, they frequently cite geographical areas such as *Antwerpen-Noord*, *Sint-Jansplein*, and *Schijnpoort* as locations where a DCR would be desirable. These neighbourhoods are, according to the local stakeholders, characterized by high levels of problematic drug use. Therefore, without *“creating a metaphorical Molokai for those drug users”* (IV4), these neighbourhoods would be good locations to reach a large proportion of the target population. Some of the locations, for example *Schijnpoort* (where the MSOC is also based), are not specifically located in the city centre (though at the periphery), but accessible for potential clients.

*“The target group will find its way, even at the outskirts of the city centre. In my opinion, the physical location is maybe not that critical. I especially think that the services offered there, and the way things are organised, determines the success far more than its geography. I am not saying it’s irrelevant, but the offer determines success rather than where you’re located.” (IV13)*

Locating a DCR in such an area would be beneficial to PWUD because it would be close to other services (like the MSOC), thus increasing the accessibility and the likelihood and ease of use. However, whereas having a DCR proximate to other services would increase the likelihood of PWUD using those services, this option may also lead to a concentration of services in one specific neighbourhood and thereby

neglecting other areas in Antwerp. Furthermore, implementing a DCR in such areas would also lead to a concentration of PWUD, which would be negative for neighbourhood residents.

*“As close as possible to drug users, in problematic neighbourhoods. But often there are already many services in these areas, and local residents won’t be pleased if there will be ‘yet another’ service for drug users located in their neighbourhood, where they will hang around, in terms of concentration.” (IV14)*

Geographically, distance to the DCR was an important factor for local PWUD; a DCR should be easily accessible for the target group. Some say that craving and withdrawal symptoms may interfere with travelling to a DCR after buying their drugs. Location-wise, most PWUD favour a facility to be situated near other social, welfare and/or drug-related services, without being necessarily physically integrated within these organisations/services. According to the participants in the focus group, possible locations include near the MSOC (Free Clinic) or the Stuivenberg hospital.

### **Organisation and integration**

Every single stakeholder from Antwerp advocates an integrated DCR (rather than a specialised facility). However, no single model was clearly preferred by interviewees. Many stakeholders thought that a DCR could be partnered with (and integrated within) existing harm reduction programmes, because they already serve the needs of PWUD. Many saw integration with other services as important to the effectiveness of a DCR in Antwerp. Stakeholders especially favoured physically integrating a DCR into the MSOC (Free-Clinic), which was identified as an appropriate partner. Such integration would allow the DCR to offer a variety of auxiliary services on-site, beyond supervised drug consumption, including basic medical care and social services. Most of these services are already accessible in the MSOC, which was deemed a large advantage of such partnership—also financially: *“otherwise, I think it will be a very expensive investment for relatively few people” (IV4).*

*“Separate, detached... That doesn’t seem realistic to me. I think you should embed it. Because, by embedding such a facility, financially, it undoubtedly has a number of benefits: staff can be permanently present, follow-up, and so on. If you would provide an autonomous consumption room, you’ll face some serious organisational challenges...” (IV10).*

In addition to the provision of auxiliary services, other advantages include, according to participants, the possibility for on-site referrals (for example to OST), the familiarity of the service with PWUD, and the possibility for an internal flow of staff (between the DCR and other general MSOC operations).

*“An integrated operation, with sufficient demarcation: ‘this door is clearly for the consumption room, and this door is focused on non-use, health care, or another perspective’. But integrated. Organisationally, you will be able to work in teams more fluidity. I have no idea how it’s like to work in a drug consumption room, but I think it’s a mentally challenging job. But if you would be able to combine that facility with another form of service... it would be much more feasible. Staff can alternate between services, for example working half-time in the consumption room. So integrated; not only organisational but equally with regard to provision of services. In case of a stand-alone facility, you’ll miss some perspective to other things. Whereas if you integrate it, you have... Okay, it’s possible that clients will be merely interested in drug consumption, but there’s a possibility to something else. You can also have a medical consultation or contact with a social worker. A springboard to something more... on a voluntarily basis.” (IV13)*

Several disadvantages should nonetheless be considered when integrating a DCR within the MSOC. For example, a younger segment of drug users (and potential DCR clients) would perceive the MSOC as a barriers *“because they would find it hard to identify themselves with these ‘junks’ as they are commonly perceived in the MSOC”* (IV13). When linking a DCR to the MSOC, the perceived image of marginalized PWUD there might perhaps be even more present among younger individuals. A second limitation may entail the mixing of several target groups. More specifically, when integrating a DCR within the MSOC, clients of the MSOC will come into contact with DCR clients—although they are certainly not mutually exclusive groups—which could install an barrier and heighten the threshold to visit the MSOC for non-DCR clients: *“the confrontation of rather ‘stabilized’ people with active users, with dealers—with their past”* (IV13). Stakeholders discussed whether the advantages of integrating a DCR in the MSOC would outweigh these disadvantages, which was mostly answered positively. One option, raised by several stakeholders, is to install a physical separation between the DCR on the one hand, and general MSOC operations on the other hand, while still located in a same building. Suggestions primarily included a separate entrance (e.g., side door).

In this context, another suggestion (from three interviewees; including law enforcement) for a DCR partnership included hospitals, where mixing ‘active’ and ‘stabilized’ users would be no concern, while still maintaining the advantages of existing expertise, medical staff present, a shared building (and thus reduced costs) etc. Integrating a DCR within a hospital would also, according to these stakeholders, benefit security of the facility.

One stakeholder preferred the implementation of a DCR as a 'department' of the MSOC; thus locating the facility in a separate building rather than in the MSOC itself (or close by), however, still embedded with the MSOC organisation (rather than a fully stand-alone facility). The reasons for not integrating the DCR physically was that it will lower the threshold for potential clients to make use of the facility, who would otherwise perceive the care-oriented setting of the MSOC as a barrier. The advantages of management by the MSOC would remain (e.g., expertise, experience and medical staff). However, one important drawback would be to find a building (and related additional costs) for the facility.

*"Some clients just want to use drugs. Which should be possible in a consumption room. And by organising a consumption room within the framework of Free Clinic [MSOC], you're in a care-oriented system right away. For most people, it seems logical to connect a consumption room to something more, but perhaps, for some users, it should be purely using drugs. Might there be too much care or services offered at the facility, even social-administrative matters... This group of users will stay away. Thus, although logical and practical, it would be best to watch over the low-threshold nature of the facility and just focus on drug consumption." (IV11)*

In line with their perceived objective of a DCR (a safe and peaceful facility), PWUD advocated a clinical facility, primarily focused at drug consumption. Safety should be guaranteed, by means of available materials (needles, syringes and other paraphernalia) and staff supervision.

### **Services and staff**

Alongside the supervised consumption of drugs, there was little to no discussion that several specific services should be delivered on-site; more specifically the provision of sterile injecting equipment (i.e., NSP) and other paraphernalia, as well as education and advice on safer (injecting) drug use by staff. One recurrent theme was the possibility for drug testing. Providing this service to DCR clients would allow them to test the quality of their substances, which was deemed a valuable addition to a DCR. In line with the large preference to integrate a DCR within an existing (harm reduction) facility, a majority of stakeholders furthermore stressed the need to provide auxiliary services on-site where possible: *"in a consumption room, we should maximally invest in care and treatment. Merely relying on referrals is, in my opinion, insufficient; these services must be directly addressable by clients"* (IV4). Others on the other hand (see above) were more propelled towards the idea of providing additional care and services (such as social services, medical care, and psychosocial counselling) on a referral-based ground rather than on-site, since this would heighten the threshold and possibly create barriers for some PWUD. In the perception of these interviewees, there was also some concern that 'overshooting' would lead to

the duplication of existing services in Antwerp that already serve the needs of the target group, and of PWUD by extension.

*“It’s necessary to work demand-driven; make sure outreachers, such as street corner work, are present, so they can refer to the appropriate services or even accompany the clients. Otherwise you’ll implement services that already exist in other places [...] Don’t create a ‘Samusocial’, or you’ll be doing net-widening. Then the target audience becomes too wide; it shouldn’t become a general service centre.” (IV10)*

A similar result was observed regarding social activation and the provision of purposeful activity. Five stakeholders mentioned this option, four of whom (including law enforcement) thought it would not be a priority to link a DCR to such a drop-in centre or to additionally create possibilities for purposeful activity. If (another) drop-in centre would be created in Antwerp, in the present case linked to a DCR, participants are wary that you would create a subgroup of ‘DRC users’ within the wider population of clients (including ex-PWUD) who would make use of the centre.

*“We already have these in Antwerp; drop-in centres, night- and day care services, ... Should we create similar initiatives in the context of a drug consumption room? I think not. Might there be the need, yes. But it’s perhaps unnecessary to implement it too. Priorities are elsewhere; you shouldn’t create overlap.” (IV14)*

Overall, however, most of the stakeholders acknowledge the need for framing a DCR within a wider continuum of further care and services, whether or not delivered on-site. This view resonates with the belief that a DCR should focus on improving PWUD’s health and increase access to (harm reduction) services—in addition to its core goal of providing a supervised place to use drugs.

The above-mentioned preference for a wide integration of services in a DCR is also translated into how respondents perceive staffing in the facility. First and foremost, medical personnel should be always present in the DCR; however, in the embodiment of a nurse (preferably a psychiatric nurse) rather than a physician. A MD would significantly elevate staffing costs, and their physical presence in the DCR was rather perceived as overshooting by most stakeholders. Though not necessarily present on-site, a MD linked to the facility was however deemed necessary with regard to responsibility.

*“Of course, in an ideal scenario, there’s a physician present permanently, but this would be a very expensive matter. If you’re integrating the consumption room within the MSOC, you will*

*have your medical expertise directly at hand, easily contactable by telephone during MSOC's opening hours, in case there is an emergency.” (IV13)*

Although a central part, staff was described as encompassing more than just medical personnel. More specifically, all respondents stressed the need for “psychosocial staff” (commonly referred to as social workers) to be present in the facility. In their opinion, such personnel is complementary to the medical approach. Social workers (should) have sufficient knowledge of available services in Antwerp, and they should provide with targeted referrals (if services are not delivered on-site). The advantage of having social workers present in the DCR would, according to the stakeholders, especially be valuable in the resting area (i.e., separate from the room where the drug consumption occurs) where staff are on hand to interact in a more informal way with those that want help and refer them to other services where appropriate. Last, security personnel were only cited in the context of a stand-alone facility. In the case of an integrated DCR (in a MSOC and hospital alike), most stakeholders thought that sufficient security measures are readily in place, and specific security personnel would not be necessary. Other suggestions with regard to security included CCTV and locating a facility near a police station. Last, involvement and engagement of peer workers in the organisation and operation of the facility were deemed a valuable addition to the DCR by the majority of stakeholders (including law enforcement).

According to PWUD in the Antwerp focus group, the availability of auxiliary services, in addition to the designated consumption area(s), should be kept to a minimum. Core services that should be delivered on-site include nursing services (e.g., wound care), NSP, and drug testing. Additional psychosocial or welfare services were not desirable for PWUD: *“No, we have sufficient day centres... Why should the consumption room also function as... In my opinion, a consumption room should focus on drug use. If you want, you can be referred to other services”*. Referrals and follow-up could be *“present in the background”*, available if wanted. For these functions, PWUD favoured the presence of social staff in the facility, in addition to medical staff (not necessarily a physician). Security was an important issue, however, specific security staff was not deemed necessary by most of the respondents: *“not someone from Group 4 for example, but someone from the regular staff who's responsible for safety and security; not everything will always run as smoothly as hoped for”*.



## **Law enforcement**

The absolute necessity for clear agreements with police and Justice officers was emphasized by all of the stakeholders. Many alluded to the concept of a perimeter of non-enforcement around the facility. Some agreed that police should have a protocol agreement of some kind to ensure that clients would feel safe from arrest when going to and from the DCR. Others, including law enforcement, seriously doubt if such a written protocol would be feasible at all.

*“For police, it will be impossible to put that to paper, a ‘free zone’. Otherwise, you will attract dealers to that specific area. But I am convinced that it should be possible to say ‘in that zone, the instruction of the chief of police to its officers is that they won’t fixate that location’, to set a ‘de facto’ perimeter, without actually calling it a perimeter... Naturally, drug dealing should be tackled in that zone.” (IV10)*

Other concerns related to police and law enforcement include medical confidentiality of clients’ data, which should be protected at all costs in order to ensure their privacy, and the possible function of police officers to refer PWUD to the DCR.

## **Authority and funding**

In Antwerp, the responsible administration should be local; both enforcement (the mayor) and welfare (municipal office), although emphasis was placed on the latter. For funding, stakeholders acknowledge this will be a mixed story, but most commonly cite the Flemish government as main funding source—since they are responsible for drug matters—maybe supplemented by other (local) funds.

### 3.3 Brussels

#### Goals

The main objective of a DCR in Brussels, according to care professionals, is to facilitate contact and gateway to other services, including low threshold services, with people who are not in touch with care services.

*“It really is a door to the care pathway, a place for close contact with users who are not always in touch with social services or who have fallen off the radar. So it’s a place to reach these people.” (IV32)*

Other stakeholders also put forward public safety objectives, e.g. reduction of public nuisance.

*“There is not just one goal but many. Rules for both public health and public safety are needed. The drug consumption room serves both ends.” (IV20)*

Regarding PWUD, the main objective of a DCR is to improve their daily safety and quality of life, by providing them with safe and adequate consumption space.

*“It’s nice because you’re safe and get support. I’ve taken drugs today, but I was on my own. If anything had happened there wouldn’t have been anyone to help.” (IV45)*

#### Target group and admission criteria

Consistently with a low-threshold approach, most stakeholders specify that there should be no target group excluded. According to all stakeholders, drug types and modes of consumption should not be considered as access criteria. In addition, as consumption practices and products change over time, considering products and consumption modes as criteria would not be useful.

*“I think we have to be as inclusive as possible regarding different drugs and different ways of consuming them. We don’t want to discriminate or prioritise one drug over another. As far as I’m concerned any type of drug can be taken in the room, and in any way they like.” (IV32)*

According to PWUD, it is necessary to provide individual consumption spaces in order not to mix people using different drugs or having different modes of consumption.

*“I prefer small separate cubicles because if someone who doesn’t inject has to do drugs with people who do they could end up wanting to try shooting up. And that way everyone has his own space where they take the drugs they want.” (IV45)*

Stakeholders have different views regarding the access to the DCR for first-time consumers. The care professionals highlight the importance to consider it on a case-by-case basis. If a person is really determined to consume, he/she should be provided with safe conditions.

*“Every case is different. If you know that the person’s going to use drugs anyway it’s better to provide them with a safe place as long as they check in with a member of staff.” (IV20)*

However, law enforcement stakeholders (police and justice) emphasize that first-time consumers should not have access to the DCR and should be referred to other services. They argue that a public authority is not allowed to give access to a DCR to a non-consumer. Anyway, many PWUD believe that those who are not yet drug users will not want to go to a DCR.

All stakeholders agree that no proof of local residence is required. Care professionals and law enforcement professionals point out that this would exclude some target-groups, such as homeless people and those who live in the outskirts of Brussels. Some stakeholders state themselves that the concern of a possible ‘pulling factor’ of PWUD coming from elsewhere is an understandable fear, although the experience of other countries showed that the phenomenon was limited.

*“Don’t forget there are 100,000 undocumented people in Brussels. So we need a system that doesn’t depend on having a local residency or address. These persons must be given access to the consumption room.” (IV32)*

Stakeholders have also different views regarding the accessibility of the room for OST clients. Care professionals emphasize the need of specific attention to these users, e.g., because methadone injection is more risky than heroin injection. Law enforcement stakeholders argue that excluding substitute treatment users would exclude the majority of the target population. However, one law enforcement professional put forward that allowing access to DCR for substitute treatment users would sign the failure of substitute treatment interventions.

*“We obviously have to accommodate people who abuse drug substitutes. Special support is needed for those injecting methadone for example, because they are taking so many risks. They need information and support.” (IV47)*

Care professionals and law enforcement stakeholders agree to consider specifically the access of underage PWUD in the DCR for early management of the problem. However, some stakeholders argue that, even if desirable, the access of underage PWUD to DCRs would not be politically acceptable.

According to all stakeholders, pregnant women have to get access to the DCR within a harm reduction approach, with specific support and care alternatives, and consumption supervision if needed.

*“They shouldn’t be excluded. There is a real risk for them and a real risk to their children’s health. If they’re not allowed in they’ll take the drugs in worse conditions. We can even monitor their drug taking if necessary but also try and find other solutions. But we shouldn’t exclude them because that would be defeating the objective.” (IV31)*

Care professionals have mixed views regarding the access to the DCR for intoxicated PWUD. Some of them point out that, if a person definitely wants to consume, there is a risk of overdose, and professionals should supervise it. However, others consider that, if the staff has been noting a significant level of consumption, it is their duty to advise the PWUD against overdose, to explain risks, and to restrict access to the DCR as long as the risk is too high.

## **Location**

All stakeholders and PWUD believe that a DCR should primarily be located in Ribaucourt, Molenbeek. The criteria in favour of Ribaucourt are: the proximity of PWUD, easy access, and a rather quiet crossing point in a not too residential area.

*“It’s the best location [Ribaucourt] because that’s where it goes on. It’s easy to get to; there are main roads and plenty of people around so that makes the place blend in.” (IV32)*

All stakeholders and PWUD also believe that several DCRs would be preferable to one single room in Brussels, for accessibility and discretion reasons, although some raised a concern about financial barriers. The municipalities of Brussels-City, Schaerbeek, and Anderlecht are also cited for the implementation of DCRs. Care professionals would favour a model including a large accommodation

service (*integrated care centre*, including a DCR) in the Ribaucourt area, and smaller DCRs in the other areas. These smaller DCRs could be the extension of the current syringe exchange counters.

*“We don’t have the budget yet to set up multiple consumption rooms. What we need is one big facility at Ribaucourt. Later, in order to reach more geographical areas and to improve public health, it would be good to create a network of consumption rooms around this one.” (IV46)*

### **Organisation and integration**

Several stakeholders suggest integrating the DCR into a project of ‘integrated centre’ for drug addicts, which should be opened in the Ribaucourt area. Actually, a space for a DCR is planned within the current project.

*“So we’re moving towards a future integrated centre, and I’m not going to hide that we will set aside an area for a safe drug consumption room. The premises would be made available in the integrated centre for the day when the law allows it. So it would be part of a bigger system: welcoming them, providing counselling, a crisis shelter, and more long-term help.” (IV20)*

If the DCR is part of the integrated centre project, its administration would be shared by the Centre Transit,<sup>72</sup> Projet Lama,<sup>73</sup> Médecins du Monde,<sup>74</sup> and a partnership with other actors like the MASS<sup>75</sup> and Dune<sup>76</sup>. The integrated centre would be funded by the regional authorities (Brussels-Capital Region) within the “plan global de prévention et sécurité.” Therefore, the administration would also be under the responsibility of the Brussels-Capital Region authorities.

*“This future centre would provide a base for coordination between prevention and harm reduction organisations such as Transit or Lama which provide health care and harm reduction, Médecins du Monde and other stakeholders such as Dune.” (IV32)*

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<sup>72</sup> Low-threshold drug treatment service, center for crisis, emergency and accommodation of PWUD.

<sup>73</sup> Drug treatment service, medical psycho social assessment and substitution treatment

<sup>74</sup> Medical assistance to vulnerable groups

<sup>75</sup> Local low-threshold (harm reduction) services including substitution treatment

<sup>76</sup> Street work (harm reduction) for PWUD

## Services

According to most stakeholders, in the event that the DCR is integrated into a larger centre, various additional services could be provided, such as: generic medical visits, social support, housing, and support for employment. In addition, care professionals also point out that providing a space for discussion and rest is as important as washing machines, showers, and a drop-in space. According to PWUD, it is also important to provide drug-testing in the DCR, so that they can assess the quality of the product they want to consume.

*“We need tests. I saw it on the internet. You give your product and they test it and tell you ‘be careful it’s mixed with lots of rubbish’ so you know what you’re taking.” (IV45).*

## Staff

All stakeholders say that a multidisciplinary team is needed, including nurses, educators, and social workers. Some care professionals are concerned with the cost of medical staff, and emphasise that some of the existing DCRs are running without it. If the DCR is in an integrated centre, it is possible to run the DCR sharing the medical staff with the other services of the centre.

*“Multidisciplinary staff; we need nurses, educators and social workers. I’m not so sure about doctors because they cost lots of money. There are centres abroad which don’t have any medics at all where there has never been a single overdose. So you don’t necessarily need a doctor in the consumption room. But if the centre is part of a wider health system involving doctors that’s the simplest way of doing things.” (IV20)*

However, according to PWUD, medical staff (doctors, nurses) is required to take care of health problems related to drug use, and social staff (educators, social workers) is required to assist PWUD in life projects outside consumption.

*“We need people to avoid preventable deaths, overdoses, we want no risk of infection, we don’t want to ‘catch’ anything. We need prevention, support, so we can survive” (IV45)*

Several stakeholders are in favour of security staff in the DCR in order to release the clinical and social staff from violence management activity. In addition, security personnel is already foreseen within the integrated centre project.

However, other care professionals argue that the presence of security personnel in the DCR could provoke violent behaviour from PWUD, and that the proximity of a police station would be a better alternative for PWUD and staff's safety.

*"I do wonder whether the mere presence of security guards might actually provoke violence. For example, 'I can act tough because the security people are around.' But why not locate it near a police station?" (IV21)*

Some PWUD are in favour of having security personnel in the DCR so to avoid violence or robbery between PWUD.

*"We have to avoid racketeering and stuff like that. If I don't feel safe I won't go. Yes, we need security guards." (IV45)*

Care professionals indicate that PWUD and PWUD' views should be taken into account for organising and operating the DCR. For example, PWUD could be involved in the collection of used syringes or in injection practice advices. However, some care professionals express concern regarding the possibility of PWUD having an active role in DCR that could lead to organisational issues, such as power management, relationships, and frustration between PWUD. Most of law enforcement stakeholders say that they do not have any real opinion and expertise about this topic, and leave it to care professionals and PWUD.

*"Yes, we're increasingly moving towards including drug users in these centres. At the same time you have to manage the balance of power, people's frustrations, make sure everyone knows where they stand, so it's far from easy. We could for example get the users to pick up syringes outside—if they're willing that is." (IV32)*

### **Law enforcement**

Most stakeholders consider that the police must be part of the DCR project. The police should be present in the neighbourhood of the DCR to maintain order, avoid the concentration of dealers, and reassure workers, PWUD, and neighbours of the DCR. However, a care professional specify that the police could observe whereabouts around the DCR, although they should only intervene in the DCR in case of obvious offense. In addition, the DCR staff should be protected so that they are not obliged to provide information to the police.

*“They have to continue to do their normal job around here. So not stop all the drug users, show tolerance towards users but if they see a deal in progress, then they can intervene. They can watch who comes in and goes out if they want but not ask those working in the room for any information. In cases where it’s obvious an offence has been committed then yes, they can come in.” (IV32)*

### **Authority and funding**

In Brussels, stakeholders agree that the Region should be politically responsible for the DCR, which means, according to the current division of competences in Brussels, that it should be placed under the responsibility of the Common Community Commission (CoCom). This authority is responsible for prevention and health policies in the region, and is already involved in the future development of the integrated centre mentioned earlier. However, one stakeholder emphasizes that the responsibility should be shared between the Federal government, the French-speaking Community Commission (CoCoF) and the CoCom.

*“A debate in the federal parliament is inevitable. It’s a federal law so we need a federal position on it. But the consumption room is overseen by the Brussels Regional Authority as are its health and safety issues. The integrated centre is subject to its authority so the room could be as well.” (IV20)*

In addition, stakeholders agree that financing should come from the responsible authority, i.e. CoCom, possibly combined with funds from the Federal authority (mixed funding).



### 3.4 Liège

#### Goals

All stakeholders interviewed state that the main objective of a DCR in Liège is twofold: improve the health of PWUD, and reduce public nuisance and insecurity.

*“People should feel comfortable on the streets, both users—because there is nothing good about consuming drugs in front of everyone else in bad conditions—and citizens who do not want to see... It’s quite a violent act, especially injecting.” (IV24)*

Care professionals also emphasize a goal of care accessibility for people who currently do not have currently access to (low-threshold) care.

*“Establish a link, direct contact with a part of the drug using population who have no contact with the support and health-care system... An open door, open to everyone irrespective of their circumstances” (IV23)*

However, law enforcement stakeholder (police and justice) point out the challenge of considering both sanitary and security objectives as they may be opposite.

*“The question is how we can reconcile the public safety aspects of this with the rules of patient confidentiality, without being too extreme about either one... But we have to reconcile the two in some way. Neither can be ignored.” (IV38)*

PWUD would like to have a DCR running in Liège in order to consume in a protected environment, without the stress related to the lack of intimacy of public surroundings, and within a clean space to decrease the risk of infection.

*“I’ll go because I won’t have to smoke outside any more where everyone can see you. I would feel more comfortable, so that’s good. I won’t be stressed out about having to rush things in case police arrives.” (IV49)*

## **Target group and admission criteria**

According to care professionals, consistently with a low threshold approach, there must be as few exclusion criteria as possible. The mode of administration and the type of drug used should not be considered as exclusion criteria. It is necessary to be able to adapt and supervise different modes of consumption because they evolve over time. In addition, some care professionals point out that non-heroin/cocaine drug users are unlikely to go to this service type.

*“As far as the method of drug taking is concerned, we saw at TADAM in Liège that we have to provide room for inhaling as well. We can’t just have an area for the injectors, like some rooms do... Bbecause in Liège there is a trend towards inhaling.” (IV37)*

However, a care professional points out a potential difficulty for PWUD of different products/modes of consumption to cohabit with each other in the same service because of behaviour differences.

All PWUD point out that the DCR must be accessible for those who want to go there. They suggest having separate spaces for injecting and smoking people, arguing that a former injector does not want to stay next to someone who is injecting. They also suggest that different spaces are needed for heroin and cocaine addicts, arguing for different behaviours after consumption.

*“The room has to be available for everyone, but we could use the right-hand side for those who want to inject and the left for those who smoke.” (IV49)*

PWUD prefer a large room that facilitates socialisation and conversation, but individual cabins for the act of consumption. A good combination could be several cabins opening in a large room.

According to law enforcement stakeholders, an important criterion of inclusion is the requirement for a local residence, in order to avoid a ‘pulling factor’ of PWUD on the city of Liège.

*“We don’t want people to start descending on Liège. We should stipulate that you need to have a Liège address otherwise everyone’ll end up going there.” (IV24)*

Conversely, according to the care professionals, the requirement of a local residence does not seem to make sense because consumers will not travel for several kilometres in an ‘emergency’ consumption

context, and because of transport costs. In addition, the requirement for a local residence would exclude a part of the target group population that do not have a reference address.

*“It’s hard for the homeless with no fixed address. Do we throw them out? Even though they’re the most vulnerable. That would be defeating the objective.” (IV25)*

According to most stakeholders, primary consumption should not be a criterion for exclusion. They argue that a first consumption act in good conditions and a preparatory meeting with the person is preferable than a first experience in bad conditions.

If a PWUD presents him/herself already intoxicated at the DCR, the stakeholders consider that he/she should be welcomed and that the consumption act should be delayed if possible, but should not be used to refuse access to the DCR.

According to most stakeholders, the issue of a minimum age to access the DCR should go beyond ethical, moral and legal concerns. PWUD under the age of 18 should be accepted if they meet the other inclusion criteria, accordingly to harm reduction objectives. For example, some stakeholders consider that the room should be accessible from 16 years old for pragmatic reasons.

*“Personally I’d go for 16 years, and for one simple reason. The figures show that people are already heavy consumers at the age of 16 so that’s the right time to intervene. Why wait and waste two years before providing the right advice?” (IV37)*

Nevertheless, care professionals do not believe that a legal framework would allow such underage DCR access. Law enforcement stakeholders state that the current legislation should be modified. One law enforcement stakeholder suggests that if underage PWUD are admitted in DCR, there must be an intensive collaboration between youth welfare services, Justice, and DCR staff.

*“One of the first things to do is change the law. If we’ve decided to exercise tolerance the state can agree not to prosecute the room staff for breaking the law of 1921. But the state can’t stop a family taking them to court.” (IV38)*

All stakeholders agree that pregnant women should not be excluded, in a harm reduction approach. However, one law enforcement stakeholder specifies that medical liability could be engaged in the event of an incident with a pregnant woman in the DCR, and therefore the legal framework should be adapted.

### **Location**

The city centre of Liège, between the *Guillemins*, the *Saint-Lambert Place*, and the *Saint-Leonard Place*, is often designated as the adequate location for the DCR. According to all stakeholders, the most important criterion for the location of the DCR is the proximity for PWUD with a goal of accessibility.

Some other criteria for location are mentioned by the stakeholders, such as: not being close to a school or shops, and accessibility by public transport. According to some stakeholders, following the TADAM experiment, which was close to a police station, proximity to the police may also be a criterion for the location of a DCR, in particular with a view to public safety. Nevertheless, one law enforcement stakeholder points out that proximity to a police station may deter some PWUD from using the DCR because whether they undergo problems with Justice.

*“If you put the centre next to a police station I think quite a few people who want to do drugs might be put off if they’re wanted by the police. For instance a homeless person who’s wanted by the police, someone who’s been sentenced and is on the run, etc.” (IV34)*

According to the majority of stakeholders, several DCRs on the territory of Liège are not required to meet the local demand. Several stakeholders raise concern about its potential cost.

According to PWUD, the DCR should be located in the city centre for accessibility reasons. They also highlight the urgency of the consumption need once the substance has been acquired. They also prefer a quiet location. They do not want to be easily seen and identified when entering and leaving the DCR.

*“You should put the consumption room in the town centre because that’s where all the users are. Once they’ve got their drugs they’re craving for their dose and they’re not going to walk miles or get on a bus to go and take them.” (IV49)*

*“It has to be inconspicuous, we don’t want a sign which says ‘room for drug users’. Thus a secret place, away from the crowds” (IV49)*

## **Organisation and integration**

According to care professionals, different drug treatment services should collaborate with each other to manage the DCR, e.g. in the form of a steering committee. That would make it possible to gather different points of view, promote networking, and pool resources.

*“Not one, several. A consortium. We have fantastic people in the different institutions who can work wonders together... They can organise things more efficiently and save money.” (IV26)*

A care professional suggests that the DCR must be ruled under the responsibility of the city of Liège (Mayor), in order to facilitate contacts with the police and other services of the health and social network. Other stakeholders suggested that the TADAM foundation should manage the DCR. Many stakeholders support the idea of integrating the DCR into the CASS project in Liège<sup>77</sup> (Centre d’Accueil Socio Sanitaire), in order to meet the different needs of the target group.

*“We’re thinking about a Social Health Centre, housing different basic services for vulnerable and drug-dependent people. So it would be better to have a consumption room as part of a broader process where people have access to good hygiene, clean clothes, showers, toilets and social contact.” (IV24)*

## **Services**

According to the all stakeholders, the types of services proposed within the DCR should be defined according to the objectives of the room and to the proposed model. If the DCR is integrated into a larger social and sanitary centre, such as the CASS project (Centre d’Accueil Socio Sanitaire), other services will be available. According to many stakeholders, social support and guidance, as well as basic hygiene services, should be offered. Health care professionals emphasize the importance of providing complementary services to what already exists, and not duplicating or replacing existing services.

*“If a specific need arises the service must work with other services which can meet that need. It should be backed by the whole sector since we are diversifying our services for drug users while maintaining the infrastructure we already have.” (IV26)*

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<sup>77</sup> Project of integrated drug centre not yet implemented but under negotiation.

## **Staff**

All stakeholders agree on the need for a multidisciplinary team, in order to implement a bio-psycho-social approach to the issue of drug consumption. Many stakeholders also specify that staff specificity may depend on the type of services provided within the DCR. Two care professionals point out that, if the DCR mainly provides a supervised room for consumption, only educational and nursing staff is needed. The medical, social, and psychological staff can be provided by other services to which the DCR staff can refer PWUD.

*“There could be a link to external services for the medical staff... Other services also have social workers. Mainly I think of nurses and education support workers who should be connected to other existing services.” (IV26)*

According to several stakeholders, the nursing staff is paramount in a DCR, as they have to monitor injection and manage potential complications, and thus, have expertise on hygiene rules, injection education, and general nursing care. The requirement of medical staff in the room is controversial. Many stakeholders emphasize the need for a doctor to guarantee medical responsibility in the DCR. However, some other stakeholders consider that there is no need for a continuous medical function.

*“We need on-the-spot physicians, not necessarily a permanent presence but available to take responsibility for certain acts which nurses cannot be held accountable for.” (IV37)*

Some care professionals argue that it is possible to run the DCR without medical staff, and consider that permanent medical staff would be very costly.

PWUD consider that the DCR should provide psychologists and social workers. They would also like to have a rest area, where they could go before or after consumption. A medical doctor is needed for medical prescription, although not permanently. Time visits could be organised. However, PWUD emphasize the need for permanent nursing staff regarding basic care and possible emergency needs.

*“We don’t just need a room where you take drugs and then you’re out. I like to take my time, get a coffee afterwards. So it’d be nice to have a separate relaxation room next to it. (IV49)*

*“We need a doctor on the premises, not necessarily all the time, but someone who can write prescriptions etc. We also need people like nurses on the spot who can provide first aid if there’s a problem, for instance if you have an abscess or an infection.” (IV49)*

The issue of the need for security personnel is also controversial. According to Law enforcement professionals and some care professionals, security personnel is not required. They argue that the current low threshold services operate without security personnel, as the staff is able to manage violence by themselves, and if needed, in close collaboration with the police.

*“There are no security guards on the syringe exchange counters etc. It’s important to be able to call the police if the staff or users are at risk... Though that doesn’t happen very often.” (IV27)*

However, according to other stakeholders, security personnel and measures are required, based on the TADAM experience. In addition, other professionals point out the importance of security personnel around the DCR in order to reassure the neighbourhood. However, they specify that security personnel must be trained to work with this target group.

According to care professionals and law enforcement professionals, PWUD should be involved in the organisation of the DCR. Car professionals refer to the operation *Boule-de-Neige*, which is a peer-run prevention intervention.

*“The time has come to ask for their opinion. There is often a world of difference between our theory and their actual experience, so it’s crucial they be asked.” (IV26)*

Nevertheless, some care professionals state that giving an active role to PWUD in the organisation of the DCR is challenging to manage (e.g. potential conflicts between PWUD and peers, and the setting of managerial rules with peers).

*“It’s interesting but complicated in practice; for those who would benefit it’s not useful to say: ‘your next appointment is on Tuesday at 10am’.” (IV25)*

## **Law enforcement**

Care professionals consider that there must be a good collaboration level with the police, although police intervention in the surroundings of the DCR must be limited, as some PWUD will not use the DCR if there is police presence around them.

*“The police shouldn’t be hanging around outside all the time... We need to agree with them on an area around the centre where they won’t go looking for dealers who might not even be around. But if they’re called they should be able to get here as quickly as possible and have permission to come into the building.” (IV37)*

Many stakeholders note that the TADAM project was close to the police station without any major problem, and that a good collaboration level was already in place with the police.

Law enforcement professionals also consider that the police involvement presence around the DCR is needed to avoid drug deal in the surroundings of the DCR. Some stakeholders emphasize that, with a DCR, there will be zero tolerance for public drug use.

*“Outside the consumption room it’s zero tolerance; enforcement needs to be stepped up on the streets if we are making a place available.” (IV26)*

Several stakeholders also point out that the police should take on a role of information and orientation of PWUD towards the DCR. According to PWUD, it is necessary to set up an agreement with the local police about the DCR surroundings. On the one hand, they do not want to be intercepted when using the DCR. However, on the other hand, they want to avoid problems related to drug dealers and the neighbourhood.

*“We need an agreement with the local police. People shouldn’t be arrested before they get to the consumption room. If the police catches us and confiscate everything before we get here, we’ll stop coming.” (IV49)*



## **Authority and funding**

Several stakeholders consider that the mayor of the city of Liège should be the authority responsible for the DCR. The Mayor seems in favour of the project, he has already been involved in previous drug policy interventions in Liege, he is the highest local political authority, and he has the responsibility for local security and local health competences. However, one care professional emphasizes that, even if the mayor is the responsible authority, the continuity of the project running should not only rely on the mayor's will. Indeed, several stakeholders consider that the responsibility for a DCR should be shared between the local, regional, and federal authorities with a view to national coherence.

*“The room is on the territory of one of the municipalities so the mayor is responsible. However, there should also be involvement and responsibility taken by the health ministers of the Region and at federal level too... Federal institutions should be stakeholders in this process to ensure equality and consistency in Belgium as a whole.” (IV24)*

In terms of funding, various stakeholders suggest that the DCR should receive mixed funding from the federal, regional, and municipal authorities, according to their respective competences. They emphasize that this topic is under the competences of the Region within the latest State Reform, and so that the most important share of fund should come from the Region.

### 3.5 Charleroi

#### Goals

All stakeholders highlight many objectives for a potential DCR belonging to two broad types: public health and public security. There is sometimes a tension expressed between these objectives. From the care professionals' point of view, the priority is the contact and contact maintenance with the marginalized group of population who is not currently in touch with health services.

*"The aim is to protect and maintain a link with a section of the population who by definition are marginal and excluded. So I also see it as a way of reaching out and staying in touch." (IV28)*

However, to law enforcement professionals (police and justice), the priority is to reduce the feeling of insecurity and public nuisances related to drug use in the public space. A feeling of insecurity for both PWUD and the population.

*"We have a security plan for the area. One of our priorities is to combat the nuisance factor of drug trafficking and consumption in public areas—open drug scenes, drug waste materials, dealing and so on... Anything that makes people feel unsafe." (IV22)*

The establishment of a DCR in Charleroi is requested by PWUD, in order to have a clean space to consume, and avoid diseases and incidents.

*"It's good because that way we don't have to go to slums or squats. I have to shoot up in filthy places. I'd like a clean place where I won't catch anything, and even have a doctor there if we overdose." (IV48)*

#### Target group and admission criteria

The target group, according to all stakeholders, are the marginalised people who do not have currently access to support and assistance. In addition, stakeholders state that, within a low-threshold approach, there should not be but a few inclusion and exclusion criteria.

*"I don't like the idea of criteria—that might exclude part of the target population. We're talking about those at the bottom of the pile. It's important for the door to stay open. Maybe in time we can introduce certain criteria, if deemed necessary." (IV19)*

According to many stakeholders, there is no need for criteria relating to consumption patterns and types of drugs. Care professionals state that inappropriate PWUD, such as cannabis smokers, would not attend a DCR anyway.

However, a care professional emphasizes that it is necessary to provide separate spaces for different types of users, claiming that PWUD who have switched from injection to a less risky mode of consumption would be reluctant to face other drug injectors.

*“We should allow different forms of consumption but in relatively separate areas. I think there are former injectors who have made the effort to stop and don’t want to be too close to those who are still doing it.” (IV42)*

In terms of practical organisation, PWUD would prefer to have individual cabins for the consumption act, in order to avoid product and material sharing. There should also be different facilities for injecting users and smokers.

*“We need small, separate cubicles. Everyone is entitled to their privacy as well as protection from other people’s diseases etc. This also means an area for those injecting and another for the smokers.” (IV48)*

According to law enforcement professionals, first-time consumers should not have access to the DCR. Staff should orient them towards other services. By contrast, other stakeholders consider that first-time consumers should not be excluded, and should receive specific attention to avoid additional risks.

*“The first-time users often take a huge risk so in my opinion those who want to do it for the first time should be welcomed and given special care.” (IV18)*

Law enforcement professionals point out that the requirement of a local residence to avoid a ‘pulling factor’ is not useful. Indeed, they consider that it is unlikely that people coming from far away will want to attend the DCR. In addition, some stakeholders emphasize that it is necessary to welcome people unconditionally, regardless of where they live.

*“No, because most of the people we’re dealing with are disadvantaged, so they won’t have the means to travel. That will take care of itself, it won’t attract people from further afield.” (IV22)*

Several stakeholders also believe that underage PWUD should be admitted, because they are particularly vulnerable. However, some care professionals express concern regarding the potential legal issue for this specific group.

*“Legally I don’t see how we could allow minors. Although... that would mean leaving younger users outside to take risks. Admittedly we have 17 year old users on our list.” (IV18)*

PWUD have controversial views regarding underage PWUD: some point out the interest of a first experience in a clean and supervised place, while others consider that they should not access the DCR and attend other services.

*“I’m both for and against because at least you won’t get minors dying in a squat somewhere. But I’m against because you are talking about a minor after all. Or you’d have to closely monitor the minor.” (IV48)*

According to several stakeholders, users of a substitute treatment should also have access to the DCR. An exclusion criterion towards them would make no sense and would affect a large part of the target group. According to many stakeholders, pregnant women should also have access and receive specific information regarding maternity risks. In the same logic, people who are intoxicated already should be admitted in the room anyway, in order to avoid possible complications related to overconsumption in public spaces.

*“We have to take them in. Allowing them to consume is another matter but first of all welcome them and explain the risks. But again, if you refuse them entry they’ll go somewhere else to shoot up.” (IV40)*

## **Location**

According to all stakeholders, the DCR has to be located in the city centre of Charleroi, in the so-called ‘intra-ring’ area. Some care professionals point out that recent urban policy to improve the city centre led to the migration of some marginalized groups towards the periphery, and in consequence, the location of the DCR could be reconsidered.

*“Before we had specific places in mind; we were thinking of setting them up generally around the inner ring road while still being located in town. But today those areas have changed, so they’re no longer necessarily convenient. There is a clear political intention to improve the urban environment in the town centre, the districts located inside the inner ring road, by taking certain measures. Those measures displace sections of the population and some of them no longer frequent the town centre and end up in the suburbs. So the question is whether our services will still be in the right place in 5 years’ time.” (IV28)*

All stakeholders highlight the importance of the proximity of PWUD, accessibility, and the need for a quiet place in a relatively anonymous building.

*“The users don’t move around much so it’s important to be nearby... The building should be relatively inconspicuous.” (IV41)*

All PWUD agree that the DCR should be located in the city centre, close to the usual places for deal and consumption. It should be a quiet place.

*“In the town centre but in a quiet spot, and not too far from the dealers because once we’ve bought the smack we have to use it quickly.” (IV48)*

All stakeholders and PWUD agree that one single DCR would be sufficient for Charleroi.

### **Organisation and integration**

Stakeholders in Charleroi have been considering the establishment of a DCR for a long time. They agreed that the syringe exchange service Le Comptoir<sup>78</sup> (private structure) would be the best service to run the DCR, in partnership with the Public Centre for Social Assistance (CPAS; public structure) and in collaboration with the remaining drug addiction services.

*“Le Comptoir would manage the place. Today there is general agreement that it would be a combination of Le Comptoir which is a private organisation and the CPAS of Charleroi, which is public.” (IV28)*

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<sup>78</sup> NSP, medical care and social support for PWUD.

According to various stakeholders, the DCR would be integrated into the syringe exchange service, possibly relocated in a larger building.

*“Many feel that the consumption room would be an extension of Le Comptoir—so it wouldn’t be created from scratch but would be an extension of Le Comptoir.” (IV28)*

## **Services**

In the event that the DCR is integrated into Le Comptoir, the exchange of syringes, medical care, and the social support (including showers) provided within the service would be added to the DCR intervention.

*“Le Comptoir services and the consumption room would have a permanent social assistance office which would be in charge of starting any procedure or arranging support.” (IV29)*

Care professionals point out the importance of working with the existing services.

PWUD suggest the possibility to carry out drug testing in the DCR in order to assess the quality of products. They also want a space where they can settle before and after consumption, and possibly to discuss with each other and with professionals.

*“Yes you don’t just turn up, shoot up and clear out. You need a place where you can relax and have a chat if you want, with the others. It’s also about socialising.” (IV48)*

## **Staff**

According to many stakeholders, a multidisciplinary team is needed, including educators, social workers, nurses, and doctors. Some stakeholders state that paramedical nurses are always required, but that the medical staff is not permanently required.

According to PWUD, medical and social staff are required in the DCR, in particular to supervise the injection.

*“There are people who claim they know how to shoot up but they don’t, they end up with huge abscesses. So some drug users need to be trained in how to inject.” (IV48)*

However, stakeholders have divergent opinions regarding security personnel. Some care professionals point out that existing services operate without security personnel and collaborate with the police when needed. They argue that the presence of security personnel could deter some PWUD from attending the DCR.

*“I’m not convinced that we need the [security] staff. It could be counterproductive or put people off. I think protocols for cooperating with the police and with peace officers would be better.”*  
(IV29)

Other stakeholders argue that the presence of security personnel would allow the care professionals to focus only on assistance to PWUD, and that it would have a reassuring effect on the neighbourhood. In that case, they consider that security personnel should be specifically trained for this context.

PWUD point out the need for security personnel, to protect workers as well as PWUD.

*“Some of the users are not easy to deal with. They’re volatile and liable to lose their temper at any moment. Some of them are schizophrenics and stuff like that for instance. Some have mental health issues and when they’re using—better stay away... So we need security guards. But the guard shouldn’t be a bad-tempered type who doesn’t understand how these things work. We need a guy who understands these people.”* (IV48)

The majority of stakeholders emphasize the importance of taking into account the opinion of PWUD for the organisation of the DCR. Some care professionals suggest that it should be possible to give responsibilities to PWUD for the organisation of the DCR or the running of activities. However, they are somewhat reluctant to hire active PWUD as employees.

*“We need supervision if only because of the dealing, but police presence could put users off, so we should go for minimal supervision to reassure the general population and the staff.”* (IV40)

## **Law enforcement**

Several stakeholders state that collaboration is good in the context of the syringe exchange counter running. All stakeholders point out the importance of a good collaboration with the police. The police would guarantee public safety in the surroundings of the DCR, in particular regarding drug deal. Obviously, the police should not interfere with PWUD attending DCR.

PWUD have different opinions regarding the police involvement. Some suggest that they have to contribute avoiding the concentration of drug dealers around the DCR, while others suggest that the presence of the police would be a barrier for the DCR use.

*“We need police presence because we don’t want too many dealers around. Yes, I’m in favour. When dealing is going on we need police presence because dealing is still illegal. We don’t want dealing going on right outside the room.” (IV48)*

*“Personally I don’t want the police around. Because a guy who’s just taken drugs or is carrying them, he sees the police, he gets scared and scarpers. It would stress him out.” (IV48)*

According to law enforcement professionals, the role of the police would remain the fight against drug traffic, but with a certain tolerance level towards the users of the DCR.

### **Authority and funding**

According many stakeholders, the political authority responsible for the DCR should be the Public Centre for Social Assistance (CPAS) of Charleroi relaying the city mayor (Bourgmestre).

*“The president of the CPAS is now also on the town council so has responsibility for substance abuse issues too. He is the custodian of social action in general and responsible for everything closely or remotely connected with the drugs phenomenon in Charleroi. I think that’s his remit which he receives from the town council, an explicit remit.” (IV28)*

In terms of DCR funding, the majority of stakeholders favours a regional funding. Some stakeholders suggest a mixed funding between the Region and the federal authorities, as the DCRs would also have an impact on public health and public security at the national level.



### **3.6 Findings across cities**

Several findings were not city-level specific, and were similar across each of the five cities. Therefore, they are discussed below together. Where deemed necessary, specifications are made to a particular city.

#### **Opening hours**

Almost all stakeholders suggested that, ideally, a DCR should be accessible 24 hours, 7 days a week. In respect to opening hours, most acknowledged that this would be financially unrealistic. They however emphasize that it is important to cover the widest possible time range to cover periods of consumption such as 8h–22h or two time slots (one in the morning and one in the evening). Others point out that hours of operation should focus on the day (e.g., starting as from 10 pm), since this schedule seems to cover periods of user consumption based on the experience of syringe exchange counters and is complementary. Indeed, PWUD stated that although opening hours should ideally cover a 24/7 period, a more feasible option was starting from 10 am to evening hours (as long as budgetary possible), and opening hours should be complemented to other harm reduction and low-threshold services in the city in order to provide an opening span on city-level as broad as possible. If the DCR was part of an integrated centre, it might be possible to take advantage of the opening hours of that centre, which would provide night, staffed accommodation. Otherwise, the DCR could be linked to syringe exchange counters, that are accessible from 1 pm until midnight. Some state that, if opening hours insufficiently cover consumption periods, the effectiveness of the DCR will not be met. Similarly, PWUD advocate long opening hours, from morning to evening, to cover their periods of consumption as much as possible.

#### **House rules and registration**

Stakeholders consider that rules should be transparent and kept to a minimum. They are unanimous about clear, basic rules such as respect and the prohibition of violence, aggression and dealing—those already implemented in other low-threshold services. Most acknowledged that a *no-sharing* rule is likely to be necessary. Forbidding abusive or aggressive behaviour was imperative to create a safe environment for clients and staff alike. Specifically for DCRs, other necessary rules were posited by professional stakeholders: no alcohol consumption inside the DCR, hygiene (clean up after use) and safety (no walking with uncovered needles) guidelines, and a time limit in the drug consumption area. According to stakeholders, a maximum duration policy for consumption will ensure sufficient throughput of clients and thus avoid waiting times at the facility—which could discourage PWUD to utilize the

DCR, especially in times of craving. No time limit was deemed necessary in (when present) the “chill room” in which clients could rest after consumption. In order to avoid dealing or sharing of drugs, some stakeholders suggest that clients should present their substances to a staff member before accessing the DCR. In case house rules (violence and dealing) were to be violated, stakeholders propose that pre-established penalties should be applied. Both rules and sanctions should be explicated in a contract between the DCR and clients, which should be signed upon first visit. Most stakeholders acknowledge the value of such a contract to avoid discussion. However, at the same time, several professionals think that some (e.g., time limits) but not all (e.g., physical violence) rules should be carried out with a certain individual flexibility. Nearly all PWUD in the focus groups were proponents of transparent rules in the DCR in order to maintain a safe and manageable facility. Sanctions for violation of policies should be clearly specified and should be proportionate and need to balance the obligation to manage a safe environment with the desire to operate a service that is as inclusive as possible of a marginalized group. If a DCR has a too constraining internal regulation policy, clients may prefer to consume elsewhere, e.g., (back) in public spaces.

On the issue of mandatory registration of clients before using the service, stakeholders have diverging views within the five cities. Many indicated that clients would be required to provide identification prior to entry. While most were convinced that this would provide important statistical information, for informing local drug policy as well as for DCR evaluation purposes, several issues for an adequate registration procedure were posited (lack or loss of ID card). Furthermore, while some advocated such a registration to be completely anonymous, via a unique code or an alias, and protected under medical confidentiality, others favoured a non-anonymous identification at each visit, however, with respect for anonymity and privacy. Some explain the importance of a prior discussion between DCR staff and law enforcement (police and justice) of the use and protection of these data.

*“In my view the room manager would register new users and maybe organise the files ready to be sent on. So for example you can do a TDI-type form. In any case you need something that connects up with what already exists, not create something different.” (IV32)*

Overall, these findings are in keeping with opinions by PWUD in the focus groups across cities. For example, in Ghent, all participants were in favour of clear house rules in the facility: *“rules should be established, otherwise it things will go astray. [...] That’s also the case in the MSOC.”* Essential rules should include the strict prohibition of dealing and sharing drugs, as well as alcohol consumption. In-house regulations should focus on a maximum duration policy in the consumption area to avoid waiting lines; PWUD proposed a time limit of approximately half an hour. Other important rules for

PWUD included those aimed at maintaining a safe and hygienic environment: clean-up of own material and cleanliness in general.

Formalizing a declaration of agreement with these rules in the form of a user contract was deemed necessary and would, according to the respondents, not at all pose a barrier to go to the DCR. An intake at first visit was also desirable, especially to make sure that only drugs users, and not dealers, would be allowed entrance to the facility. Participants discussed whether minors should be allowed access in the DCR; opinions were (strongly) divided. Also in keeping with a clinical approach, PWUD thought there should be a time limit in the consumption room (proposed to be half an hour): “it shouldn’t become a shelter” where clients stay all day.

In Antwerp, PWUD stated that, when using the DCR, information should be totally confidential. In this respect, PWUD strongly favoured an anonymous entry to the facility. Some even indicated that they would not use a DCR if they would be required to provide identification (e.g., their name) prior to entry. However, PWUD generally agreed with a registration system (e.g., name, substances, frequency of use) if it is protected by medical confidentiality and under no circumstances released to authorities.

### **Implementation and community consultation**

Should a DCR be set up in any of the five cities, professional stakeholders consider that all decision-makers (both at the Regional and the local level), the local police, Justice, various services specialised in drug treatment, and low-threshold harm reduction services should be involved in the development of the project. Some suggested to involve a representative of a DCR in another country. A specific ‘DCR committee’ should be established from the beginning, equally responsible for follow-up and evaluation once the DCR is up and running. In a second step, but not from the initial planning phase, community members and user representatives should be involved and represented in the committee. A successful implementation plan needs to provide opportunities for community members to contribute to its development. Participation in these processes is necessary to develop support within the community and among local policy makers. With regard to neighbourhood and community members, opposition is largely expected by professional stakeholders. Therefore, most of the interviewees state one should anticipate this “not in my backyard” phenomenon. To reduce the resistance of the neighbourhood of the DCR, various stakeholders propose to associate them in the project. Suggestions include meetings with residents to present the project and address worries; inviting a neighbourhood representative to the DCR steering committee; organising DCR visits; or inviting a district collective from a DCR from a neighbouring country to discuss with the community members. The key element, according to many stakeholders, is communication and transparency before, during and after the establishment of the

DCR. Partnerships with hospitals and other health care agencies (e.g., MSOC/MASS) may make a DCR appear more credible and legitimate to community members; advocates of an integrated facility say that a stand-alone, specialised DCR will encounter much more resistance and opposition in the community. Finally, showing that local political authorities support the project is also important.

*“You have to show you’re in control and that you have political support. Because you have to live in Liège, walk around Liège to realise the potential benefits this room. So it will be good for everyone.” (IV27)*

## **Evaluation**

Stakeholders consider evaluation of a DCR essential, especially when implemented as a (scientific) pilot project. For nearly all professionals, this should be conducted by an independent actor with adequate scientific expertise, such as a university. Different stakeholders explain that the data must be collected and recorded by DCR staff. Some emphasize the importance of working with a common data collection tool that is related to what already exists in other (low-threshold) services.

Stakeholders were also asked to describe what outcomes would indicate the success or failure of a DCR if such an intervention were to be implemented and evaluated. Most stated that indicators should echo DCR objectives as *a priori* established, and cited a multitude of indicators of effectiveness. The main indicator, according to professionals across cities, is the number of clients coming to the DCR and their profile, in order to assess whether the target public is reached. Other indicators include those assessing aspects of clients’ health and public safety, depending on the sector where professionals are working. For example, across cities, main indicators should measure the impact on public nuisance and public safety according to most law enforcement stakeholders. Other professionals clearly favoured an evaluation that extends ‘objective’ measures (such as HIV incidence, ambulance calls, overdoses on city-level, referrals to drug treatment), but equally incorporates subjective experiences of clients. Last, some stated that too much reliance on outcome indicators is challenging, since goals and aims of DCRs may change over time, and thus may impact its evaluation.

# CHAPTER V

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## DISCUSSION, CONCLUSION AND RECOMMENDATIONS

*Louis Favril*

*Pierre Smith*

*Laurens van Puyenbroeck*

*Pablo Nicaise*

*Tom Decorte*

*Jessica De Maeyer*

*Freya Vander Laenen*



## CHAPTER 5

# DISCUSSION, CONCLUSION AND RECOMMENDATIONS

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Drug consumption rooms (DCRs) are legally sanctioned facilities offering a hygienic environment where individuals can use pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff. These harm reduction facilities have been operating worldwide for the last 30 years. Since then, an extant body of scientific literature indicates that DCRs are an important public health intervention for mitigating drug-related harms, as well as facilitating uptake of health services among PWUD. DCRs are actively used by PWUD, including people at higher risk of harm, and frequent use has been associated with entry into drug detoxification, safer injection practices, and decreased syringe sharing, without increasing rates of relapse or reducing rates of drug use cessation. At the community level, DCR implementation is associated with reductions in drug use in public spaces and unsafely discarded syringes. In short, DCRs are effectively meeting both their primary public health and order objectives and therefore supports their role within a continuum of services for PWUD (Kennedy *et al.*, 2017). Despite this abundance of evidence, implementation of DCRs has remained highly controversial, and no DCR has been established in Belgium to date. Against this background, we conducted a study on DCRs in Belgium in order to assess its feasibility in five cities, and to formulate recommendations for potential DCR implementation in Belgium.

### 1. WHAT THE RESULTS DO *NOT* IMPLY

The current feasibility study does not address the question whether there is a *need* for a DCR in Belgium or in one of the five cities, nor whether there is *support* among local stakeholders for a DCR. Rather, we investigated possible options and scenarios for a DCR, including the pros and cons, might it be deemed needed. As such, policy makers should assess the need for (a) DCR(s) in relation to the local problems relating to both the health and well-being of PWUD, as well as public nuisance dimensions that are typically addressed by DCRs (e.g., Bayoumi & Strike, 2012; Hunt, 2006b). Qualitative data are needed to characterize the epidemiology of (injecting) drug use and the health of PWUD (on national and local level). Possible research questions include:

1. *What is the distribution of drug use, risk behaviours, and drug-related health problems?*
2. *Given the prevalence of drug-related harms and/or public nuisance, is there a need for a DCR on the local level?*

In addition, studies could focus on the likelihood of PWUD visiting a DCR. Surveys measuring PWUD's willingness to use a DCR have been conducted elsewhere (e.g., Bouvier *et al.*, 2017; Butler, Chapman, & Terry, 2018; Kerr *et al.*, 2003b; León *et al.*, 2017; Mitra *et al.*, 2017; Reddon *et al.*, 2011; Shaw *et al.*, 2015) and constitute a useful indicator of potential clients' scale and characteristics, especially since research indicates that PWUD's reported willingness regarding potential DCR use prior to its opening predicts subsequent attendance (DeBeck *et al.*, 2012). Some small-scale surveys have been conducted in the Flanders region of Belgium, suggesting that DCRs are likely to be used by a substantial proportion of the surveyed target population. For instance, in 2016, two-thirds (68%) of all surveyed PWUD in contact with NSPs throughout Flanders stated that they would use a DCR, of whom 45% would use a DCR on a daily basis (Windelinckx, 2016).

In short, a needs assessment should be conducted, encompassing (at minimum) an assessment of local drug-related harms, existing services, willingness to use a DCR among local PWID, and support from key stakeholder groups (BCCSU, 2017). If a Belgian city should decide to move forward with the implementation of one or more DCRs, following such an epidemiological and needs assessment, the present study provides empirically-founded and hands-on recommendations.

## **2. DISCUSSION AND RECOMMENDATIONS**

If either city decides to move forward with the implementation of one or more DCRs, several general recommendations and preconditions, applicable to each city, are provided below. We categorized the recommendations chronologically in four groups; (1) essential preconditions; (2) main considerations when implementing a DCR; (3) the implementation process; and (4) monitoring and evaluation.

### **2.1 Essential preconditions**

#### **Legal framework**

Establishing a clear legal framework is a fundamental precondition for the implementation of DCRs in Belgium. This stems firstly from the fact that Belgium, as party to the three basic UN Drug Conventions, is obliged to enforce the Conventions regime in good faith. This includes the obligation to respect the main prohibitionist principle enshrined in article 4 of the 1961 Convention, which requires the parties to take such legislative and administrative measures as may be necessary to limit exclusively to medical and scientific purposes the use and possession of drugs. As the Conventions are *health-oriented treaties*, they do not form a legal obstacle for the implementation of DCRs, as long as the DCR—as an extreme form of harm reduction—aims to reduce the adverse consequences of problematic drug use.



This implies not only the need to take account of the relevant international legal (and soft law) framework on harm reduction (such as the UN Resolutions UNGASS 1988 and UNGASS 2016, as well as the EU Action Plan on Drugs 2017–2020), but also the need to base the implementation of DCRs on a legal framework that clearly expresses the focus on the health and welfare of the users and follows an integrated approach (offering treatment, health and social integration services). As such, the DCR would meet the requirements of the INCB (as expressed in its most recent reports) and would not violate the international legal framework.

A further reason why a solid legal framework is imperative, stems from the fact that the implementation of DCRs in Belgium would lead to a number of legal questions, particularly related to their ‘facilitating’ effect, the ‘illegal possession’ by service users, and ‘public safety and order’ concerns. It is therefore required that the implementation strategy deals with these legal issues in order to provide a maximum level of legal protection for the (management of the) DCR, its staff and the users.

Three options for legally implementing DCRs in Belgium have been found, whereby the feasibility of each option is determined by the time span for its implementation and the amount of political support. A *first option* would be to provide an explicit exception to the principle embedded in Article 3 paragraph 2 of the law of 24 February 1921, thus creating an explicit legal basis for DCRs to operate. This option implies a long-term implementation and would therefore require a considerable amount of political support (the legislative change would at least require the signature of the Minister of Justice and the Minister of Health). If a statutory protection/recognition would be opted for, it is recommended to look at the legislative implementation of France, which serves as a good example of the way in which primary legislation (allowing for the establishment of a DCR and providing protection to the users and staff in the law of 24 February 1921) can be combined with secondary legislation (stipulating the preconditions and criteria in order for a DCR to be legally protected in a Royal Decree). In this respect, the 10 minimum criteria as introduced in the German legislation could be a useful inspiration.

If statutory protection through primary legislation would not be possible—or while awaiting the legislative process—a *second option* to establish DCRs could be to modify the reach of Article 3, §2 of the law of 24 February 1921 by means of a royal decree, on the grounds that these facilities would act as a specific harm reduction measure aimed at protecting the health of the users, justifying an exception to the application of the offence as mentioned in Article 3, paragraph 2 (a) and, as such, providing a significant degree of protection from prosecution under the basic law. This option would imply a mid-long-term implementation and would require a medium amount of political support (the Royal Decree would require the signature of the Minister of Health).

*A third option*, implying a short-term implementation and being feasible with even a limited amount of political support, is the implementation of DCRs—without prior legislative changes—in the form of a (temporary) scientific or medical experiment. This pilot would not only be in accordance with the general aim of the UN Drug Conventions, but would also meet the recommendations of the UNGASS resolutions (1998 and 2016) and the recommendation of the WHO in its 2012 technical guide to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Given the sensitive nature of DCRs and the possible political implications, it is strongly recommended for such a pilot to acquire a ministerial recognition or authorisation (by the Minister of Public Health).

In any of the foregoing options, it is deemed necessary to complement the implementation with an amendment to the prosecutorial guidelines on drug-related offences (see COL 15/2015) in order for the users to be freely able to possess a small amount of illicit drugs for personal use in the facility. As discussed, the feasibility and sustainability of the third option in particular is hugely dependent on the full support of (local) prosecutorial authorities. The prosecutorial policy and subsequent agreements on police intervention should include a clear registration procedures of clients, a definition of and/or criteria on the ‘perimeter’ in which no or an alternative action would be taken (in and outside the DCR), as well as specific preconditions such as the absence of indications regarding sale or other aggravating circumstances as well as public nuisance. Furthermore, any change in the prosecutorial guidelines should take account of the need to provide (new) rules on the seizure of the (illicit) drugs for personal use in the DCR, as well as the relevant paraphernalia (additional to those already excluded from seizure according to COL 15/2015). Finally, a cooperation protocol/accord between the relevant actors should be considered for each location, including the DCR management, administrative authorities (mayor), law enforcement authorities (prosecutor and police), and all relevant treatment services.

Regarding the risk for liability and damage claims (resulting from drug-related deaths or serious health damage), a number of measures were identified which allow to minimise the risk and offer a sufficient level of protection for the staff, the users and the local government. These include the provision of a clean environment in which to use drugs, along with a clear set of house rules and protocols (including the response to overdose incidents). Finally, a contract between the DCR and the clients should stress the responsibility of the service users. In drafting these regulations, it is key to strictly limit the nature of the intervention by the (medical) staff when supervising the injection/administration by users. Any form of active assistance during the injecting/administration should be ruled out, thereby taking into account the relevant provisions of the law of 10 May 2015 on health professions. Last, specific training should be provided to those working in or with the DCR, raising awareness on the criteria regarding (civil and criminal) liability.

### **Recommendation 1: Establish a clear legal framework**

The establishment of DCRs in Belgium requires a legal framework that clearly expresses the focus on the health and welfare of PWUD and follows an integrated approach. It is key that the legal framework provides a maximum level of legal protection by dealing with the fundamental legal issues concerning the ‘facilitating’ effect, the ‘illegal possession’ by clients, and ‘public safety and order’ concerns. Three options for legally implementing DCRs in Belgium have been identified, whereby the feasibility of each option is determined by the time span for its implementation and the amount of political support. In any of these options, it is necessary to complement the implementation with an amendment to the prosecutorial guidelines on drug-related offences. Finally, it is vital to take a broad range of measures in order to effectively minimise the risk of (civil and criminal) liability, thus offering a sufficient level of protection for the staff, the service users, and the local government.

### **Political support and funding**

Besides a conducive legal framework, both political support and (subsequent) funding are essential conditions for (effective) implementation of a DCR. Support for implementing a DCR should be present amongst the relevant political bodies. In this respect, public ambivalence may be an important issue since decision makers are more likely to act when public opinion is supportive of policies and vice versa (Hyshka, Bubela, & Wild, 2013; Jauffret-Roustide, Pedrono, & Beltzer, 2013). Past experiences in other countries indicate that development of DCRs was highly politicized and their establishment was often contested in public referendums and in courts despite evidence demonstrating their effectiveness (Semaan *et al.*, 2011). As Fry *et al.* (2006) noted: “silence on the political and ethical dimensions of the policy debate [...] can mean that ‘evidence’ becomes a less important issue within policy debates, where dominant interests are also expressed in public opinion (e.g., in the media), through lobby groups, and in partisan politics” (p. 465). Political opposition may hinder the implementation of such facilities. Even when political support would be articulated from the municipal (local) level, this will not suffice given the juridical (see RECOMMENDATION 1) and budgetary implications of DCRs. Regarding the latter, (prospects of) new facilities have to secure financial support from municipal, regional, and/or national authorities before they can practically move forward (Hyshka *et al.*, 2013). According to professional stakeholders in our study, funding for a DCR would primarily be obtained through the regional health ministries in Belgium, which can be difficult if there is resistance from the municipal level (mayor) or the regional government in power. Specifically, costs of DCR implementation will depend on many factors, including its location, the type of service model (stand-alone vs. integrated), the capacity of the DCR, hours of operation, staff composition, level of on-site services and resources.

A rough estimation of costs and a budget template that can be used to estimate operating and capital costs is attached in APPENDIX H. Since DCRs have shown to be cost-effective (Andresen & Boyd, 2010; Andresen & Jozaghi, 2012; Bayoumi & Zaric, 2008; Pinkerton, 2010, 2011), and are able to fill a unique niche of high-risk PWUD, allocation of sufficient resources for DCRs is crucial (Semaan *et al.*, 2011).

**Recommendation 2: Political support and securing funding are principal preconditions**

Political support from municipal, regional, and federal levels, as well as securing financial support from (at least one of) these authority levels, are crucial preconditions before practically moving forward to the implementation of a DCR in Belgium.

## 2.2 Main considerations when implementing a DCR

For guidelines, considerations, policies, and procedures of a DCR, we refer to the excellent operational guidance recently developed by the *British Columbia Centre on Substance Use* (BCCSU, 2017), which should be embraced when considering to implement a DCR in Belgium. Similarly, the toolkit developed by the *Toronto Drug Strategy* (Perks *et al.*, 2013) provides hands-on information and guidance to assist when considering the implementation of one or more DCRs. Several of their findings are incorporated in the recommendations below.

### Reasons for establishing DCRs and relations with law enforcement

Although professional stakeholders from all five cities cited multiple reasons for implementing a DCR, the most predominant one was to improve safety and health of PWUD. Many of them highlighted the opportunities a DCR would provide for health promotion advice, health care, and entry to treatment services. A large number identified the potential to reach particularly high-risk individuals who are not currently engaging with existing treatment options and to build trust in health care services. Reducing public nuisance and improving public safety was also deemed important, albeit to a lesser extent. This resonates with the views of PWUD, who cited that a DCR should essentially be a safe and peaceful environment where they are able to consume their drugs in a hygienic manner. Indeed, for DCR clients, a facility is often perceived as a *safe haven* or *refuge* (Jozaghi, Hodgkinson, & Andresen, 2015; McNeil & Small, 2014). A survey in Sydney found that two-thirds used the service because it was clean and safer than using in public, assistance was available in the event of an overdose, sterile equipment was available and can be safely disposed of (NCHECR, 2007a). Similarly, a Dutch survey found that clients' main reasons for attending a DCR were safety, social interaction, and police avoidance (Peacey, 2014).

**Recommendation 3: A DCR should primarily focus on health and safety of PWUD**

A DCR should be implemented with the main objective of improving health and safety of local PWUD, by providing a safe and hygienic environment to use drugs under supervision of trained staff, as well as connecting users to health and social services. Additionally, the aim is to reduce public nuisance and improving public safety (e.g., public drug use and publicly discarded injection equipment).

Regarding police avoidance, many respondents from the focus groups raised concerns about police presence in the vicinity of the DCR. For them, as well as for professional stakeholders in all of the cities, the need for solid and clear-cut agreements with police were a central aspect in respondents' accounts. For obvious reasons, PWUD stated they would be reluctant to use the DCR if there would be no assurance that they would not be arrested for visiting the DCR. Likewise, literature indicates that PWUD may be reluctant to use harm reduction services out of fear of police crackdowns or arrest (Rhodes *et al.*, 2006; Small *et al.*, 2007). Stakeholders in the interviews stated that clear agreements (often specified in the form of a written protocol) are certainly possible, since they already exist in most cities for other harm reduction programmes (e.g., OST and NSP). They however stressed the 'controversial' nature of DCRs, making such agreements and partnerships key for the implementation, success, and continuity of a DCR. Indeed, a collaboration between law enforcement and the public health sector is central to police engagement in initiatives, and ensures that police practices do not interfere with these efforts and, instead, complement them (Mitra & Globerman, 2016). More specifically for DCRs, their success is contingent on clear agreements and good working relationships with local law enforcement agencies (DeBeck *et al.*, 2008; NHSGGC, 2016), especially given the *apparent* conflicting interests—public safety and crime concerns vs. public health (Graham, 2008). In the vast majority of countries where DCRs operate, local agreements have been reached, through which police agree not to target clients in the vicinity of the facility, nor to monitor its entrance or exit to ensure clients are not deterred from using the DCR (Broadhead *et al.*, 2002), while still addressing other forms of crime in the neighbourhood and maintaining close ties with the facility and offer assistance if circumstances require it (Wood *et al.*, 2004c). Specifically, police should commit to clear and consistent operations with regard to a DCR, refer users to DCR services where appropriate (yet not coercive), and establish an agreement with DCR operators on how to handle possible user congregations and/or the presence of drug dealers in a demarcated area around a DCR (Fischer & Allard, 2007). In Vancouver for instance, police were involved in the planning of *Insite*, and operational plans and protocols were put in place to clarify the role of police with respect to the DCR. This included outlining procedures for occasions when police need to enter the DCR (e.g., emergency access, fresh pursuit), and procedures for police

response outside the DCR. Police and *Insite's* operators also set up an alternative dispute mechanism with biweekly meetings. This process was effective in promoting communication, resolving frictions and conflicts, and building positive relationships between the police and the staff working at the DCR (Perks *et al.*, 2013). Similarly, in a 2006 report outlining best practices and recommendations for the implementation of NSP, Strike *et al.* (2006) indeed stress the importance of establishing positive relationships with law enforcement in the development phases of a NSP.

When agreements and procedures are fully established, the international literature indicates that law enforcement officials are generally supportive of DCRs, and even help divert public IDU and drug-related activities to DCRs. For instance, in Vancouver, police now refer individuals found using in public to the DCR instead of pursuing punitive action (one in six clients had been referred to the facility by police; DeBeck *et al.*, 2008), whilst in Copenhagen two police officers act as dedicated liaisons to the facility and sit on its board (NHSGGC, 2016). In Hannover, almost all (94%) of the surveyed clients reported no negative experiences with police in the neighbourhood of the DCR (Dolan *et al.*, 2000). All in all, it is essential—both for potential clients as well as for successful operation of the DCR—that local and well-defined protocol agreements are established; as is equally the case with other harm reduction initiatives (Mitra & Globerman, 2016; Wood *et al.*, 2003). Such involvement and cooperation with local police (before actual implementation) is recommended to ensure that police understand why and how the service will operate, and to clarify respective roles and responsibilities.

**Recommendation 4: Agreement protocols and cooperation with law enforcement are imperative**

Clear cooperation agreements (formalised in a protocol) with local police and law enforcement should be established in order to ensure safety, that everyone agrees in terms of what is acceptable and what is not, and prevent that fear of arrest will deter PWUD to use the facility, while still addressing crime in the neighbourhood and maintaining close ties with the facility.

**Target group and admission criteria**

In keeping with other harm reduction programmes, where age restrictions often formally exclude this population (Fletcher & Krug, 2012), the vast majority of DCRs worldwide exclude individuals under the age of 18 (Schatz & Nougier, 2012; Woods, 2014). However, research shows that younger PWID engage in high-risk behaviours to a greater extent than older or more experienced users, including sharing needles and paraphernalia, increasing their risk for blood-borne diseases and other adverse outcomes (Barrett, Hunt, & Stoicescu, 2013; Hadland *et al.*, 2014). Since minors are almost without exception excluded in DCRs throughout the world, the existing evidence base regarding the effectiveness of

services is largely limited to adults and says little about the feasibility or impact of providing services to young people (Hunt, 2008). Across all of the five cities, most respondents (both professionals and PWUD) felt that being 18 years or older was a necessary admission criterion for access to a DCR, which resonates with other recent studies (Atkin-Brenninkmeyer *et al.*, 2017; Watson *et al.*, 2015). Many felt that young PWUD should instead be referred to a drug treatment programme or other services than a DCR. On the other hand, opponents of an 18+ age limit stated that this would leave a particularly vulnerable group (albeit relatively few in number compared to their adult counterparts) outside the scope of service. Young PWUD are also in need of services, and restricted access might expose them to more risky behaviours than they would face inside a DCR, as well as obstruct them from accessing other services available through the DCR. Further specific age restrictions (e.g., 21 or 26 years) were not specifically mentioned by most stakeholders, noting that people of any age can use drugs; duration of (problematic) drug use was deemed far more important than biological age of potential clients. Relatedly, most participants (PWUD and local professionals) found that there should be no exclusion based on specific type of illicit substance (e.g., heroin or amphetamines), nor on administration route (injecting, inhaling or smoking). Regarding the latter, however, many of the interviewees stated that *injecting* use should comprise the main focus of a DCR—especially when policy choices should have to be made due to budgetary reasons—since PWUD are deemed a particular “high risk, high need” population. However, the provision of a non-injecting option alongside services for PWUD may not only serve the needs of non-PWUD, but may also help promote transitions away from IDU (Bridge, 2010). Consistent with prior research (Watson *et al.*, 2013), PWUD in the focus groups had a strong preference for a DCR which allows both injecting and smoking within the same facility, though with some sort of spatial separation between the two—which is fairly common in DCRs throughout Europe (EMCDDA, 2017c). This separation is largely based on different highs and comforts regarding exposure to different methods of drug administration.

Another subpopulation of PWUD that is frequently excluded or dissuaded from attending DCRs based on operating rules are non-local residents. This perspective was reflected in local stakeholders’ views. A reason for excluding non-local residents was especially to avoid a ‘honeypot’ effect of PWUD from neighbouring cities without a DCR. Similarly, primarily to avoid attracting more drug users to the vicinity of the DCR, many Swiss and Dutch DCRs do not admit PWUD who are not resident in the local area (Schatz & Nougier, 2012). However, an important downside of applying this eligibility criterion is that it excludes non-local residents who may benefit from such a service, and vulnerable groups such as illegal immigrants and refugees. Some stakeholders stated that such a residency criterion may not be necessary since PWUD will not travel long distances to the DCR, and given the intake interview at first visit. Other admission criteria adopted in several countries include homelessness and not being

enrolled in an OST programme. These criteria were not endorsed by any of the groups of respondents; on the contrary.

Operational DCR models vary between countries—some having more lenient eligibility criteria (e.g., in Germany and Australia) and others being more targeted and restrictive (e.g. in the Netherlands and Switzerland). In this way, local policy makers have been able to determine whether they prioritise throughput and coverage or high need. Such policy choices may bear on concerns about ‘honeypot’ effects and will certainly relate to the general impact of DCRs. From our study we can conclude that, in order to maintain a low-threshold nature, DCRs should avoid a plethora of admission criteria and conditions, in order to reach as many potential clients as possible. However, two criteria for exclusion were frequently mentioned by professional stakeholders across cities: minors (< 18 years) and non-local residents (especially in Ghent and Antwerp). Interviewees did stress the importance of flexibility when applying admission criteria and regulations, for example with intoxicated clients, pregnant women, and first-time injecting drug users. For these high-risk groups of PWUD, special considerations and protocols should be in place (see BCCSU, 2017; Solai *et al.*, 2006). *Overtly intoxicated individuals* present unique problems due to the likelihood of even higher risk than usual of fatal overdose, assault or unsafe injection practices if they are denied access to clean equipment and a safe location with on-site supervision. Having such individuals accessing a DCR may, however, increase the likelihood of overdosing. On the other hand, the odds of a positive outcome after an overdose is far greater as to when it occurs outside. Second, *pregnant women* may be amenable to interventions to reduce harm, or even access treatment services if low-threshold services are provided. By allowing this subgroup in the facility, it may be possible to assist them in moving towards safer drug-using behaviours or recovery and prenatal care services. Denying DCR access to pregnant women is unlikely to result in their abstinence from drug use. Third, *first-time drug injectors*—PWUD who may be transitioning into IDU—present both an opportunity to provide them appropriate harm reduction information, and at the same time an opportunity to deter them from initiating a potentially high risk behaviour. Individuals who are willing to present themselves to the DCR as a first-time user may have already made the decision to begin IDU, and would not be denied the benefits of DCR and harm reduction services. For these individuals, the negative health consequences of denial of access would be potentially mitigated. Taken together, several high-risk subgroups of PWUD should not be *a priori* denied access to a DCR, since provision of such service results in a hygienic and safe drug consumption (other than public use), and may provide opportunities for appropriate information, education and access to auxiliary services.



#### **Recommendation 5: A DCR should clearly define its target group and related admission criteria**

The target group of DCRs should encompass high-risk and hard-to-reach PWUD. A DCR should find a balance between maintaining its low-threshold nature (to maximize utilization and minimize barriers), while delineating clear eligibility criteria for the target population (e.g., individuals aged 18 and over and local residents). Special considerations should be given to high-risk, vulnerable groups of PWUD including intoxicated clients, pregnant women, first-time injectors. Ideally, DCRs should provide the possibility for both injecting and non-injecting drug use within the same facility, with some form of physical separation.

#### **Location**

Determining a suitable location of a DCR is important in order to have good prospects of being effective (Hathaway & Tousaw, 2008). Factors that lead (local) stakeholders to consider introducing a DCR, such as high levels of public drug use and associated nuisance or a high prevalence of drug-related health emergencies, may point to the general locality in which the service should be situated. DCRs have been established near open drug scenes and in areas where there is a long-standing drug market. Proximity to the place where people purchase drugs has been identified as an important factor in the use of DCRs (Hedrich, 2004). Yet, it should be noted that efforts to relocate drug scenes/drug-using populations by providing DCRs in other areas away from drug markets may not be successful and just result in poor service utilisation (Hunt, 2008). During the interviews, different opinions arose within and between cities where to best locate a DCR. For some, DCRs would be best situated in a centralized location (e.g., Ghent and Liège); having a centrally located facility, proximate to other services, would increase the likelihood of PWUD using those services. On the other hand, such a centralization option may also lead to a concentration of services in one area and thereby neglecting other neighbourhoods. Therefore, others advocate DCRs to be located in specific areas, away from central neighbourhoods, which may have the advantage of geographically spreading services and de-stigmatizing specific areas. However, DCRs may be less accessible for clients when located too far from central neighbourhoods or other services (Bardwell *et al.*, 2017). All in all, wherever the specific geographic location in a specific city, the main consideration expressed by PWUD and professionals alike was that a DCR should be easily *accessible*, irrespective of (de)centralization. For example, Welton *et al.* (2004) studied locations for NSP and found that spatial distribution of drug use, ease and proximity to public transportation, proximity to police stations, and the walking distance from areas heavily concentrated with drug use are all vital factors that should be taken into account when selecting a site for harm reduction projects. If a DCR is located too far, or difficult to reach, a segment of the target population will not be reached.

For instance, some studies (Petrar *et al.*, 2007), but not all (Mitra *et al.*, 2017), indicate that PWUD are generally not willing to travel great distances to use a DCR—meaning that the location and accessibility of the DCR is an important factor to consider. This was confirmed by PWUD in our focus groups, and mainly related to the intensity of withdrawal symptoms that may influence PWUD’s willingness to travel to a DCR (Bayoumi & Strike, 2012). Travelling presents extra hassles as well as transportation costs, which is often described as a barrier.

**Recommendation 6: The location of a DCR should be easily accessible for its target population**

A location and neighbourhood should be carefully selected when implementing a DCR. Wherever its specific geographic location in a specific city, a main consideration should be that the facility is easily accessible for clients, irrespective of (de)centralization, in order to sufficiently reach the target group.

**DCR integration: models and services**

Every single professional stakeholder advocated that a DCR should be part of an integrated local drug strategy, that is, a DCR as one option in a continuum of services for PWUD that encompasses not only drug consumption, but also (psycho)social and medical services and support mechanisms. Indeed, the available evidence suggests that these facilities should be part of a comprehensive drug policy in order to adequately and effectively respond to drug-related harms that acknowledges public and individual health objectives (EMCDDA, 2017c, 2017e; Hedrich, 2004; Hedrich *et al.*, 2010; Kennedy *et al.*, 2017). This embedding in a comprehensive local, regional and national strategy to reach and fulfil a diverse range of individual and community needs, is in accordance with the UN Drug Conventions, stating that the establishment of a DCR is compatible with the international drug control system if a clear integrated model is foreseen in which the DCR is included in a wider range of health, treatment and social integrated services, either directly in the DCRs or by active referral for access to these services. If those preconditions are met, this form of harm reduction can be reconciled with the general principle of medical purposes as enshrined in the Conventions (see RECOMMENDATION 1). Indeed, as noted by the VAD (Aertsen *et al.*, 2014), DCRs should not be implemented at the expense of other existing initiatives.

**Recommendation 7: A DCR should be part of a comprehensive, integrated drug strategy**

A DCR should be an integrated part of a comprehensive local, regional and national drug strategy, included in a wider range of health, treatment and social services, to reach and fulfil a diverse range of individual and community needs that arise from illicit drug use.

However, in contrast, opinions within each of the cities were rather mixed whether a DCR should be *physically* integrated within an existing organisation, or integrated within a network of services mainly through referrals. On the one hand, (a majority of) local professionals throughout Belgium advocate a physical integration within an existing service; most frequently proposed were low-threshold (harm reduction) services (such as MSOC/MASS, Transit, CASS), and, to a lesser extent, hospitals. In general, an integrated DCR (i.e., the most common model in Europe; EMCDDA, 2017c) has several advantages compared to its stand-alone counterpart. For example, integrated service models are often perceived as best practice because clients can access a range of services under one roof; compared to stand-alone services, integrated facilities would seem likely to have an in-built advantage in promoting engagement with other health and welfare services (Hunt, 2006c), which may lower the threshold (both in time and distance) for use of such services as they are directly available; thereby helping to prevent loss to care, to decrease barriers in access to care, and to ensure continuity of care. Indeed, studies indicate that low-threshold programmes offered at DCRs effectively attracts higher-risk PWUD (Toth *et al.*, 2016; Wood *et al.*, 2006c) and helps to connect these individuals to health care and substance use treatment services (Kimber *et al.*, 2008; Wood *et al.*, 2007). During the interviews, local professionals clearly emphasized such advantages.

Furthermore, according to these stakeholders, a major advantage of the integrated option is that it allows sharing of resources (and expertise), such as the premises and staff. Opportunities for staff to rotate between services (the DCR and other projects), increasing their knowledge and skills and also reducing any risk of burn-out is considered another advantage of an integrated DCR (Hunt, 2008). As a result, such a DCR will cost less to set up and run, whereas a specialised DCR would be more expensive due to rental costs of a building and starting a programme from scratch. Local low-threshold facilities (e.g., MSOC/MASS, Transit, CASS) were commonly cited as suitable organisations for such a partnership. However, a major caveat would be the mixing of DCR clients and other PWUD coming to the organisation for reasons other than drug consumption. Indeed, according to several of the interviewees and as indicated by Schäffer *et al.* (2014), while this integration may work well for active PWUD, the impact on people enrolled in OST programme from these centres may be less helpful. Each day they have to manage picking up their methadone/buprenorphine in the immediate vicinity of the DCR. This situation may be more challenging for those in a detoxification centre, as they have to undertake their detoxification while they can be confronted with (illicit) drug use in the same building. The integration of services for active PWUD and those enrolled in OST inevitably triggers clients who are trying to stay away from illicit drug use, which provides a risk of relapse. More generally, one challenge to the physical integration of a DCR into an existing organisation is that other service users might not want to be around (or associated with) PWUD. Therefore, in the scenario of a physical integration in a low-threshold facility, stakeholders clearly emphasized the need for a spatial/physical

separation of the DCR and other areas within the same building (for OST dispersion and consultations), for example by means of a different entrance. Indeed, it is important to clearly demarcate spaces where drug use can take place within the larger facility and where it cannot, so that clients who are not using the DCR (i.e., may be trying to reduce or avoid illegal drug use) can easily avoid these areas. In this regard, one alternative option is to integrate a DCR within a hospital. The first known embedded DCR to operate in a hospital is at the Lariboisière Hospital in Paris, which opened in October 2016. The advantages of integrating a DCR in a hospital context (with a separate entrance) are similar to those of integrating it in low-threshold services (MSOC/MASS), without mixing a heterogeneous population of PWUD who are coming to the specific service for reasons other than drug consumption. PWUD have shown willingness to access a DCR in a hospital (McNeil *et al.*, 2016; Ti *et al.*, 2015), and may thus be a feasible option. Importantly, organisations seeking to implement integrated DCR will need to consider how the service fits within and complements other services provided by that (low-threshold) agency.

On the other hand, partly for the above-mentioned reasons, some professional stakeholders explicitly advocated the idea of a stand-alone facility—still partnered with other local agencies, but not physically integrated. The main reason for advocating such a specialised model was that a DCR should focus on its core business—drug consumption—because ‘flooding’ a DCR with auxiliary services and programmes would install a barrier for hard-to-reach drug users. Indeed, while services in the stand-alone model are much more restricted, the advantage is that those PWUD who come into these facilities all have the same goal. The range of other auxiliary services is still available (elsewhere), and PWUD can be informed (or already know) that services like counselling or detoxification are provided by another local organisation (Schäffer *et al.*, 2014). Incorporating (social, medical, or drug treatment) services within a DCR may potentially raise the threshold for individuals who are merely interested in drug consumption. Indeed, it has been suggested that a stand-alone DCR may be more effective in reaching clients who actively avoid or do not seek health care services, if they perceive the facility as a place to safely use their drugs, rather than as a health care facility *per se* (Wolf, Linssen, & de Graaf, 2003). The main advantage of a stand-alone facility—though integrated within a network of local services to improve access to additional services and referrals—was that this option may significantly lower the threshold due to the exclusive focus on drug consumption, and thus reach a specific segment of PWUD who are not (yet) reached by other local agencies. Still, several services were deemed essential in a stand-alone facility, such as NSP, wound care, and (for some) drug testing. These services were also endorsed by PWUD in the focus groups. A minority of professional stakeholders spontaneously cited the inclusion of a take-home naloxone programme in the DCR as an important strategy. Overall, proponents of a stand-alone facility advocate that, in addition to the core services provided in the DCRs, clients may be referred to more extensive support services if desirable and necessary.

The latter option—a specialised, stand-alone DCR—was overwhelmingly preferred by PWUD during the focus groups in each city. PWUD consistently advocated a rather clinical operationalization of a DCR in their city, which should specifically focus on drug consumption. Though they were opposed to the idea that a DCR was too much embedded within a service model, they clearly stated that some possibilities to pass clients on to other care and support services should be present. Moreover, PWUD (similar to professional stakeholders advocating a stand-alone facility) stated that such auxiliary (social, welfare, medical, and drug-related) services and support should be provided through referrals rather than delivered on-site. This resonates with the primary objective of a DCR as perceived by PWUD: to be able to consume their drugs in a safe and hygienic environment (cf. supra). An important argument posited by professionals to work through referrals rather than on-site delivery was that most services already exist and that implementing them on-site as well would be financially inefficient since it would create overlap of services within the same city.

Overall, the choice between providing services based on a specialised or integrated model is one of the main choices to be made when determining what form of service might be provided (Hunt, 2006c). Each of the DCR models has their advantages and disadvantages (see TABLE 7). Because a single DCR model cannot fit all needs, the choice of a particular model needs to reflect the nature of the local context, needs of PWUD, as well as interests of the wider local community. When implementing a DCR, stakeholders will have to decide which of these models might fit best with their drug service system. Next to this, the budgetary implications will most likely influence the final choice.

**Recommendation 8: The optimal DCR model is one integrated within a continuum of care**

Existing low-threshold facilities (e.g., MSOC/MASS, Transit, CASS) already working with PWUD appear promising locations for setting up a DCR; such organisations will need to consider how such a facility may fit within and complement other services provided by the agency. The decision whether or not to physically embed a DCR within an existing local organisation should balance between the advantages of such integration, while maintaining a low-threshold nature for both DCR clients and individuals who are coming to the specific service for reasons other than drug consumption. Irrespective of physical embedment, integration and close linkages with existing local organisations are imperative in order to ensure that a DCR provides access to health and social services and referrals, but does not duplicate what is already available at the local level.

**Table 7.** Overview of specialised and integrated facilities’ characteristics, benefits, and considerations.

	<b>Integrated model</b>	<b>Stand-alone/specialised model</b>
<b>Characteristics</b>	<ul style="list-style-type: none"> <li>- the most common type of DCR</li> <li>- physically located within a low-threshold centre, alongside other services such as NSP, testing for blood-borne infections, drug treatment, primary care, and other social and welfare services</li> <li>- important additional component of services for PWUD</li> </ul>	<ul style="list-style-type: none"> <li>- focus is on providing a supervised, hygienic location for PWUD</li> <li>- usually set up close to other services for PWUD and located near open drug scenes</li> <li>- staff are available to refer service users to other community services like OST, drug treatment, primary care, and housing</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>- often seen as ‘best practice’ because it allows service users to access a wide range of services under one roof without having to go to a different location</li> <li>- may be more socially accepted if integrated into services already serving PWUD</li> <li>- pre-established trust/ relationships with clients/people who use drugs</li> <li>- less expensive as many of the programmes could share resources (and expertise), such as the premises and staff</li> </ul>	<ul style="list-style-type: none"> <li>- all who come into the DCR have the same goal; to consume drugs</li> <li>- all PWUD accessing the service are likely at a similar place in their drug use (i.e. all actively using), which provides a level of comfort for those accessing services and reduces trigger risks for those who may be trying to reduce use, who are in treatment, or in recovery</li> <li>- may lower the threshold due to the exclusive focus on drug consumption</li> <li>- as they primarily serve PWUD, the facility’s services can be tailored to their needs</li> <li>- Referral and link to other services is still available, just not on-site</li> </ul>
<b>Considerations</b>	<ul style="list-style-type: none"> <li>- integration of people using a DCR as well as people accessing harm reduction, OST or other treatment could be a trigger for relapse for those in various stages of recovery</li> <li>- integration within (treatment) services may raise the threshold for (often hard-to-reach) individuals who are merely interested in drug consumption</li> </ul>	<ul style="list-style-type: none"> <li>- services available on site are more limited, and therefore rely on referral and/or partnerships with other community service providers</li> <li>- risk that clients “get lost in transition” (i.e., interested in accessing a certain off-site service but because they have to go to another location do not end up making it there)</li> <li>- more expensive due to rental costs of a building and starting a programme from scratch</li> </ul>

*Adapted from Ottawa Public Health (2016).*

**Staff**

In accordance with (and reliant on) the specific DCR model and services provided within, policy makers will need to consider the type of staff who are involved in running a DCR. Across cities and respondent groups (professionals and PWUD), two types of staff were consistently cited as essential within a DCR. First and foremost, medical staff was spontaneously mentioned by respondents, which is in keeping with the above-mentioned focus on health promotion as a goal through providing a safe and hygienic

environment to use drugs. Nurses, and for some *psychiatric* nurses more specifically, were deemed the most essential staff in DCRs across cities. Indeed, given the health challenges experienced by PWUD accessing DCRs, and the need for emergency overdose response, it is ideal if staffing models include a supervising (psychiatric) nurse (BCCSU, 2017), who is especially trained to provide interventions such as safer injection education (Fast *et al.*, 2008; Wood *et al.*, 2005c, 2008). Although desirable, the actual presence of physicians was mostly not deemed necessary in the DCR, particularly given their high cost of employment. For ‘basic’ medical care (wound care) and intervention in case of an overdose, nurses were deemed more than suitable; a physician thus should not be physically present at the DCR. Rather, though not physically nor permanently present on-site, a physician linked to the facility (on-call during opening hours) was however thought to be a necessary condition with regard to responsibility/liability. When integrated in a low-threshold facility (e.g., MSOC/MASS) or a hospital, there would be no need to additionally staff the DCR with a physician, since they are already present there.

Social staff (mostly cited as educators and social workers by participants) is a second important category of personnel that should be present in a DCR, according to the participants. In addition to a medical focus provided by nurses, social staff are able to assist clients with different aspects of referral to a variety of social and welfare agencies (including those who specialise in substance use treatment and support services). For example, in the Netherlands, DCRs provide clients with access to an in-house social worker—65% of PWUD access this service, and most find it helpful for housing or legal issues, and alcohol/drug treatment referrals (Peacey, 2014).

Overall, consistent with our results, the most common staffing model is a team of health care workers such as (psychiatric) nurses and social workers in order to provide a multidisciplinary approach (Woods, 2014). Irrespective of type of staff, trusting and non-judgemental relationships with staff are key in being able to have open conversations about health and drug use, and in facilitating timely care and connections to other health and social services (Jozaghi & Andresen, 2013; Krusi *et al.*, 2009). This was explicated by PWUD during the focus groups; staff should be present ‘in the background’ and the service provision should be demand-based rather than conditional. Furthermore, PWUD emphasized that interactions and conversations with staff should not always relate to drug use or referrals.

Stakeholders held mixed views concerning the need to hire security personnel in the DCR. On the one hand, some stated that this would not be necessary, especially when a DCR is integrated in an existing low-threshold facility. Regular staff may take up security issues; some argue that the presence of security personnel might increase the threshold and could provoke undesirable behaviour from DCR clients. Being located in the proximity of a police station would be a more desirable alternative. On the other hand, in a specialised DCR, security personnel was deemed necessary since no support from the wider facility is available, and (specifically trained) security personnel around the DCR may furthermore reassure the neighbourhood.

Last, individuals identified as peers (i.e., people who formerly used or currently use illicit drugs) also play important roles in the planning and operation of DCRs worldwide (Woods, 2014), which was (rather strongly) acknowledged by professional stakeholders during the interviews. More specifically, they noted that the particular value of peers is to relate to DCR clients given their shared experiences, as well as their ability to make clients feel comfortable and welcome. This was supported during some of the focus groups. A previous feasibility study has also shown that PWUD value the inclusion of peers within DCRs, and feel that their inclusion in the injecting room would be an asset (Kerr *et al.*, 2003a). Taken together, many argued that peers should be considered for involvement in DCR operations where possible. Examples are involvement of DCR clients in the establishment of the services on offer, or employment of (former) drug users. However, several concerns were highlighted by respondents, such as the challenge to expose active users to an environment in which drugs are consumed regularly.

**Recommendation 9: A multidisciplinary team of staff should be present in a DCR**

A DCR needs to provide a sufficient number of trained staff. At minimum, a team of (psychiatric) nurses and social workers should be permanently present in the facility in order to provide a multidisciplinary approach. A physician may be on-call during opening hours, yet not necessarily physically present on-site. Where possible, involvement of peer workers in daily DCR operations should be considered.

Furthermore, the successful operation of a DCR is contingent on the establishment of relevant policies and procedures. At minimum, as noted by the BCCSU (2017), these should include: documentation procedures; referral pathways; procedures for contacting police in the event of aggression or safety related issues; and code of conduct/rights and responsibilities for clients and staff. A specific overdose response protocol is required for identifying overdose or other medical emergencies and determining when to intervene. Special efforts—by means of (continued) staff training and education—are needed to ensure that staff are trained to provide trauma-informed and culturally safe care, amongst others. A framework in cases when staff are exposed to ethically conflicting situations should be elaborated (Solai *et al.*, 2006).

**Recommendation 10: Clear procedural protocols should be outlined**

An effective operation of a DCR requires a minimum set of policies and procedures, known by all staff, and consistent with those procedures adopted in corresponding community drug services.



### **House rules, contract and registration**

Worldwide, DCRs operate under clear eligibility criteria, and there are explicit rules and responsibilities which clients are expected to adhere to (EMCDDA, 2017c; Woods, 2014). For professionals, the most essential house rules to establish in a DCR are: no aggression and violence, prohibition of dealing and sharing drugs, and no alcohol consumption on the premises. The main reason provided by stakeholders for alcohol prohibition is to reduce violence and drug use risks. These basic rules, which apply in most countries (Belackova *et al.*, 2017), were also clearly supported by the views of PWUD during the focus groups. Similarly, both professionals and PWUD endorsed the fact that a facility should apply a time limit policy in consumption areas, but not necessarily in the resting area where clients may go after drug consumption. Overall, a time limit of circa 30 minutes was proposed, which largely resonates with international practices (Woods, 2014), however, while maintaining a certain individual flexibility. The main reason stated for a time limit is to allow as many users as possible into the DCR, and prevent use of the facility as a substitute shelter (especially applicable to stand-alone DCRs), and waiting times. Indeed, most international facilities have to deal with queues, so to keep the DCR accessible to all and adhere to their objective to reduce public drug use, a set time limit is utilised. Relatedly, similar to waiting times, limited days/hours of operation poses an important barrier for PWUD to access the DCR (Petrař *et al.*, 2007; Small *et al.*, 2011a). When asking what days and hours a DCR should be operational, a spontaneous first reaction of most participants was that 24/7 access would be ideal. They however acknowledged that this would be unrealistic for budgetary reasons. Estimates of opening hours ranged widely, but most expressed the idea that a DCR (1) should be open on later hours (not, for example, at 8 am), and (2) that specific hours of operation should be adjusted and complemented to other local harm reduction programmes. Even if there are more than one DCR in the same city, this should be guaranteed in order to provide an opening span on city-level as broad as possible (as is the case, for example, in Frankfurt).

#### **Recommendation 11: A DCR should have clearly established house rules**

It is essential that clear policies concerning service users' conduct are established. These are explained to anyone using the service, and clients agree to abide by these rules of conduct. Policies should include clearly specified sanctions that are applicable if policies are violated. Rules should be proportionate and need to balance the obligation to manage a safe environment with the desire to operate a service that is as inclusive as possible vis-à-vis a marginalised population.

**Recommendation 12: A DCR's capacity and opening hours should meet local needs**

The impact of DCRs is tied to their ability to reach sufficient proportions of high-risk PWUD. Therefore, as with its geographical location, the capacity and opening hours of a DCR should respond to the local needs of the individuals who will be using the service in that community.

A majority of stakeholders in all cities further expressed the need to ‘formalize’ the house rules in some sort of a contract (a declaration of agreement with house rules) when a potential client first arrives at the facility. This is a common practice in European DCR (for examples, see APPENDICES B–F). A code of conduct on which DCR use is conditional—and corresponding sanctions—should be explained and agreed (by contract). Local professionals in the interviews stated that this would provide some ground to exert a time-out or suspension as a sanction in case house rules are violated, but equally to assure clients’ rights—a two-way contract. One important example was that a contract may safeguard the non-distribution of DCR clients’ personal information. Indeed, in Europe, almost 90% of DCRs register some data on visitors (Woods, 2014). This tends to be basic information such as the date and frequency of visiting, and often including details on the substance the visitor is using. Furthermore, clients often have to undergo an entry interview upon their first visit or a one-time registration survey at intake—during which the ‘terms of use’ document is signed by both parties. This may include the registration of personal information such as day of birth or name. Later, while most facilities worldwide allow access to clients on an anonymous basis, about one out of three DCRs require their clients to present with a non-anonymous identification. For most PWUD in the focus groups, a non-anonymous registration at intake would not pose a barrier for using the service, however, with the clear understanding and assurance that these data will not be shared with police or other agencies outside of the DCR—hence the two-way contract. After initial registration (thus for each subsequent DCR visit), while confidential codes for identification were more readily supported than showing identification, many PWUD prefer to enter and leave a DCR anonymously. Indeed, in order to attract the target population without raising fears about confidentiality, and to make the service as low threshold as possible, all clients of the DCR should ideally remain anonymous (Wood *et al.*, 2004a). One possible option includes the strategy that was used in Vancouver’s *Insite*. Since fears regarding reduced willingness to use the DCR, if a client registration was required, were observed in feasibility studies conducted prior to the opening of the first DCR in Canada (Kerr *et al.*, 2003b), the DCR operated as a completely low-threshold service in the first six months of operation and maximizing access to the DCR was the top priority. During this time only paper records were maintained. After its initial six months

of operation, and after trust was developed between the DCR operators and the target community, service use was tracked at an individual level (see Wood *et al.*, 2004a).

Professionals state that intake and subsequent registrations would be of great value, given the data this could generate (e.g., types of illicit drugs used, frequency of use, number of unique clients) for informing drug policy, as well as for evaluation purposes. Despite its advantages, some stakeholders cited several barriers for adequate registration. These especially include lack of ID for refugees or illegal immigrants, and distrust among PWUD. Stakeholders endorsed policies that protect the anonymity and privacy of DCR clients; a clear system is required for identifying returning clients and linking them to their assessment information. Overall, a possible solution, like in Frankfurt, may include a one-time, non-anonymous registration at intake where afterwards a unique identification code is given to each clients for subsequent visits (Stöver & Förster, 2017). This unique code is linked with the data of the respective user, anonymized, and may be useful for statistical analysis (see, for example, Stöver & Förster, 2017) and to work out a care plan in dialogue with the client. Since 2003, the data registration process works according to a uniform system across the four facilities in Frankfurt; the characteristics of the documentation system are made according to international standards (EMCDDA, 2000).<sup>79</sup> Ideally, the registration system should be integrated within existing systems—or at the least being compatible with already adopted systems in order to prevent a fragmentation of registrations. This range of information to be gathered for (new) clients should balance the need for relevant information that underpins care and evaluation, while avoiding collecting too much information that assessment becomes a deterrent to service utilisation. These collected data should be protected under medical confidentiality, and a clear framework (an intelligence-sharing protocol) for what can(not) be shared and how information can be used should be developed and agreed (Hunt, 2008). Use of operational procedures, protocols, and policies is crucial for protecting personally identifying information, privacy of clients, and confidentiality of the collected data (Fry, 2003; Semaan *et al.*, 2011; Solai *et al.*, 2006).

**Recommendation 13: Client registration should safeguard confidentiality and anonymity**

Assessment and registration of service users should be considered in order to determine eligibility of potential DCR clients. One must balance the need for relevant information, while avoiding collecting so much that assessment becomes a deterrent to service utilisation. Policy and programme measures should be in place to ensure the privacy of people using the service and confidentiality of the collected data through a client recording system.

<sup>79</sup> The EMCDDA is conducting a study on data collection and monitoring in DCRs in Europe, and how data and its collection might be adapted to better suit the needs of DCR services. The goal is to develop a standardised 'EU data set' and test this by completing a data collection in the second half of 2018.

## 2.3 The implementation process

### Multi-agency task force

Options regarding the implementation process and evaluation were topics that did not arise in focus groups with PWUD. According to professional stakeholders, the planning and development of a DCR in Belgium should be facilitated by extensive roundtable consultation with all relevant stakeholders, including but not limited to local authorities, social and healthcare service providers, police and law enforcement officers (in respect to the latter group, see also RECOMMENDATION 4) as this is equally the case for NSP (Strike *et al.*, 2006). In this view, a local multi-agency task force should be installed—with representatives from all relevant sectors—in which all professional stakeholders are engaged in the consultation, planning, and implementation process (BCCSU, 2017; Favril *et al.*, 2015; Hunt, 2008).

#### **Recommendation 14: A multi-agency, local task force with relevant professionals should be installed**

All relevant stakeholders should be engaged in the development of DCR options from early planning stages onward. Ideally, a multi-agency partnership is established in the form of a steering committee or local task force overseeing the consultation and implementation process.

### “Nothing about us without us”—User involvement

Decision-makers in cities contemplating DCR implementation should carefully consider the opinions and preferences of potential clients regarding DCR design and operational preferences to ensure that facilities will attract, retain, and engage PWUD (Petrar *et al.*, 2007; Small *et al.*, 2011a; Watson *et al.*, 2013). Including their perspectives in DCR implementation research—and policy development more generally (Vander Laenen, Favril, & Decorte, 2016)—is vital to maximize the uptake of DCRs and increase future utilization (Hunt, Albert, & Sánchez, 2010; Jalloh *et al.*, 2017; Jürgens, 2008; Lancaster, Ritter, & Stafford, 2013; Luchenski *et al.*, 2018; Neale *et al.*, 2017; Ti, Tzemis, & Buxton, 2012), because of the nuanced descriptions they can provide about their drug-using practices and environments (Bayoumi & Strike, 2012; Kerr *et al.*, 2003a). In order to ensure adequate engagement of the target population and assessment of need, PWUD should be involved in the planning and implementation of a DCR (for example through a representative from an advocacy group of PWUD being present during meetings), but equally once the DCR is operational (BCCSU, 2017). For example, in Australia, some of the operational rules were pre-tested with DCR potential clients, to examine deterrent effects (Fry, 2002). User involvement—in all its forms—is essential to ensure equity, acceptability and relevance of (DCR) services and should be a standard practice (Luchenski *et al.*, 2018). Peer worker programmes are

an acceptable and effective method to involve service users. Indeed, a Canadian feasibility study has shown that PWUD value the inclusion of peers within DCRs, and feel that their inclusion would be an asset (Kerr *et al.*, 2003a).

**Recommendation 15: Local PWUD should be involved in the planning and implementation phases**

Decision-makers in cities contemplating DCR implementation should carefully consider the opinions and preferences of potential clients regarding DCR design and operational preferences to ensure that DCRs will attract, retain, and engage PWUD.

**Community consultation and communication**

Public opinion is an important factor in decision-making regarding the implementation of public health programmes (Burstein, 2003), and for DCRs more specifically (Hyshka *et al.*, 2013). Despite evidence on the contrary, negative connotations associated with DCRs may persist. For example, a qualitative evaluation of stakeholder opinions in Canada identified opposition to, or concern about, DCRs (Strike *et al.*, 2015). Specifically, seven reasons for ambivalence were identified, including: lack of knowledge of evidence about DCRs; concern that DCR goals are too narrow; uncertainty that the community drug problem is large enough to warrant a DCR; the need to know more about the ‘right’ places to locate a DCR to avoid damaging communities or businesses; worry that a DCRs will renew problems that existed prior to gentrification; concern that resources for drug use prevention and treatment efforts will be diverted to pay for a DCR; and concern that DCR implementation must include evaluation, community consultation, and an explicit commitment to discontinue a DCR in the event of adverse outcomes. Such perceptions are often unfounded, as several studies in different countries have suggested that, though DCRs are often met with mixed public opinion prior to introduction, the attitudes of local residents and businesses tend to become more positive over time (Firestone-Cruz *et al.*, 2007; Salmon *et al.*, 2007; Strike *et al.*, 2014; Thein *et al.*, 2005; Woods, 2014). Nonetheless, because of fears that DCRs may encourage drug use, delay treatment and aggravate open drug scenes, there is often community resistance to the establishment of these facilities. Resident-based opposition to the implementation of these policies is known as the NIMBY-phenomenon; characterised by the opposition by residents to the implementation of a controversial or perceivably dangerous new development (i.e., OST, NSP, or in this case a DCR) in a particular place, without questioning its usefulness. Harm reduction strategies often face NIMBY-opposition that can result in limitations on the delivery and location of services (e.g., Bernstein & Bennett, 2013; Kolla *et al.*, 2017; Tempalski *et al.*, 2007). In the above-mentioned study by Strike *et al.* (2015), for example, while most respondents agreed that there might be a ‘right place’

for a DCR, they excluded locations near their homes and businesses. Community engagement is thus imperative if DCRs are to be successful (EMCDDA, 2017e). During the interviews, indeed, stakeholders strongly favoured involving residents and businesses during the whole process of implementation. In addition, in order to reduce opposition of a specific neighborhood, stakeholders propose to always communicate transparently, to organise DCR visits, and a ‘hotline’ for questions and concerns. A possible option is to set up a community advisory committee during the planning stage to be proactive in addressing any community concerns (Perks *et al.*, 2013). Such community consultations are a way of educating the community about the importance of this strategy, as well as a place to disseminate the evidence surrounding the benefits of DCRs. Recently, an operational guidance was published aimed to support policy makers with the consultation and engagement process related to implementation of a DCR (BCCSU, 2017), based on experiences of the *Dr. Peter Centre* in Vancouver (DPC, 2017). Similarly, prior experiences with establishing OST, relevant to DCRs, could serve as a guidance for building public support and increasing acceptance (e.g., Erdelyan & Young, 2009). The *Pivot Legal Society* (Pivot, 2011) developed a toolkit for addressing NIMBY-concerns in the community. Collectively, these documents should be adopted as a guidance for key stakeholder consultation as well as a broader local community consultation when (thinking about) the implementation of a DCR. Several advocacy actions include:

- develop a Frequently Asked Questions (FAQ) sheet,
- designate a ‘DCR reference person’ for the community,
- organise meetings with local residents to present the project and address worries,
- invite managers, police officers or residents from DCRs abroad to talk about their experiences,
- awareness raising sessions on harm reduction/DCR issues for various stakeholders

For example, prior to opening a DCR to clients, the operating agency may consider organising an ‘open house’ and inviting the local community, media, elected officials and interested members of the public. Seeing how the DCR is set up and how it will operate may help to satisfy curiosity as well as alleviate any concerns about how the program will work (Perks *et al.*, 2013). Overall, given the controversial nature of DCRs and often limited public knowledge of these services, providing information and open communication about the facility and its operations should be promoted in order to reduce community resistance and ensure successful integration in the community.

**Recommendation 16: Clear communication with community stakeholders is key**

As with other harm reduction interventions, consultation with local residents, businesses and other community stakeholders prior to DCR implementation is essential to minimise community resistance. Transparency and open communication between all parties are fundamental in this process.

### **Ongoing transparency and involvement of relevant stakeholders after implementation**

A DCR must work collaboratively with all relevant stakeholders, including PWUD, partnering agencies, community residents and other neighbours to promote open communication about the service and its operations in order to ensure successful integration in the community. Stakeholders in the interviews not only stressed the importance of community consultation in the early process of DCR planning and implementation, but equally ongoing communication once implemented. According to Hedrich *et al.* (2010), DCRs, more so than other public health services, rely on acceptance by PWUD, communities, health and social service workers, law enforcement and politicians to be implemented *and sustained over time*. As such, ongoing assessment of public opinion is necessary to inform public health policy regarding this issue. Maintaining good relationships with local communities, businesses, and other stakeholders is imperative for the successful operation of DCRs. A DCR—and its steering committee—should ensure ongoing liaison with all local stakeholders, and adjust operations where needed. Again, transparency and good communication are essential.

#### **Recommendation 17: Ongoing liaison with local stakeholders should be assured once implemented**

In order to ensure continuity of a DCR, and adapt its operations if deemed necessary, ongoing dialogue with all local stakeholders involved should be a prerequisite.

## **2.4 Monitoring and evaluation**

According to stakeholders, it is crucial to evaluate the (cost-)effectiveness and impact of these facilities carefully, and build the evidence base that justifies their implementation (especially given the fact that DCRs remain controversial measures in the drug policy framework). Without evaluating the impact of services that are first introduced, no judgement can be made about their effectiveness, their value for money and whether they are a valuable addition to existing services. Detailed process and outcome evaluations would need to be conducted. Importantly, detailed data before DCRs were to commence (a 'baseline' measure), and comparative data from sites where DCRs were not to be introduced, would need to be collected. An advisory board, ideally including an international expert of DCRs (e.g., France or Canada), should be assembled to design the evaluation protocol for the DCR (pilot). Such evaluation should be conducted by an independent organisation (external to facility operations) with expertise in the area of drug policy—such as a university—in consultation with all relevant stakeholders, including DCR clients, service providers, and local residents and businesses. Sufficient funds for a comprehensive evaluation should be included when the costs of a DCR are calculated. As a scientific pilot programme,

the Vancouver team developed a rigorous methodology to conduct an external 3-year evaluation of the DCR's impacts (Wood *et al.*, 2004a, 2004b, 2006b). Such a design could be adopted in a Belgian setting—however, adapted to the specific local context and locally determined objectives. With regard to the latter, (clearly defined and measurable) evaluation indicators should echo initial DCR aims. However, it should be kept in mind that the goals and aims of a facility may change over time, in accordance with funding and staffing ratios, as well as changes in the needs of the client population, local service networks, and local drug scene (BCCSU, 2017). As noted by Hunt (2008), the following list of evaluation components is indicative of the range of ways in which the evaluation of DCRs has been approached elsewhere:

- *Surveys of DCR attenders*: Identify changes in knowledge, attitude and behaviour of clients.
- *Process monitoring*: (1) Quantify activity levels such as number of new DCR client registrations, injections managed on-site, overdoses managed, referrals made and 'honeypot' effects; and (2) determine whether attenders are from the locality in which the service is being provided.
- *Surveys of the local PWUD population as a whole*: (1) Identify uptake of the DCR service and characteristics of attenders/non-attenders; (2) identify service delivery factors that promote or impede service utilisation.
- *Surveys of local residents and businesses*: Identify changes in perception and experiences of drug-related nuisance and attitudes to the service.
- *Population-level mortality data*: Provide trend data on drug-related deaths and any association with the introduction of the service in the longer term.
- *Economic analyses*: Describe operating costs which can contribute towards cost-effectiveness studies in the longer term.
- *Neighbourhood surveys/litter counts*: Provide before-and-after evaluation of public injecting and drug-related litter.
- *Ambulance/hospital data*: Indicate impacts on overdose- and injecting-related emergencies and health problems.
- *Drug treatment data*: Indicate treatment referral, uptake, engagement and rates of treatment participation for drug treatment and treatment of allied problems such as HCV or HIV that may be attributable to the DCR.
- *Arrest/conviction data*: Provide before-and-after measures that contribute to an assessment of any possible impact on local crime.
- *Drug market data*: Provide data that may contribute to explanations of change, and relevant confounding factors, e.g., effects of drug enforcement, changes to drug price/purity, and other changes within drug trends.



It should be noted that, as with NSP, evaluating the impact of DCRs on outcomes such as blood-borne viruses prevalence may be challenging. For example, when examining outcomes, attributing causality to DCRs rather than concurrent strategies (e.g., NSP and OST) may be difficult (EMCDDA, 2017c). The potential for confounding is indeed significant, given the absence of randomised controlled trials (for obvious ethical reasons) and the multiplicity of factors influencing the epidemiology and harms of drug use—e.g., changes in supply, other harm reduction initiatives, and law enforcement activity (NHSGGC, 2016). Such methodological challenges should be clearly investigated and addressed. Furthermore, both the number and scope of outcome indicators should be determined by the length of time a DCR has been in operation. Influencing behavioural change and measuring long-term outcomes in a meaningful way takes time, and may need to be extended for several years (Perks *et al.*, 2013).

**Recommendation 18: A rigorous scientific evaluation of a (pilot) DCR is as an essential component**

A DCR should be subjected to detailed process and outcome evaluations by an external organisation, in consultation with all relevant stakeholders. A well-defined, methodologically sound evaluation plan with clear objectives should be established before implementation.

## 2.5 Summary of recommendations

Based on an in-depth review of the scientific literature and a study on the feasibility of DCRs in Belgium, the research team sets forth the following recommendations (see also BOX 9):

1. Establish a clear legal framework
2. Political support and securing funding are principal preconditions
3. A DCR should primarily focus on health and safety of PWUD
4. Agreement protocols and cooperation with law enforcement are imperative
5. A DCR should clearly define its target group and related admission criteria
6. The location of a DCR should be easily accessible for its target population
7. A DCR should be part of a comprehensive, integrated drug strategy
8. The optimal DCR model is one integrated within a continuum of care
9. A multidisciplinary team of staff should be present in a DCR
10. Clear procedural protocols should be outlined
11. A DCR should have clearly established house rules
12. A DCR's capacity and opening hours should meet local needs
13. Client registration should safeguard confidentiality and anonymity
14. A multi-agency, local task force with relevant professionals should be installed
15. Local PWUD should be involved in the planning and implementation phases
16. Clear communication with community stakeholders is key
17. Ongoing liaison with local stakeholders should be assured once implemented
18. A rigorous scientific evaluation of a (pilot) DCR is as an essential component

### **Box 9. General recommendations for DCR implementation**

Overall, DCRs can only be effective if these are (1) integrated into a comprehensive drug strategy as part of a continuum of services aiming to reduce individual and social harms arising from problem drug use; (2) based on support and active cooperation among key local actors, especially health, police, local authorities, and local communities; and (3) seen for what they are—specific services aiming to reduce problems of health and social harm involving particular high-risk populations of problematic drug users and addressing needs that other responses have failed to meet (Hedrich *et al.*, 2010). Building on data collected through needs assessments, tailoring DCRs to the specific setting and needs of the both the community and PWUD is key. A low-threshold nature of a DCR is one of the main principles recognised, along with the integration across a network of local services and involvement of the target population. Meaningful participation of people with lived experiences of drug use should be included throughout the consultation, development, implementation, operation and evaluation stages of the service.

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# APPENDICES

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Appendix A — Historical overview of INCB reports with regard to DCRs (1998–2016)

Appendix B — Intake form AMOC, Amsterdam

Appendix C — Users contract AMOC, Amsterdam

Appendix D — User agreement Niddastraße, Frankfurt

Appendix E — Intake form Abrigado, Luxembourg

Appendix F — User contract Abrigado, Luxembourg

Appendix G — Interview guide

Appendix H — Cost estimations

## HISTORICAL OVERVIEW OF INCB REPORTS (1998–2016)

### 1998

Some States in Europe have established so-called “shooting galleries”, where drug abusers can administer drugs under supervision and in supposedly hygienic conditions. The Board urges those States to consider carefully all the implications of such “shooting galleries”, including the legal implications, the congregation of addicts, the facilitation of illicit trafficking, the message that the existence of such places may send to the general public and the impact on the general perception of drug abuse (*INCB report 1998, p. 53, nr. 437*).

### 1999

Drug injection rooms, where addicts may inject themselves with illicit substances, are being established in a number of developed countries, often with the approval of national and/or local authorities. The Board believes that any national, state or local authority that permits the establishment and operation of drug injection rooms or any outlet to facilitate the abuse of drugs (by injection or any other route of administration) also facilitates illicit drug trafficking. The Board reminds Governments that they have an obligation to combat illicit drug trafficking in all its forms. Parties to the 1988 Convention are required, subject to their constitutional principles and the basic concepts of their legal systems, to establish as a criminal offence the possession and purchase of drugs for personal (non-medical) consumption. By permitting drug injection rooms, a Government could be considered to be in contravention of the international drug control treaties by facilitating in, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking. The international drug control treaties were established many decades ago precisely to eliminate places, such as opium dens, where drugs could be used with impunity.

The Board, recognizing that the spread of drug abuse, human immunodeficiency virus (HIV) infection and hepatitis are serious concerns, encourages Governments to provide a wide range of facilities for the treatment of drug abuse, including the medically supervised administration of prescription drugs in line with sound medical practice and the international drug control treaties, instead of establishing drug injection rooms or similar outlets that facilitate drug abuse (*ICNB report 1999, p. 26-27, nr. 176-177*).

The Board regrets that draft laws introduced in Germany and Luxembourg would allow for the establishment of drug injection rooms, also known as “shooting galleries” (*INCB report 1999, p. 57, nr. 451*).

The Board is concerned by the decision of the German authorities to establish a legal basis for the operation of drug injection rooms. Instead, the authorities should provide the largest variety possible of treatment options, including substitution treatment. The Board notes the positive experience of several German cities, such as Berlin, which base their drug policy on a balanced approach comprising both demand and supply reduction efforts (*INCB report 1999, p. 60, nr. 480*).

The Board urges the Government of Australia not to permit the establishment and operation of drug injection rooms, or so-called “shooting galleries”. In the view of the Board, such establishments would provide an outlet for illicit drug abuse and facilitate or encourage illicit drug trafficking, which, under the international drug control treaties, Governments are obliged to combat in all its forms (*INCB report 1999, p. 62, nr. 500*).

### 2000

Drug policy discussions in Western Europe have focused on the implementation of harm reduction activities such as the establishment of drug injection rooms or the effectiveness of heroin maintenance programmes. Following the attention given to harm reduction in Western Europe, it appears that some countries in Central and Eastern Europe have also started to put more emphasis on harm reduction.

The Board acknowledged many years ago, in its report for 1993, that harm reduction had a role to play in a tertiary prevention strategy for demand reduction purposes. However, the Board also drew attention to the fact that harm reduction programmes could not be considered substitutes for demand reduction programmes. The Board would like to reiterate that harm reduction programmes can play a part in a comprehensive drug demand reduction strategy but such programmes should not be carried out at the expense of other important activities to reduce the demand for illicit drugs, for example drug abuse prevention activities.

Since some harm reduction measures are controversial, discussions of their advantages and disadvantages have dominated the public debate on drug policy. The fact that harm reduction programmes should constitute only one element of a larger, more comprehensive strategy to reduce the demand for illicit drugs has been neglected. The Board regrets that the discussion on drug injection rooms and some other harm reduction measures has diverted the attention (and, in some cases, funds) of Governments from important demand reduction activities such as primary prevention or abstinence-oriented treatment (*INCB report 2000, p. 59-60, nr. 444-445-446*).

In February 2000, Germany adopted an amendment to its narcotics act, allowing for the establishment and operation of drug injection rooms. The amendment sets forth 10 minimum standards for the security and control of the use of narcotics in drug injection rooms. The Board notes that the Government of Germany has responded to some of the concerns of the Board such as the emergence of rampant drug trafficking on and around the premises of drug injection rooms; however, the Board maintains its principal objection to the establishment and operation of such facilities, which was expressed in its report for 1999. The Board notes that the non-medical use of drugs obtained on the illicit market without prescription runs counter to the main principle of all the international drug control treaties, namely that drugs should be used for medical and scientific purposes only (*INCB report 2000, p. 61, nr. 460*).

The mission to Spain visited a pilot project established by the community of Madrid aimed at reaching out to severely addicted heroin abusers. The pilot project provides, in particular, the use of heroin injection facilities intended to be a first step to attract those abusers who have previously not been incorporated into any type of health-care network or into other drug abuse treatment programmes. The Board reiterates its concern over such facilities, which it expressed in its report for 1999.

The Board continues to be concerned over the practice not in line with international conventions of establishing drug injection rooms where non-medical use of drugs is taking place. Switzerland is a country with a highly developed social and health-care system and should be able to provide all types of facilities for treatment, instead of establishing drug injection rooms that maintain and facilitate drug abuse under supposedly hygienic conditions (*INCB report 2000, p. 66, nr. 499 and 504*).

## **2001**

The Board wishes to reiterate that the establishment of drug injection rooms, where addicts can abuse drugs obtained from illicit sources, under direct or indirect supervision of the Government, is contrary to the international drug control treaties (*INCB report 2001, p. 74, nr. 510*).

The Board visited the Holy See in March 2001. The Board appreciates the activities of the Roman Catholic Church in the area of drug demand reduction, freeing people from the scourge of drug addiction. The Board appreciates the stand taken by the Holy See against the opening of drug injection rooms, where addicts take drugs obtained from illicit markets, which echoes the view expressed by the Board in its report for 1999 (*INCB report 2001, p. 78, nr. 540*).

The Board regrets that local authorities in the Australian state of New South Wales have permitted the establishment of a drug injection room, setting aside the concerns expressed by the Board that the operation of such facilities, where addicts inject themselves with illicit substances, condones illicit drug use and drug trafficking and runs counter to the provisions of the international drug control treaties. The Board notes that the national policy in Australia does not support the establishment of drug injection rooms. The Board urges the Government to ensure that all of its states comply fully with the provisions of the international drug control treaties, to which Australia is a party (*INCB report 2001, p. 80, nr. 559*).

## **2002**

In Zurich, Switzerland, a drug inhalation room for users who administer drugs through inhalation was opened in April 2002, since inhaling drug abusers are banned from using facilities that primarily cater to injection drug abusers. While the establishment of drug injection rooms was claimed to be necessary to reduce risks to the general public and to illicit drug abusers by the act of drug injection, similar reasons have not been advanced for the establishment of drug inhalation rooms. The Board wishes to reiterate that drug injection rooms (or any other similar outlets established in some developed countries) might even facilitate drug abuse, are contrary to

the international drug control treaties and interfere with obligations of law enforcement authorities. The Board therefore encourages Governments to provide a wider range of facilities for the treatment of drug abuse that are in line with sound medical practice and the international drug control treaties, instead of aiding and abetting drug abuse (and possibly illicit drug trafficking), through drug injection rooms and similar outlets (*INCB report 2002, p. 70, nr. 504*).

The Board maintains its opposition, expressed in its report for 2001, on the establishment in Australia of a drug injection room in the state of New South Wales, and regrets that the project has been extended (*INCB report 2002, p. 74, nr. 535*).

## **2003**

The Board notes with concern that, in June 2003, the Government of Canada approved the establishment of a drug injection room in the city of Vancouver, the first such site in North America. The drug injection room, which opened in September 2003, will be subject to an evaluation in three years' time.

The Board has on numerous occasions expressed its concern regarding the operation of drug injection rooms, where persons can inject drugs acquired with impunity on the illicit market. The Board reiterates its views that such sites are contrary to the fundamental provisions of the international drug control treaties, which oblige States parties to ensure that drugs are used only for medical or scientific purposes (*INCB 2003 report, p. 49, nr. 325-326*).

At the invitation of the Government of Germany, the Board sent a mission to that country in July 2003. The primary objective of the mission was to visit drug injection rooms in operation in that country and to discuss with the authorities the Board's concerns regarding such facilities. The Board also viewed numerous facilities in several cities for the treatment and rehabilitation of drug-dependent persons.

The Government had underlined that the drug injection rooms in operation in Germany were not in contravention of the international drug control treaties, as they were subject to stringent regulations and had been incorporated into the general health system. In this regard, the Government had argued that the drug injection rooms served an important function in ensuring that drug-dependent persons who otherwise could not be reached by the authorities were referred to therapy and other public services.

The Board notes the efforts of the German authorities to ensure that drug injection rooms are integrated into the general health-care services for drug addicts and are well maintained and clean. The Board also notes that the establishment of such injection rooms is perceived as a success by a large part of the local authorities and the local population. However, the Board also notes that, according to the data collected by the Government, there is little evidence that drug injection rooms actually serve to ensure that the drug-dependent persons undergo treatment and that their existence contributes to a reduction in drug-related deaths. The Board reiterates its views that, insofar as they serve as forums in which drugs acquired on the illicit market can be abused, they are not in compliance with the international drug control treaties. The existence of facilities aimed at ensuring that drug-dependent persons are encouraged to undergo treatment is desirable, but such facilities must be in compliance with the treaties. The Board urges the Government to take the necessary measures to ensure compliance with the international drug control treaties (*INCB 2003 report, p. 78, nr. 559-560-561*).

In previous reports, the Board expressed its concern about the decision on the establishment in Australia of a drug injection room in the State of New South Wales. The Board notes that the Government of Australia does not support that decision but has no power to intervene since it leaves certain matters of health and law enforcement under the jurisdiction of its states and territories. That, however, puts into question the capacity of the Commonwealth of Australia to ensure the implementation of the provisions of the international drug control treaties throughout its territories (*INCB report 2003, p. 80, nr. 576*).

## **2004**

The establishment of rooms for drug injection, consumption and/or inhalation or other facilities where illicit drugs are administered continues to be a contentious issue, particularly in the member States of the European Union. While it is sometimes argued that drug injection rooms have some positive effects, such as establishing contact between social services and the hard-to-reach population of injecting drug abusers, the provision of such facilities raises legal and ethical issues. Drug injection rooms are legal facilities for the purpose of facilitating behavior that is both illegal and damaging. The drugs used in those facilities come from the illicit market. The

Board notes that the Governments of many European countries with drug-control policies as diverse as those of Denmark and Portugal have opted against the establishment of drug injection rooms, and the Board strongly supports their decisions. The Board also reiterates that drug injection rooms are against the central principle embodied in the international drug control treaties, namely that the use of drugs should be limited to medical and scientific purposes only (*INCB report 2004, p. 76-77, nr. 510*).

As mentioned in its previous reports, the Board continues to be concerned about the establishment of a drug injection room in the Australian state of New South Wales and about the four-year extension of the trial period. The Board is pleased to note that no other state of Australia plans to establish such an injection room (*INCB report 2004, p. 83, nr. 562*).

## **2005**

The Board reiterates its position that drug injection rooms or other facilities, where persons may use drugs acquired illicitly, facilitate the illicit use of internationally controlled substances and violate the provisions of the international drug control treaties. Drug injection rooms contravene the major principle of the treaties, namely that the use of drugs should be limited to medical and scientific purposes. The Board therefore deeply regrets the opening of a drug injection room in Norway in January 2005 and urges the Government to take immediate and necessary steps to ensure full compliance with the international drug control treaties (*INCB report 2005, p. 84, nr. 590*).

## **2006**

Pursuant to its 2003 mission to Germany, where the Board visited drug injection rooms (called “drug consumption rooms” in Germany) and some drug abuse treatment establishments, the Board reiterated to the Government its view that such rooms violate the international drug control treaties and recommended that the Government take immediate measures to ensure compliance with its international obligations.

The Board remains concerned that the policy of the Government of Germany in this area has not changed, and that rooms for the “consumption” of drugs, including by injection, continue to be in operation in the country. The Board urges the Government to take the steps necessary to ensure that the provisions of the international drug control treaties are fully implemented in the country and that the operation of such rooms is brought to a halt. The Board encourages the Government to continue its efforts to ensure that adequate services are made available to those in need of treatment, rehabilitation and social integration, in conformity with the international drug control treaties, rather than establishing such rooms (*INCB report 2006, p. 25, nr. 153-154*).

The Board notes with concern that, despite its ongoing dialogue with the Governments concerned, drug injection rooms, where drug abusers can abuse with impunity drugs acquired on the illicit market, remain in operation in a number of countries, including Australia, Canada, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland. The Board regrets that no measures have been taken to terminate the operation of such facilities in the countries concerned, and, in some cases, the number of such rooms has increased. Some of the facilities in those countries also provide areas for abusers to inhale drugs, as well as to inject drugs.

The Board wishes to reiterate that the provision of rooms for the abuse of drugs, regardless of whether they are under the direct or indirect supervision of the Government, are contrary to the international drug control treaties, particularly article 4 of the 1961 Convention, which obligates State parties to ensure that the production, manufacture, import, export, distribution of, trade in, use and possession of drugs are limited exclusively to medical and scientific purposes.

The Board believes that any national State or local authority that permits the establishment and operation of rooms or any outlet to facilitate the abuse of drugs, by injection or any other route of administration, also provides an opportunity for illicit drug distribution. The Board would like to emphasize that Governments have an obligation to combat illicit drug trafficking in all its forms and that parties to the 1988 Convention are required, subject to their constitutional principles and the basic concepts of their legal systems, to establish as a criminal offence the possession and purchase of drugs for personal non-medical use.

In some jurisdictions, local authorities have encouraged or promoted the establishment of rooms for the abuse of drugs. The Board would stress that it is the Government that is responsible for ensuring compliance with the country’s obligations under the international drug control treaties.

The Board encourages all Governments to ensure that efficient measures are taken to address drug abuse and the spread of HIV/AIDS, in compliance with their obligations under the international drug control

treaties. The Board urges the Governments of countries where rooms for the abuse of drugs are in operation to provide adequate services to those in need of treatment and rehabilitation, in accordance with the provisions of the international drug control treaties, rather than providing such rooms (*INCB report 2006, p. 28, nr. 175-176-177-178-179*).

The number of drug injection rooms in Germany continued to increase during 2006. There are currently 25 drug injection rooms in Germany. The Board has repeatedly expressed its concern that such rooms (called “drug consumption rooms” in Germany) are in violation of the international drug control treaties. The Board encourages the Government to continue its efforts to ensure that adequate services are made available to those in need of treatment, rehabilitation and social integration in conformity with the international drug control treaties, rather than continue operating drug injection rooms (*INCB report 2006, p. 76-77, nr. 576*).

Drug injection rooms (sometimes called “drug consumption rooms”) continue to operate in a small number of countries, mainly in Europe. The Board reiterates its position that, insofar as they are facilities where persons can abuse with impunity drugs acquired on the illicit market, such rooms contravene the most fundamental principle of the international drug control treaties: drugs should be used only for medical or scientific purposes. The Board urges the Governments of all countries where drug injection rooms are in operation to take prompt action to close those facilities and to provide appropriate services and facilities for the treatment of drug abusers, in accordance with the provisions of the international drug control treaties (*INCB report 2006, p. 87, recommendation 9*).

## **2007**

The Board, while taking note of the Government’s views on the drug injection room in Vancouver, wishes to reiterate its position on that issue as expressed directly to the Government and in its annual reports, namely that the provision of rooms for the abuse of drugs is contrary article 4 of the 1961 Convention, which obligates State parties to ensure that the production, manufacture, import, export and distribution of, trade in and use and possession of drugs are limited exclusively to medical and scientific purposes. The Board trusts that the Government will reach a decision that will be in compliance with the provisions of the international drug control treaties (*INCB report 2007, p. 30-31, nr. 161*).

The Board notes with concern that drug injection rooms continue to operate in a small number of countries, mainly in Europe. The Board reiterates its position that facilities where persons can abuse with impunity drugs illegally acquired, contravene the most fundamental principle of the international drug control conventions: drugs should be used only for medical and scientific purposes. The Board urges the Governments of countries where drug injection rooms are operated for the purpose of administering illicitly obtained drugs, to close those facilities and to provide appropriate evidence-based medical services and facilities for the treatment of drug abusers (*INCB report 2007, p. 111, recommendation 24*).

## **2008**

The Board has longstanding concerns regarding certain policies adopted by the Government of the Netherlands, in particular the policy that allows small amounts of cannabis to be sold and abused in so-called “coffee-shops”. The Board is also concerned about the operation of so-called “drug consumption rooms”, facilities where drug addicts can abuse illicit drugs. The medical prescription of cannabis and the heroin maintenance programme in the Netherlands are also issues that the Board is monitoring closely (*INCB report 2008, p. 32, nr. 178*).

The Board, while noting the explanations given for the operation of “drug consumption rooms” in Switzerland, urges the Government to provide adequate treatment facilities to drug addicts in accordance with the provisions of the international drug control treaties (*INCB report 2008, p. 37, nr. 222*).

The board is concerned that distribution of “safer crack kits” has continued in several cities in Canada and that a Supreme Court of British Columbia issued a decision in May 2008 permitting a “drug injection room” in Vancouver, the first “drug injection room” in the Americas, to continue to operate. The Board views such programmes with great concern and considers that they violate the international drug control treaties (*INCB report 2008, p. 66, nr. 430*).

The Board notes that in the evaluation of a project to establish a “drug injection room” in Norway it is stated that there is no evidence that the scheme has resulted in a reduction in drug overdose rates or fatalities. Also mentioned in the evaluation are important issues such as the fact that the drug injection room may contribute to the perpetuation of drug abuse and that health authorities might be perceived as condoning drug use. The Government has decided that the temporary act relating to a trial scheme for drug consumption rooms will remain in force until December 2009. The Board urges all Governments to refrain from establishing “drug consumption rooms” and to pursue alternative ways to increase access to health and social services, including services for the treatment of drug abusers (*INCB report 2008, p. 103, nr. 709*).

The Board remains concerned that, in a small number of countries, “drug consumption rooms” and “drug injection rooms”, where persons can abuse with impunity drugs acquired on the illicit market, remain in operation. **The Board urges Governments to terminate the operation of these drug abuse rooms and similar outlets and to promote the access of drug abusers to health, social and drug abuse treatment services** (*INCB report 2008, p. 116, recommendation 29*).

## **2009**

Following its 2006 mission to Luxembourg, when members of the Board visited a so-called “drug consumption room”, the Board, in a letter to the Government, reiterated its view that such facilities violated the international drug control treaties, particularly the 1961 Convention, and recommended that the Government take immediate measures to terminate the operation of that facility.

The Board notes with concern, however, that the policy of the Government of Luxembourg in that area has not changed and that a room for the “consumption”, including by injection, of drugs acquired on the illicit market, continues to be in operation in the country. The Board urges the Government to provide adequate services to those in need of treatment, rehabilitation and social integration, in conformity with the provisions of the international drug control treaties (*INCB report 2009, p. 39, nr. 210-211*).

The Board requests the Government to terminate the operation of the “drug injection room” in Sydney and provide drug abusers who will be affected by the closure with access to appropriate social and health services, including for the treatment and rehabilitation of drug abusers (*INCB report 2009, p. 35, nr. 185*).

Despite the almost universal application of the international drug control treaties, the Board has noted with concern that a number of States parties to the treaties have been turning to and persisting in the implementation of national policies that are not in line with the treaties. In particular, the Board has noted that a number of States parties have permitted the use of “safer crack kits”, the “medical” use of cannabis, “coffee shops” and the establishment and operation of so-called “drug injection rooms”, which contravene the international drug control treaties.

In response to the Board’s repeated warnings that those measures promote social and legal tolerance of drug abuse and drug trafficking and run counter to the provisions of the international drug control treaties, those States parties continue to argue that their domestic legal systems prevent them from fully complying with the treaties, as their state and/or provincial legislative and judicial structures and competencies are independent and prevail over their national or federal legislation and jurisdiction.

The Board is aware that current international law recognizes the various national legal tradition and systems. The Board also acknowledges that all States parties to the international drug control treaties follow differing legal systems and apply legal traditions in which, in some instances, the relationship between state or provincial and national or federal legislative, judiciary and jurisdictional issues is highly complex, sensitive an even controversial.

In this connection, the Board wishes to stress the basic principles of international law enshrined in the provisions of articles 26 (on the obligation of parties to fulfil their treaty-based obligations in good faith) and 27 (on the primacy of international law over national legislation) of the Vienna Convention on the Law of Treaties, as well as the international drug control treaties (*INCB report 2009, p. 49, nr. 278-279-280-281*).

The Board notes with concern that, in a small number of countries, “drug consumption rooms” and “drug injection rooms”, where persons can abuse with impunity drugs acquired on the illicit market, continue to operate. **The Board calls upon Governments to close those facilities and similar outlets and to promote the access of drug abusers to health and social services, including services for the treatment of drug abuse, in conformity with the provision of the international drug control treaties** (*INCB report 2009, p. 127*).

**2010**

The Board sent a mission to Spain in July 2009. The Board notes that Spain, a party to all three international drug control conventions, is firmly committed to the goals and objectives of those treaties. That commitment is reflected in the national drug control strategy and the national drug control action plan adopted by the Government, which are implemented within a well-designed administrative framework. The Government has established effective procedures for control over the illicit manufacture of, trade in and use of narcotic drugs, psychotropic substances and precursors. A comprehensive and well-balanced system of prevention, treatment, rehabilitation and social reintegration programmes has been put in place to deal with drug abuse. The Board remains concerned, however, about the continued availability of “drug consumption rooms” in Spain (*INCB report 2010, p. 21, nr. 123*).

**2011**

Over the last few decades, the majority of States parties to the international drug control treaties have applied adequate control measures, as required under the treaties, to ensure that narcotic drugs and psychotropic substances are used only for medical and scientific purposes. For example, consensus among States parties had developed in favour of firm control over cannabis, a substance included not only in Schedule I but also in Schedule IV of the 1961 Convention as amended by the 1972 Protocol, which requires the most stringent control measures. The Board notes that almost all States parties have applied the strict control measures foreseen in the international drug control treaties. The almost universal application of the treaties had substantially enhanced the efforts of the international community to fight drug abuse and drug trafficking.

The Board notes, however, some exceptions to those developments. A number of States parties are shifting towards more lenient national drug policies that are not in line with the international drug control treaties. For example, some States parties have permitted the use of “safer crack kits”, the existence of so-called “drug injection rooms”. The Board has warned that such policies promote social and legal tolerance of drug abuse and drug trafficking and therefore contravene the international drug control treaties.

In Australia, the local authorities in the state of New South Wales permitted the establishment of a “drug injection room”, despite the fact that, at that time, the national policy in Australia did not support the establishment of such facilities.

The situations described above make it difficult for the Governments of those countries to fulfil their obligations under the international drug control treaties and to ensure the implementation of the treaties on their entire territory. Some of the Governments concerned have stated that their domestic legal systems prevent them from fully complying with the treaties, as their state and/or provincial legislative and judicial structures and competencies are independent and prevail over their national or federal legislation and jurisdiction.

The Board underlines the fact that certain state, regional and/or provincial powers, jurisdictions and delegated competencies are expressly granted and guaranteed in the constitutional frameworks of some States parties. Acceding to the international drug control treaties should result in States parties adopting national strategies and measures that ensure their full compliance with the treaties. Those treaty obligations are applicable with respect to the entire territory of each State party, including its federated states and/or provinces.

Moreover, according to international law, as well as the international obligations of all parties to the international obligations of all parties to the international drug control treaties, state and/or provincial legislative and/or judicial measures and actions should be in compliance with each State’s policies and obligations at the international level. If a State, irrespective of its constitutional framework and legal system, enters into an international agreement by acceding to the international drug control treaties, that State must ensure that all state and/or provincial policies and measures do not undermine its efforts to combat drug abuse and trafficking in narcotic drugs, psychotropic substances and precursor chemicals.

The Board expresses its concern about the decision of the Supreme Court of Canada, permitting a “drug injection room” to continue to operate in Vancouver. Under international law, by virtue of the hierarchy of norms, the provisions of internal law cannot be invoked to justify non-compliance with provisions of the international drug control treaties to which a State has become a party. Those treaties do not permit the use of controlled drugs for any purposes except medical or scientific purposes (*INCB report 2011, p. 38-39, nr. 282-283-284-285-286-287 and 289*).

In seeking to implement their international drug control obligations, the Governments of Canada and the United States have faced particular challenges owing to the division of powers within their respective federal structures. In Canada, the Government lodged an appeal with the Supreme Court against a decision by the Court of Appeal



of British Columbia allowing so-called “drug injection rooms” to continue to be exempted from federal drug control legislation; the appeal was rejected. The Board continues to emphasize to the Governments of all States that, in order to respect their international obligations under the drug control treaties; States must ensure the consistent implementation of those norms over the entire national territory, irrespective of their internal legal orders (*INCB report 2011, p. 58, nr. 428*).

## **2012**

The Board, while taking note of the recent decision of the Supreme Court and the Government’s views on the drug injection room in Vancouver, wishes to reiterate its position on that issue as expressed on numerous occasions, namely that the provision of such facilities for the abuse of drugs is contrary to the international drug control treaties, particularly article 4 of the 1961 Convention, under which States parties are obligated to ensure that the production, manufacture, import, export and distribution of, trade in and use and possession of drugs are limited exclusively to medical and scientific purposes (*INCB report 2012, p. 10, nr. 71*).

In July 2012 in Denmark, an amendment to the drug law was to come into effect that would empower the Minister of Health to license, at the request of municipal governments, “drug consumption rooms” and regulate their operation by municipal authorities and private organizations with operational agreements with the municipal authorities. The Government of Denmark has been informed of the position of the Board that consumption rooms are in violation of the provisions of the international drug control conventions (*INCB report 2012, p. 99-100, nr. 752*).

## **2013**

The Board has long-standing concerns regarding certain drug control policies adopted by the Government of the Netherlands, in particular the policy that allows small amounts of cannabis to be sold and abused in so-called “coffee shops”. The Board is also concerned about the operation of so-called “drug consumption rooms”, facilities where drug addicts can abuse drugs (*INCB report 2013, p. 8, nr. 54*).

The Board trusts that the Government of the Netherlands will also review its policy on “drug consumption rooms” and urges the Government to take the measures necessary to ensure full compliance with the international drug control treaties (*INCB report 2013, p. 9, nr. 58*).

In June 2013, the Government of Canada introduced Bill C-65, entitled the Respect for Communities Act. The bill aims to create a legal framework that would be applicable to requests for exemptions under the Controlled Drugs and Substances Act involving activities with controlled substances, including the establishment and operation of supervised drug injection sites. Under current legislation, the Minister of Health has the authority to grant an exemption to undertake activities using controlled substances for medical or scientific purposes, or in the public interest. Bill C-56 would require applications for activities involving controlled substances at a supervised drug consumption site in Canada to be accompanied by evidence of extensive consultations, including stakeholder views, before such applications could be considered by the Minister. In July 2013, the Toronto Board of Health adopted a decision to prepare a submission to the federal Government expressing its opposition to Bill C-65 and recommending the development of a simplified application process for the establishment of supervised injection sites. The Board of Health also decided to solicit the financial support of the provincial Government of Ontario for the integration of supervised injection services, on a pilot basis, into existing provincially-funded clinical health services for people in Toronto who use drugs. INCB wishes to reiterate its position that the establishment and operation of drug consumption facilities is inconsistent with the provisions of the drug control conventions (*INCB report 2013, p. 49-50, nr. 376*).

## **2014**

In June 2013, the Government of Canada introduced Bill C-65, entitled the “Respect for Communities Act”, which was aimed at creating a legal framework applicable to requests for exemptions under the Controlled Drugs and Substances Act that would allow for the establishment and operation of supervised drug injection sites. The bill outlined a set of minimum requirements for such applications, to be considered by the Minister of Health, including proof of extensive consultations among all relevant stakeholders, such as community groups and law enforcement authorities. Given the adjournment of Parliament in August 2013, before the bill could be put to a

vote, the respect for Communities Act has been reintroduced for legislative consideration (as Bill C-2) and is currently under deliberation. Consideration of the legislation is occurring as the public health authorities in several Canadian cities consider submitting applications to the federal Minister of Health for the opening of “drug injection rooms”. The Board looks forward to a continuing dialogue with Governments that have permitted such “drug consumption rooms” and reiterates its concern that such facilities could be inconsistent with the provisions of the international drug control conventions (*INCB report 2014, p. 54, nr. 362*).

## **2015**

According to the French authorities, the establishment of drug consumption rooms is part of the country’s “harm reduction” policy and has three main objectives: to forge links with drug users who constitute a marginalized group often having little or no contact with the formal health-care system and to bring them back into the system; to reduce the transmission of blood-borne diseases among individuals who abuse drugs by injection and reduce drug overdose cases; and to reduce the nuisance and disturbance to public order of drug abuse by injection.

In the past, the Board has expressed its concern that the establishment of drug consumption rooms may not be consistent with the provisions of the international drug control conventions. INCB reminds all States that the ultimate goal of drug treatment measures should be cessation of drug use through treatment of addiction, which should be accompanied by the provision of rehabilitation and social reintegration measures. As such, any form of assistance offered to persons suffering from drug dependence should be delivered within a framework that provides for the active referral of that person to treatment services.

As it does with other Governments on similar issues, the Board has actively engaged with the French authorities in an ongoing dialogue on this matter. The Board looks forward to continuing its dialogue with the Government of France to ensure that the drug control measures taken in that country continue to comply with the provisions of the international conventions (*INCB report 2015, p. 22, nr. 138-139 and 140*).

In June 2015, the Respect for Communities Act came into effect in Canada. The legislation, which amends the Controlled Drugs and Substances Act, establishes specific criteria that must be met by applicants seeking an exemption for activities involving illicit substances at a “supervised consumption site” in order for the exemption request to be considered by the Ministry of Health. Canada currently has one supervised consumption site, but additional applications for the establishment of drug consumption rooms have been received by Health Canada and are currently under consideration (*INCB report 2015, p. 56, nr. 410*).

## **2016**

Over the reporting period, the Board has continued its dialogue with the Government of Denmark on several issues related to drug control, including the question of “drug consumption rooms”. In order to fully appraise the situation with respect to treaty compliance, the Board requested the Government to provide it with more detailed information as to the applicable legal framework and the operation of such premises. The Board received an English translation of the legislation on “drug consumption rooms” in April 2016, which was accompanied by explanatory notes.

On the basis of the information provided, the Board notes that, in June 2012, the Parliament adopted an amendment to the Danish Law on Psychoactive Substances that provides the legal basis for the opening of “drug consumption rooms” in Denmark, and in 2014 the Parliament adopted a law on “drug consumption rooms”. Additional amendments to the legislative framework of the operation of such rooms followed and are contained in the Consolidated Act on Controlled Substances, which entered into force in July 2016.

**As it has done with other countries that have allowed the operation of “drug consumption rooms”, the Board reiterates that the ultimate objective of such measures is to reduce the adverse consequences of drug abuse without condoning or encouraging drug trafficking. Accordingly, any such facility must provide, or refer patients to, treatment, rehabilitation and social integration measures.**

The Board notes from the information provided by the Government that the substances consumed in the “drug consumption rooms” are acquired by users prior to entering the facilities. The Board expresses its reservations about those practices.

In March 2016, the Government of Denmark informed the Board that it had commissioned an independent evaluation of the implementation of the new policy on “drug consumption rooms”, the results of which had led to some adjustments being made to the 2014 law. The Board has requested information on the findings of that evaluation, which was conducted in 2015 (*INCB report 2016, p. 26-27, nr. 172-173-174-175-176*).

Supervised “drug consumption facilities”, where drugs can be used for non-medical purposes under the supervision of medically trained staff, have been operating in Western Europe for the last three decades. The primary aim of the facilities is to reduce the acute risks of disease transmission through unhygienic injecting, prevent drug-related overdose deaths and connect high-risk drug users with addiction treatment and other health and social services. By February 2016, there were a total of 74 official “drug consumption facilities” operating in Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland.

In March 2016, the Government of France issued decree 0072, which approved, on a trial basis, the establishment of “drug injection rooms” in the country, for a maximum period of six years. The decree was adopted following a decision by the French Constitutional Council in January 2016 that the proposed establishment of the “drug consumption rooms”, based on the aim of reducing the risks associated with drug use and leading drug users to cease their use of drugs, with limited criminal immunity for drug users and the professional practitioners inside the facility, was in conformity with the Constitution of France.

**With respect to “drug consumption rooms”, the Board wishes to reiterate its frequently expressed concern that, in order for the operation of such facilities to be consistent with the international drug conventions, certain conditions must be fulfilled. Chief among those conditions is that the ultimate objective of these measures is to reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking. “Drug consumption rooms” must be operated within a framework that offers treatment and rehabilitation services as well as social reintegration measures, either directly or by active referral for access, and must not be a substitute for demand reduction programmes, in particular prevention and treatment activities (*INCB report 2016, p. 90-91, nr. 718-719-720*).**



# USERS CONTRACT 2017

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DATE: .....

NAME CLIENT: .....

DATE OF BIRTH: .....

NAME OF THE SOCIAL WORKER: .....

NATIONALITY:.....

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## I WILL

BEHAVE ACCORDING TO THE RULES AND GOALS OF A DRUG USERS ROOM

USE WITH “SAFETY – HYGIENE – STRESS FREE”

## I WILL NOT

STEAL / DEAL / SHARE / OFFER ANY TYPE OF DRUGS  
DISPLAY MONEY / ENGAGE IN CRIMINAL ACTIVITIES  
HAVE AGGRESSIVE BEHAVIORS

## THE CONTRACT WILL STOP WHEN

I BREAK THE RULES OF GOOD CONDUCTS OF THE USERS ROOM  
I DON'T CONTACT AMOC FOR 3 MONTHS = MANDATORY RE-INTAKE WITH SOCIAL WORK

## IMPORTANT

PERSONAL BELONGINGS BECOME AMOC PROPERTY WHEN LEFT BEHIND  
THE FIRST MONTH OF THIS CONTRACT IS A “TRY OUT” PERIOD  
THE POLICE HAVE ACCESS TO YOUR NAME, YOUR DATE OF BIRTH AND YOUR NATIONALITY  
AMOC WORKERS WILL FILE A POLICE REPORT AGAINST CLIENTS WHEN NECESSARY

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## OPENING - CLOSING TIME

MONDAY TILL FRIDAY: 10:00 till 17:15 PM    SATURDAY AND SUNDAY: 12:00 till 19:30 PM

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CLIENTS WHO LEAVE AMOC HAVE TO STAY MINIMUM 30 MINUTES OUTSIDE

INJECTORS RECEIVE 2 FREE TOURNIQUETS PER YEAR, ADDITIONAL ONES ARE CHARGED 10€

INJECTORS ARE NOT ALLOWED TO INJECT IN THE NECK AND/OR IN THE GROINS

I HAVE READ AND UNDERSTOOD THE CONDITION OF AMOC USERS ROOM CONTRACT

I HEREBY AGREE ON THE CONDITION OF THE MENTIONED CONTRACT

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CLIENT SIGNATURE: .....

STAFF SIGNATURE: .....

## Nutzungsvereinbarung zwischen idh e.V. und dem /der UnterzeichnerIn

Um diese Räumlichkeiten zum eigenständigen Drogenkonsum nutzen zu können, versichere ich, das 18. Lebensjahr vollendet zu haben.

### Hausordnung Drogenkonsumraum Niddastr. 49, 60329 Frankfurt / Main

#### Folgendes ist in dieser Einrichtung verboten:

1. Jegliche Ab- und Weitergabe von Drogen (auch Filter etc.)
2. Handel und Anbahnung von Handel mit Drogen
3. Teilen von Drogen
4. Abpacken und Rationieren von Drogen
5. Besitz von Drogen (außer einer geringen Menge zum Eigenverbrauch nach § 29 Abs.1 Nr.3 BtMG)
6. Gegenseitiges Applizieren von Drogen (Auch keine aktive Hilfe leisten!)
7. Mit offener Nadel „herumlaufen“ und das Abbrechen von Nadeln
8. Konsum von Drogen außerhalb der dafür vorgesehenen Konsumplätze
9. Das Rauchen, Kratzen, Spülen etc. von Crackpfeifen außerhalb des inhalativen Konsumraums
10. Gewaltandrohung, Gewalt, Beleidigungen etc.
11. Sexismus und Rassismus
12. Das Fotografieren und Filmen in der Einrichtung sowie das Telefonieren im 1. Obergeschoss
13. Der Konsum von Alkohol in den beiden Drogenkonsumräumen im 1. Obergeschoss.

Wir weisen explizit darauf hin, dass das Führen von Kraftfahrzeugen unter Drogeneinfluss verboten ist!

Vor dem Eintritt in die Konsumräume müssen immer die Hände am Waschbecken im 1.Obergeschoss neben dem Tresen gewaschen werden.

Hiermit versichere ich, diese Hausordnung zu beachten und den Anweisungen des Personals Folge zu leisten. Die Nutzung des Drogenkonsumraums erfolgt auf eigene Gefahr. Die Hessische Verordnung über die Erlaubnis für den Betrieb von Drogenkonsumräumen vom 10.09.2001 ist in der aktuellen Fassung jederzeit einsehbar.

#### **Information zur Erhebung und Verarbeitung Ihrer Daten**

Ab Oktober 2005 wird die Datenerhebung zur Nutzung der Konsumräume in Frankfurt nicht mehr in Papierform, sondern EDV-gestützt durchgeführt. Hiermit wird eine Vereinfachung der Arbeitsabläufe beim Ausfüllen der Fragebögen für die Nutzer und die Mitarbeiter der Konsumräume erreicht. Es werden weiterhin die gleichen Fragen gestellt wie bisher und mittels einer Codierung zur Anonymisierung der Daten gespeichert.

#### **Auf Ihre Daten haben nur die MitarbeiterInnen unseres Konsumraums Zugriff.**

Entsprechend den Vorschriften des Bundesdatenschutzgesetzes (BDSG) werden nur solche Daten erhoben und gespeichert, die für die von uns zu erbringenden Leistungsnachweise und die Weiterentwicklung des Drogenhilfesystems benötigt werden.

#### **Gemäß § 34 BDSG können Sie über die zu Ihrer Person gespeicherten Daten Auskunft erhalten und in Ihre elektronische Klientenakte Einsicht nehmen.**

Für wissenschaftliche Auswertungen werden Daten in anonymisierter Form, d.h. ohne die Möglichkeit, einen Personenbezug herzustellen, an ein wissenschaftliches Institut übermittelt. Datenübermittlungen an andere Stellen oder Behörden werden nicht vorgenommen. Auch Justiz- und Polizeibehörden erhalten keinerlei Informationen.

-----  
(Datum)

-----  
(Name KlientIn im DRUCKBUCHSTABEN)

-----  
(Unterschrift)

Hinweis: Dieser Informationstext wurde datenschutzrechtlich geprüft und gilt für die Benutzung der Drogenkonsumräume in Frankfurt



## Aufnahme DKR

- Dauer: ca. 20 Minuten.
- Ins Büro gehen, Privatsphäre wahren.
- Ordner und Mappe liegen im großen Büro
- *Sprachproblem?*
  - Kollegen mit entsprechender Sprachkompetenz mit der Aufnahme beauftragen!

### 1. Zugangsvoraussetzungen prüfen!!

- ✓ Volljährig!
  - Bei Zweifel muss sich der Klient ausweisen, sonst **muss** er abgelehnt werden!
- ✓ intravenöse/ inhalative Konsumerfahrung!
  - kein Erst-/ Gelegenheitskonsument
  - Für reine Sniefer ist der Zutritt nicht erlaubt!
  - konsumiert intravenös/ inhalativ
    - Blower müssen alleine blowen können
    - i.v. Konsumenten müssen mindestens selbst präparieren können. Sie können sich jedoch Hilfe beim Schuss suchen
      - (**VOR** dem Eintritt in den DKR organisieren). Der Helfende muss Handschuhe tragen.
      - Bei Schusshilfe dient der Paravent als Begrenzung
- ✓ Der Klient ist nicht ärztlich substituiert!

## 2. Datum und persönliche Daten im Vertrag eintragen (Nummer erfolgt durch Administration)

- a. Nachname in Druckschrift und Großbuchstaben
- b. Vorname normal
- c. Geburtsdatum
- d. Mitarbeiter, Vor und Nachname!
- e. Klient soll sich nach Möglichkeit ausweisen. Ist dies nicht möglich, entsprechender Vermerk!

Foto

Luxemburg, den.....

**DKR NUTZERVEREINBARUNG** Nr.....

Vereinbarung zwischen C.N.D.S

Nachname	Vorname
Geburtsdatum	
vertreten durch: (Mitarbeiter)	
Klient hat sich ausgewiesen durch:	

Der Klient verpflichtet sich, die folgenden Regeln zu akzeptieren und einzuhalten:

1. Ich beachte die in den Räumlichkeiten ausgehängte Hausordnung.
2. Ich bestätige, dass ich:
  - a.) Bereits intravenöse / inhalative Konsumerfahrung habe (d.h. kein Erstgelegenheitskonsument bin) und intravenös/inhalativ konsumiere.
  - b.) Volljährig bin.
  - c.) Nicht ärztlich substituiert bin.
3. Ich trage die Verantwortung (und das Risiko!) für den Gebrauch von Drogen selbst.
4. Ich akzeptiere die Weisungen der Konsumraum-Mitarbeiter (z.B. Warteliste, Ablehnung wegen starker Intoxikation, Verlassen des Konsumraums bei Notfällen).
5. Ich weiß, dass, ich keinen Zugang zum Konsumraum habe, wenn ich durch Drogen-/Alkoholkonsum bereits stark beeinträchtigt bin.
6. Ich führe innerhalb der Einrichtung und in unmittelbarer Nähe<sup>\*\*\*</sup> der Einrichtung nur Drogen zum Eigenbedarf mit mir.
7. Ich kaufe, erbetele, und verkaufe oder verschenke keine illegalen Drogen und keine Substitutionsmittel bzw. Medikamente im Konsumraum, im Gebäude und in unmittelbarer Nähe<sup>\*\*\*</sup> der Einrichtung.
8. Ich unterlasse jegliches Stehlen oder Hehlen im Konsumraum und in der Einrichtung.
9. Ich nehme zur Kenntnis, dass Drogenkonsum (auch Alkohol und Joints) außerhalb des Konsumraums und innerhalb der Einrichtung nicht erlaubt ist.

\*\*\* „unmittelbare Nähe“ bedeutet: um das Gebäude herum.

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### 3. Vertrag Punkt für Punkt vorlesen (Seite 2)

*(ggf. erhält der Klient zum Durchlesen eine Version in Portugiesisch oder Russisch)*

**Der Klient verpflichtet sich, die folgenden Regeln zu akzeptieren und einzuhalten:**

1. Ich beachte die in den Räumlichkeiten ausgehängte Hausordnung.
2. Ich bestätige, dass ich:
  - a.) bereits intravenöse/ inhalative Konsumerfahrung habe (d.h. kein Erst-Gelegenheitskonsument bin) und intravenös/ inhalativ konsumiere.
  - b.) volljährig bin.
  - c.) nicht ärztlich substituiert bin.
3. Ich trage die Verantwortung (und das Risiko!) für den Gebrauch von Drogen selbst.
4. Ich akzeptiere die Weisungen der Konsumraum-Mitarbeiter (z.B. Warteliste, Ablehnung wegen starker Intoxikation, Verlassen des Konsumraums bei Notfällen).
5. Ich weiß, dass ich keinen Zugang zum Konsumraum habe wenn ich durch Drogen-/ Alkoholkonsum bereits stark beeinträchtigt bin.
6. Ich führe innerhalb der Einrichtung und in unmittelbarer Nähe\*\* der Einrichtung nur Drogen zum Eigenbedarf mit mir.
7. Ich kaufe, erbettele und verkaufe oder verschenke keine illegalen Drogen und keine Substitutionsmittel bzw. Medikamente im Konsumraum, im Gebäude und in unmittelbarer Nähe\*\* der Einrichtung.
8. Ich unterlasse jegliches Stehlen oder Hehlen im Konsumraum und in der Einrichtung.
9. Ich nehme zur Kenntnis, dass Drogenkonsum (auch Alkohol und Joints) außerhalb des Konsumraums und innerhalb der Einrichtung nicht erlaubt ist.
10. Ich bin darüber informiert worden, dass ich von den Mitarbeitern der Einrichtung medizinisch-pflegerische und sozialarbeiterische Informationen und Beratung zur Safer Use, Safer Sex und zu Hilfeleistungen der Drogenhilfe erhalten kann. Wenn ich

---

\*\* „unmittelbare Nähe“ bedeutet: um das Gebäude herum.





#### 4. Ablauf im DKR:

- a. Ticket erhältst du beim Spritzentausch
- b. Kleine Statistik an der Aufnahme durch MA, immer stehenbleiben:
  - i. Ticket abgeben
  - ii. Alter sagen
  - iii. Sagen, was du konsumierst (Heroin, Kokain oder Cocktail)
  - iv. Sagen, wie du konsumierst (intravenös, blowen oder sniefen)
  - v. Konsumeinheit vorzeigen
- c. Dann erhältst du das Material: kleine braune Nadel, lange braune Nadel oder violette Nadel bei i.v. Konsum, Sniefset (Papier, Strohhalm, Wasser) oder Alufolie (befindet sich im Blowroom)
  - i. Du darfst nur das im DKR ausgegebene Material benutzen!
- d. Du kannst einen Garrot gegen Pfand leihen oder für 5 Euro kaufen
- e. Du kannst ein Feuerzeug für 20 cent kaufen
  - i. Löffel NICHT mit brennendem Alkoholtupfer erhitzen!!!
- f. Teilen ist erlaubt: NUR bei der Aufnahme und pro Tag mit einer Person (Erklärung warum?: Dealen soll vermieden werden)
  - i. Bei Weitergabe am Tisch: 1 Woche exclu
- g. Hände und Arm waschen
- h. Dann gehst du an deinen Tisch oder in den Blowroom und kannst konsumieren
- i. Im Blowroom max. 20 Minuten Aufenthalt; du erhältst einen Zettel mit deinem Namen und der Uhrzeit, bei der du raus gehen musst
- j. Für i.v. Konsum sind 30 Minuten Aufenthalt möglich
- k. bei Problemen, eine Vene zu finden, ist natürlich auch länger möglich
- l. Wenn du einen zweiten Schuss machen willst, fragst du die Mitarbeiter und bekommst von ihnen neues Material
- m. Nach dem Konsum wirfst du alles in den Poubelle
- n. Dann säuberst du deinen Tisch
  - i. Im Blowroom: feuchtes Tuch aus Box und mit Papier trocknen
  - ii. In Fixerstube: 2 Tücher am Fenster, 1. Spüli, 2. Desinfektion, danach nicht trocknen
- o. Bei Nicht-Säubern: 2 Tage exclu



**5. Weitere Regeln:**

- i. Wichtigste Regel: **NIE** den Tisch mit einer offenen Nadel verlassen!!!
- ii. Ansonsten: 2 Tage exclu
- b.** Kein Telefonieren, sonst 2 Tage exclu
- c.** Spritze nicht ausspülen! Die gebrauchte Spritze/Nadel immer direkt nach dem Schuss in den Poubelle
- d.** Nicht türkisch aufkochen!
- e.** Kein Essen/ Trinken erlaubt



**6. Erstaufnahme-Statistik:**

- Bei Frage 8: auf Dimps hinweisen, bzw. sind auch Bluttests bei uns in der Infirmerie möglich

**Info an den Klienten:**

***Dies sind erst einmal sehr viele Informationen auf einmal.***

***Das meiste siehst du im Ablauf.***

***Wenn du Fragen hast, wende dich jederzeit an die Konsumraum-Mitarbeiter!***

**Im DKR**

- 1) Klient wird den Kollegen im DKR vorgestellt
- 2) Foto machen
- 3) Einweisung im DKR durch Kollegen
- 4) Foto auf Vertrag drucken
- 5) Foto Löschen (Digi-Cam)
- 6) Vertrag abheften (gelbe Mappe)
- 7) Erststatistik abheften (Ordner DKR)
- 8) Neuaufnahme in Tagesstatistik dokumentieren

Photo

Luxemburg, den \_\_\_\_\_

**DKR NUTZERVEREINBARUNG** Nr. \_\_\_\_\_

Verständnisvertrag zwischen C.N.D.S.

Nachname	Vorname
Geburtsdatum	
verlesen durch (Mitarbeiter)	
Klient hat sich zugewiesen durch	

Der Klient verpflichtet sich, die folgenden Regeln zu akzeptieren und einzuhalten:

1. Ich beackele die in den Räumlichkeiten ausgelegte Hausordnung.
2. Ich bestätige, dass ich:
  - a.) bereits eintrafische / inhaltliche Konsumerfahrung habe (d.h. kein Erst- oder Gelegenheitskonsument bin) und einwandelnsfähig konsumiere.
  - b.) Volljährig bin.
  - c.) nicht ärztlich substituieret bin.
3. Ich trage die Verantwortung (und das Risiko) für den Gebrauch von Drogen selbst.
4. Ich akzeptiere die Einweisung der Konsumraum-Mitarbeiter (z.B. Wächterin, Abwahrung wegen starker Intoxikation, Verlassen des Konsumraums bei Nottfällen).
5. Ich weiß, dass, ich keinen Zugang zum Konsumraum habe, wenn ich durch Drogen-/Alkoholkonsum bereits stark beeinträchtigt bin.
6. Ich führe innerhalb der Einrichtung und in unmittelbarer Nähe\* der Einrichtung nur Drogen zum Eigenbedarf mit mir.
7. Ich kaufe, erhalte, verkaufe oder verschanke keine illegalen Drogen und keine Substitutionsmittel bzw. Medikamente im Konsumraum, im Gebäude und in unmittelbarer Nähe\* der Einrichtung.
8. Ich unterlasse jegliches Stehlen oder Helfen im Konsumraum und in der Einrichtung.
9. Ich nehme zur Kenntnis, dass Drogenkonsum (auch Alkohol und Nikotin) außerhalb des Konsumraums und innerhalb der Einrichtung nicht erlaubt ist.

\* unmittelbare Nähe bedeutet um das Gebäude herum.

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Luxemburg, den.....

**DKR NUTZERVEREINBARUNG Nr.....**

**Nutzervereinbarung zwischen C.N.D.S**

und.....(Klientin/Klient)

vertreten durch.....(Mitarbeiter)

Der Klient verpflichtet sich, die folgenden Regeln zu akzeptieren und einzuhalten:

1. Ich beachte die in den Räumlichkeiten ausgehängte Hausordnung.
2. Ich bestätige, dass ich:
  - a.) Bereits intravenöse / inhalative Konsumerfahrung habe (d.h. kein Erstgelegenheitskonsument bin) und intravenös/inhalativ konsumiere.
  - b.) Volljährig bin.
  - c.) Nicht ärztlich substituiert bin.
3. Ich trage die Verantwortung (und das Risiko!) für den Gebrauch von Drogen selbst.
4. Ich akzeptiere die Weisungen der Konsumraum-Mitarbeiter (z.B. Warteliste, Ablehnung wegen starker Intoxikation, Verlassen des Konsumraums bei Notfällen).
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6. Ich führe innerhalb der Einrichtung und in unmittelbarer Nähe\*\* der Einrichtung nur Drogen zum Eigenbedarf mit mir.
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---

\*\* „unmittelbare Nähe“ bedeutet: um das Gebäude herum.

**10.** Ich bin darüber informiert worden, dass ich von den Mitarbeitern der Einrichtung medizinisch-pflegerische und sozialarbeiterisch Informationen und Beratung zur Safer Use, Safer Sex und zu Hilfeleistungen der Drogenhilfe erhalten kann. Wenn ich möchte, kann ich außerdem zu weiterführenden Hilfen (Drogenberatung, betreutes Wohnen,...) vermittelt werden.

**11.** Ich erkläre mich damit einverstanden, dass personenbezogene Daten von mir erhoben werden. Ich bin Einverstanden mich vom DKR Personal fotografieren zu lassen und es in die Lage zu setzen mich unmissverständlich identifizieren zu können. Die Daten unterliegen dem Datenschutz und werden anonym statistisch ausgewertet. Die Mitarbeiter der Einrichtung unterliegen der Schweigepflicht.

Die Nutzervereinbarung ist gültig, solange keine ärztliche Substitutionsbehandlung beim Klienten, bei der Klientin durchgeführt wird.

Die Verstöße gegen die Benutzung des Konsumraums können zum sofortigen und eventuell auch zum dauerhaften Hausverbot führen.

Ich habe die Bedingungen gelesen und verstanden und erkläre mich mit den Regeln einverstanden und unterzeichne diese.

.....  
Unterschrift Klientin/Klient

.....  
Unterschrift Mitarbeiter

Checkliste für die Mitarbeiterin/Mitarbeiter:

- Alle obigen Punkte wurden im Einzelnen durchgesprochen.
- Die Klientin/der Klient hat sie verstanden und akzeptiert.
- Die Klientin/der Klient konnte identifiziert werden.
- Die Klientin/der Klient erfüllt die Aufnahmebedingungen.

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## GEBRUIKSRUIMTES

### INTERVIEW GIDS

Naam: .....

Functie/sector: .....

Datum: ..... Interview nummer: .....

#### Doel van de studie

- Het doel van deze studie is om de *haalbaarheid* van een (hypothetische) gebruiksruiimte te onderzoeken in de 5 Belgische steden (Gent, Antwerpen, Brussel, Luik en Charleroi), mocht dit geïmplementeerd worden. Het onderzoek spreekt zich dus niet uit of dit al dan niet *wenselijk* zou zijn.
- Wij zijn geïnteresseerd om van een brede waaier aan professionelen te horen wat eventuele haalbare scenario's en essentiële randvoorwaarden zijn voor een mogelijke implementatie van een dergelijke ruimte.
- Het interview zal zich eerder richten op mogelijke concrete scenario's en randvoorwaarden: één of meer ruimtes, doelpubliek, locatie, eventuele inbedding in een bestaande organisatie, aangeboden diensten, personeel, voornaamste doelen enzovoort.

#### Definitie gebruiksruiintes

Gebruiksruiintes zijn faciliteiten waar personen illegaal verworven drugs kunnen gebruiken in een gesuperviseerde en hygiënische omgeving. Drugs kunnen er geïnjecteerd en/of gerookt worden. Gebruikers worden voorzien van steriel materieel, en getraind personeel houdt toezicht op het druggebruik en kan, indien nodig, voorzien in gezondheidsvoorlichting, (sociale) ondersteuning, EHBO en doorverwijzing naar andere diensten. Cliënten van GR mogen gebruik maken van zelf verworven drugs zonder gearresteerd te worden. Op dit moment zijn 90 GR operationeel over de hele wereld, waaronder ook in de vier buurlanden van België.

→ *Korte presentatie van mogelijke modellen*



## 1. ALGEMEEN

---

- ➔ **Wat is volgens u het meest belangrijke doel van een GR in [stad]?**
- ➔ **Kan je de volgende doelen ordenen naargelang belang (1 = meest belangrijk):**
  - ..... Bereiken en onderhouden van contact met kwetsbare en *hard-to-reach* groep
  - ..... Gezondheid van de doelgroep verbeteren (door hygiënisch gebruik)
  - ..... Algemeen welzijn van cliënten verbeteren (sociale diensten en doorverwijzing)
  - ..... Reduceren van publieke overlast (publiek gebruik, naalden/spuiten, ...)
- ➔ **Wat denk je dat het aantal potentiële cliënten van een GR is in [stad]?**

## 2. DOELGROEP

---

- ➔ **OPEN: Hoe zou jij de doelgroep van een GR definiëren en waarom (pro & contra)?**
- ➔ **CHECKLIST (indien nog niet aangehaald): vaak voorkomende inclusie/exclusie criteria zijn...**
  - Wijze van druggebruik: injecteren, roken, snuiven, allemaal
  - Type drugs: heroïne en aanverwanten, stimulantia (cocaïne, amfetamines, ...)
  - Duur van druggebruik (eerste maal injecteren?)
  - Ingeschreven in gemeente (“ingezetenen” criterium)
  - Minimum leeftijd
  - Dakloosheid
  - Substitutiebehandeling
  - Zwangerschap
  - Intoxicatie
- ➔ **PROFIEL: concluderend, hoe zou jij het profiel van de doelgroep in [stad] omschrijven?**

## 3. LOCATIE EN ORGANISATIE

---

### GEOGRAFISCH

- ➔ **Wat zou volgens u het beste gebied zijn voor een GR in [stad]? Waarom?**
  - Zijn er specifieke plaatsen in [stad] waar dit zeker *niet* geschikt zou zijn?
- ➔ **Vind je dat één site voldoende is of zouden meerdere sites vereist zijn?**

### ORGANISATORISCH

- ➔ **Welke organisatie moet verantwoordelijk zijn voor de organisatie (vb. MSOC)?**
- ➔ **Denk je dat een GR op zichzelf moet functioneren, of eerder in een andere organisatie moet worden ingebed? Indien ingebed:**
  - Welke organisatie(s)?
  - Een afzonderlijke locatie of fysiek ingebed in de organisatie?
  - Indien meerdere sites: bevragen

#### 4. OPERATIE

---

##### OPENINGSUREN EN -DAGEN

- Welke dagen en uren denk je dat een GR zou moeten open zijn en waarom?

##### DIENSTEN

- **OPEN:** Welke diensten zouden (naast drugconsumptie) beschikbaar moeten zijn in een GR?
- **CHECKLIST** (indien nog niet aangehaald): vaak aangeboden diensten zijn...
- Spuitenruil, attributen voor veilig gebruik (parafernalia)
  - Gezondheidsvoorlichting (vb. informatie over veilig gebruik/injecteren; infecties)
  - HIV en hepatitis testing
  - Medische consultaties/verzorging
  - Sociale dienst
  - Doorverwijzingen naar verslavingszorg // **on-site**
  - Douche, eten, bed
  - Inloopruimte/-huis

##### PERSONEEL

- Welk personeel (opleiding) moet werkzaam zijn in een GR? Fulltime of niet, en waarom?
- Arts
  - Verpleegkundige
  - Sociaal werker
  - Psycholoog
  - Beveiligingspersoneel
- In hoeverre moeten externe diensten (op bepaalde momenten) aanwezig zijn?
- Wat is de rol van cliënten/druggebruikers bij de organisatie en werking van een GR? Waarom en in welke mate moeten zij betrokken zijn?

#### 5. HUISREGELS

---

- **OPEN:** Welke huisregels moeten er zeker aanwezig zijn in een GR in [stad] en waarom?
- **CHECKLIST** (indien nog niet aangehaald): vaak voorkomende huisregels zijn...
- Registratie/ondertekenen contract (akkoordverklaring huisregels)
  - Tijdslimiet
  - Niet delen van drugs
  - Niet dealen in GR
  - Geen alcoholgebruik
  - ...

## 6. VERANTWOORDELIJKHEID

---

- ➔ **Welke rol zou politie en justitie moeten opnemen bij een GR?**
  - Politie: doorverwijzing naar GR; geen arrestaties in de buurt van de GR; ...
- ➔ **Welke politieke autoriteit moet verantwoordelijk zijn voor de organisatie van een GR?**
- ➔ **Mochten incidenten voorvallen (overdosis, agressie, dealen): wie is verantwoordelijk?**
- ➔ **Wie zou in de financiering en het budget moeten voorzien (lokaal/regionaal/federaal)?**

## 7. BELEID

---

- ➔ **Mocht er een beslissing worden genomen om een GR in [stad] te implementeren, welke organisaties denkt u dat zeker betrokken moeten zijn bij het opzetten van een GR?**

## 8. OPVOLGING EN EVALUATIE

---

- ➔ **Wie moet verantwoordelijk zijn voor...**
  - Opvolging en bijsturing
  - Registratie
  - Evaluatie

### INDICATOREN

- ➔ **OPEN: Welke moeten de belangrijkste uitkomstindicatoren zijn om een GR te evalueren?**
- ➔ **CHECKLIST (indien nog niet aangehaald): frequente indicatoren zijn...**
  - Bereiken en contact onderhouden met risico-druggebruikers
  - Reductie van druggerelateerd risicogedrag (hergebruik en delen van spuiten)
  - Reductie in HIV en hepatitis C
  - Reductie van somatische gevolgen (abcessen, ...)
  - Reductie van overdosis-gerelateerde morbiditeit en mortaliteit
  - Toegang/doorverwijzing naar gezondheids- en sociale diensten faciliteren
  - Doorverwijzing naar verslavingszorg/detoxificatieprogramma's faciliteren
  - Reductie van publieke overlast (openbare spuiten, publiek gebruik, ...)
  - Kosteneffectiviteit
- ➔ **CHECK: consistent met doelen (score 1–4)?**

## 9. OUTRO

---

- ➔ **Algemeen, denk je dat GRs een rol kunnen spelen in [stad]? Waarom?**
- ➔ **Hoe zou draagvlak kunnen worden gecreëerd voor een GR in [stad]? [reductie oppositie]**
  - Specifiek met betrekking tot buurtbewoners/publieke opinie?

## COST ESTIMATIONS

### General and DCR-specific costs

Collectively, estimates of total costs of a DCR vary widely. Furthermore, costs of a particular DCR will vary enormously depending on the chosen operational model. For instance, stand-alone DCRs (such as those described above in Vancouver and Sydney) tend to be more expensive than facilities integrated with other existing services due to rental and personnel costs, and starting a programme from scratch. *General costs* include the rent of a building, insurance, cleaning and waste management, energy, and so on. In addition, there are also *DCR-specific costs*. Before opening a DCR, there are some investment (start-up) costs. For example, consumption booths (for smoking or injecting) should be installed. The hygiene requirements are high (for materials; i.e., tiles and stainless steel), a disinfection machine (a clinical dishwasher) is needed in order to sterilize materials, and for a smoking booth there is a need for an air cleaning device. Installing costs for smoking/injecting booths could not be estimated since these formed part of a larger contractor cost. Other potential start-up costs, for example, include a security door, waiting room, and installation of CCTV.

Once up and running, costs include the provision of sterile consumption materials and other paraphernalia. For example, the cost of one injection kit is under €0.5 (Frankfurt), which includes a syringe with needle, extra needle, alcohol swab, sterile water, and Vitamin C. Estimates from a facility in Barcelona are similar: one injection kit costs approximately €0.3 (containing a single syringe, spoon with swab, ampoule of sterilized water). In addition, staff salaries are a big cost for a DCR. The number of (paid) staff will depend on the facility's opening hours and its capacity (i.e., the number of injecting and/or smoking booths, and the number of people consuming at one time), and the choice whether or not to employ a (full-time) physician present at the facility. Since it is impossible to calculate cost estimates of a DCR in Belgium without any details on the facility's location, capacity and number of booths, opening hours, number and nature of paid staff, and the provision of auxiliary services (e.g., NSP, drug testing, HIV-testing, etc.), some cases of European DCRs are presented below.

### Case studies

We conducted a thorough search<sup>80</sup> for detailed cost estimates of DCRs. The results from several DCRs in Europe (some of them preferred to remain anonymous) are presented below as cases.

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<sup>80</sup> We asked about DCR costs at each of the facilities the research team visited (CHAPTER 3), however, little data were obtained because such data were not available or could not be made publically. Our international partner, Dagmar Hedrich (EMCDDA), subsequently contacted European DCRs with the question to provide the available cost data of their respective DCR. Of those contacted, some answered and provided us specific data, however, ranging markedly in both quantity and quality.

**Case 1.** Costs for a facility in Frankfurt with circa 2,500 opening hours per year (not open in weekends), providing seven slots for intravenous consumption (no smoking), with a NSP, are shown below. In this DCR, there is per shift a need of at least two individuals for door services (keeping an eye on the street, and admission control to the consumption area). For the actual consumption room, there is a need of two staff members in charge (safer use advice, and first aid if necessary). In this DCR, it is common that services are run by university students ('assistant workers'). At least one social worker is however present per shift. On average, the NGOs in the Drug-Aid-System are paying €13–15 per hour to an assistant worker (university student); the wage labour costs are low. The average cost for a full-time social worker is €45,000/year (which includes wage labour costs). Given these specifications, costs for the DCR are reported as follows: (1) €77,000 material costs (which includes €25,000 for rent, €11,000 for consumption material, and €6,000 for disinfection, insurance, travel expenses, energy, etc.) and (2) staff costs (€100,000 for social workers and € 115,000 for assistant workers).<sup>81</sup> Door services and costs for lounge/waiting room are not included above.

**Case 2.** The total cost of a DCR integrated in a harm reduction center in Barcelona is €985,476 yearly, excluding premises renting and maintenance (cleaning, repairing). The DCR has eight injection booths and is open 10 hours on week days (10 am–8 pm), and 7 hours on Saturdays and Sundays (11 am–6 pm). In 2016, there were on average 611 unique clients per month (overall 2,092 unique visitors), 60,394 yearly consumptions, and 115,198 syringes distributed. In total, 29 professionals are working in the facility; with a distribution (per working hours/week) as follows:

- 1 manager (40h/w)
- 1 physician (2h/w)
- 5 social workers (200h/w)
- 6 nurses (177h/w)
- 12 nursing assistant or drug worker (407.75h/w)
- 2 clerks (80h/w)
- 1 case management supervisor (1h/w)
- 2 security staff (64h/w)

Staff is the main cost, accounting for >75% of all costs.

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<sup>81</sup> In Frankfurt, it is common that services are run by university students ('assistant workers'). At least one social worker should however be present per shift. On average, the NGOs in the Drug-Aid-System are paying €13–15 per hour to an assistant worker (university student); the wage labour costs are low. The average cost for a full-time social worker in Germany is €45.000 per year (which includes wage labour costs).

**Case 3.** For the DCR in Luxembourg (for details, see CHAPTER 3), the budget and funding for 2017 is as follows: (1) funded on Federal level (Ministry of Health): €2,700,000 for staff/HR costs (23.5 full-time posts) and €400,000 operation costs; (2) funded on city-level: 130,000 for staff/HR costs (3 full-time posts), €9,000 for material (without further specification), and electricity, garbage, gas, cleaning the outside area, etc. (numbers were not available).

**Case 4.** In another European DCR, providing 12 booths for IDU and 4 for smoking, registering circa 200 consumptions/day (approximately 70% IDU), open 7/7 for 8h, total costs are estimated at €1.3 million. Staff is the main cost, accounting for two-thirds of all costs. Staff comprises 17 FTE (of which five are present in the DCR).

## The Belgian case

In their working paper, the ACD (2016) made a rough projection of total personnel costs for a DCR in Brussels with a capacity of 10 booths (5 to inject and 5 to smoke) and a waiting room for 20 clients (so a total capacity of 30 individuals at one time), open 7/7 days from 15:00 to 23:00. For the hypothetical scenario in Brussels, the TABLE below lists the various functions and estimates of full-time equivalents (FTE) for each function aimed at an optimal operation of the DCR on the one hand and for decentralised services on the other hand. An initial estimate of the total budget for staff costs amounts to €800,000. This estimate should however be refined and supplemented with an estimate of operating costs.

**Table 8.** Estimated staffing costs (FTE's) for a DCR and decentralised services in Brussels (ACD, 2016).

Functions	Number of full-time equivalents (FTE)		
	DCR	Decentralised services	Total
Nurses	4.5	1.5	6
Other staff	7.5	1.5	9
Medical doctor, on call	Detached from specialised service		Detached
Administrative assistant	1	0	1
Project manager	1	0	1
Clients/peers		2.5	2.5

Drawing upon the FTEs outlined above in TABLE 8, we estimated the cost for a basic DCR running 365 days a year, on an average of 9 hours per day, and with a capacity for 30 clients at a time and 100 visitors per day. We estimated the costs for a stand-alone DCR and for a DCR if it is integrated into an existing service (here above, decentralised services). To provide an estimation, we used cost data from the Belgian HAT project TADAM (Van Caillie, 2013), from the Belgian National Institute for Sickness and Disability Insurance (INAMI-RIZIV) for low-threshold services (MSOC/MASS), and from the FINHOSTA server (*Federal Public Service of Health, Food Chain Safety and Environment*) on hospital and related services costs.

**Salary estimation.** Staff costs were estimated on the base of the FTEs required according to TABLE 8 and on the base of staff costs for similar services (running 9 hours a day, 7 days a week, and 365 days a year). We also compared these results with the average salary costs for low-threshold services (MSOC/MASS) in order to control their accuracy. The specific costs for security personnel was added since it may be an important budget post.

**Other revenue costs estimation.** This section includes all the operating costs for a potential DCR. Costs are also estimated on the base of similar services. Specific operating costs for a DCR (medical material, insurance, medical waste evacuation, staff training) have been estimated based on the operating costs of the TADAM project. We adapted patients-related costs for an average of 100 users per day.

**Capital costs estimation.** To estimate the cost of land, building, and equipment, we considered the costs for low-threshold services (MSOC/MASS). We calculated an average of capital costs and took into account the number of visitors per day as an estimator for setting size. In order to control the estimation accuracy, it was compared to other Belgian outpatient services. DCR-specific capital costs (e.g., an extractor for the smoking area) have been estimated based on the capital costs of the TADAM-project. As the costs are not detailed in the TADAM project accounting, we calculated these costs by subtracting the other capital costs. Note that TADAM had establishment costs for a facility planned for 6 injections and 7 smokers. We estimate the costs of a DCR with a capacity of 10 booths (5 to inject and 5 to smoke) which seems comparable. Building and land costs vary according to the specific location of the DCR.

### How to adapt these costs?

- *Salary:* Salaries should be adapted according to the number of FTEs, that is for different operating hours and a different number of clients.
- *Other revenue costs:* We assume that office supplies, informatics, and electricity will vary by operating hours. Catering, medical waste evacuation, and medical material will vary by the number of users. Insurance may vary by both parameters. Other revenue costs are constant.

- *Capital*: As previously explained, these costs must be adapted according to the location but also according to the size of the building (capacity of reception).

### Cost estimates if the DCR is integrated in an existing service

- *Salary*: Salaries have been adapted for FTEs if the DCR is integrated into an existing service (see TABLE 8).
- *Other revenue costs*: Cleaning costs, office supplies, IT, etc. will have a slight increase but will for the most part be covered by the usual costs of the host service.
- *Capital*: The costs of land, building and usual equipment are covered by the capital costs of the host service.

### Scenario A: stand-alone DCR

Salaries and salary on-costs	No. of 'FTE' posts	Total annual costs	% of total costs
Nurses	4.5	300,000	<b>82%</b>
Other staff	7.5	475,000	
Medical doctor	1	85,000	
Administrative assistant	1	49,000	
Project manager	1	63,000	
<b>Subtotal</b>	<b>15</b>	<b>972,000 €</b>	
+ Security staff	1	111,500	<b>10%</b>
Costs variation per hour of <b>day</b> activity in salary			11 % per hour of day activity
Costs variation per hour of <b>night</b> activity in salary (only for nurses, other staff and security staff)			9% per hour of night activity
Costs variation per patient per day in salary (*)			/

<i>Other revenue costs</i>	<i>Total annual costs</i>	<i>% of total costs</i>
Cleaning	5,000	<b>3%</b>
Office supplies	4,000	
Informatics / Office	5,500	
Catering	2,000	
Electricity	1,500	
Medical waste evacuation	700	
Insurance	6,000	
Publicity	2,500	
Medical material	7,000	
Personal training	800	
Others	1,200	
<b>Total</b>	<b>36,200 €</b>	
Costs variation per hour of activity in other revenue costs		3.3 % per hour of activity
Costs variation per patient per day in other revenue costs <sup>82</sup>		0.3 % per patient per day

<sup>82</sup> The costs variation per patient per day is for a DCR with a capacity of 30 patients at one time. To increase the number of patients at one time, it is also necessary to increase the FTE as well as the capital (size of the building, infrastructure, etc.).



Capital	Annuity factor	Total annual costs	% of total costs
Land, Buildings, Equipment	Incl.	50,000	5%
Equipment DCR specific	Incl.	10,000	
<b>Total</b>		<b>60,000 €</b>	
Costs variation per patient per day in capital costs (*)		/	

<b>Total annual costs</b>	<b>1,179,700 €</b>	<b>Average no. of clients per day / at one time</b>	<b>100 / 30</b>
<b>Number of operating days</b>	<b>365</b>	<b>Opening hour per day</b>	<b>9</b>

### **Scenario B: integrated DCR**

Salaries and salary on-costs	No. of 'FTE' posts	Total annual costs	% of total costs
Nurses	+ 1,5	100,000	67%
Other staff	+ 1,5	95,000	
Medical doctor, on call	Integrated	/	
Administrative assistant	0,5	24,500	
Project manager	1	63,000	
<b>subtotal</b>	<b>4,5</b>	<b>282,500 €</b>	
+ Security staff	1	111,500	26%
Costs variation per hour of <b>day</b> activity in salary			11 % per hour of day activity
Costs variation per hour of <b>night</b> activity in salary (only for nurses, other staff and security staff)			9% per hour of night activity
Costs variation per patient per day in salary (*)			/

<i>Other revenue costs</i> <sup>83</sup>	Total annual costs	% of total costs
Cleaning	5,000	4%
Office supplies	4,000	
Informatics / Office	5,500	
Catering	2,000	
Electricity	1,500	
Medical waste evacuation	700	
Insurance	6,000	
Publicity	2,500	
Medical material	7,000	
Personal training	800	
Others	1,200	
<b>Total</b>	<b>16,900 €</b>	
Costs variation per patient per day in other revenue costs (*)		0.57% per patient per day

Capital	Annuity factor	Total annual costs	% of total costs
Land, Buildings, Equipment	Incl.	50,000	3%
Equipment DCR specific	Incl.	10,000	
<b>Total</b>		<b>10,000 €</b>	
Costs variation per patient per day		/	

<sup>83</sup> The removal of some operating costs related to the integrated model is an arbitrary decision. It is indeed difficult to estimate the impact of an integrated model on these costs even if we know that they will be largely diminished. Since their impact on total annual costs is minimal (4%), they have little influence on our final estimates.

APPENDIX H — Cost estimations

<b>Total annual costs</b>	<b>420,900 €</b>	<b>Average no. of clients per day / at one time</b>	<b>100 / 30</b>
<b>Number of operating days</b>	<b>365</b>	<b>Opening hour per day</b>	<b>9</b>

