

Independent Working Group on Drug Consumption Rooms

*Paper C*

**An overview of models of delivery of drug consumption rooms**

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## **1 Introduction**

This report should be read in conjunction with the other IWG papers produced for the Joseph Rowntree Foundation's Independent Working Group on Drug Consumption Rooms (IWG Papers A to F). This report is written as a basis for considering potential models of service delivery for DCRs, with reference to any possible pilot evaluation within the UK. It provides a country-by-country, comparative summary of models of delivery regarding operational factors including: objectives; service organisation; target groups; inclusion/exclusion criteria; and costs (where available).

Drug Consumption Rooms (DCRs) have been defined as:

...protected places for the hygienic consumption of preobtained drugs in a non-judgemental environment and under the supervision of trained staff.

Akzept (2000)

Facilities currently exist within Australia, Canada, Switzerland, the Netherlands, Germany, Spain, Norway and Luxembourg. To date, however, the literature relates to services in the first six countries, as those in Oslo, Norway and Luxembourg were only established in 2005.

This report primarily draws on the English language literature and a review for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) by Hedrich (2004). Additional information from the Internet and grey literature is also used where this has been available. The report also draws on visits to assorted DCRs made by members of the Independent Working Group (IWG) over the life of the project. These have included individual visits to Sydney's Medically Supervised Injecting Centre (MSIC) and Vancouver's Safer Injecting Facility (SIF); and a group visit by members of the IWG to three services in Rotterdam, two services in Frankfurt and a service in Zurich.

## **2 Drug consumption rooms – general features of provision**

As a process, DCRs generally comprise three primary elements:

- assessment and entry arrangements to ensure that the nominated target population can enter the service;
- provision of managed space(s) that enable the hygienic administration of drugs: mainly by injection; sometimes by inhalation (smoking); and more rarely, by intra-nasal administration (sniffing) – as the IWG observed in Switzerland;
- facilities that allow monitoring of the immediate after-effects of drug administration – notably overdose risk – before the person returns outside.

In practice, these processes sometimes occur within the same space within a DCR. However, some services such as the Sydney Medically Supervised Injecting Centre (MSIC) are zoned to accommodate these different functions (see Figure 1).

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. Hedrich (2004) distinguishes three main types: *integrated*, *specialised* and *informal* (pp. 11–12).

**Integrated** facilities are the most common, as consumption rooms have frequently evolved as part of a wider network of services, being added on to and physically integrated into existing care facilities for homeless people or drug addicts. 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, as just one among many other services provided. In integrated facilities, consumption room users are just one among several different groups of clients.

**Specialised** facilities service exclusively consumption room users. They are much less common than integrated services. They are usually set up in close vicinity to other drugs services and located near important illicit 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.

**‘Informal’** consumption rooms, (are) run by current or former drug users but tolerated by the police, and mostly restricted

to drug smoking/inhalation, (they) have so far been described only for the Netherlands.

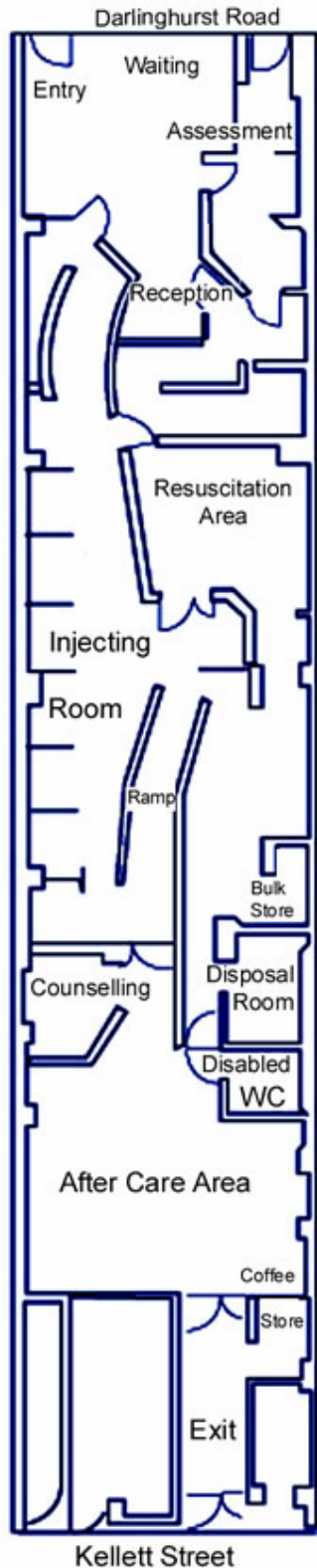
Regarding what happens within DCRs, Hedrich (2004) provides a description of a typical injecting room in an 'integrated' service, based on observations in Switzerland:

...[it] is discreetly located within a larger facility which includes a cafeteria, counselling room and a clinic for primary medical care. The rooms where the injection occurs are small and quite sterile. They contain several tables at which clients sit to prepare and inject their drugs, and injecting paraphernalia such as needles and syringes, a candle, sterile water and spoons are placed at each position at the tables. Paper towels, cotton pads, bandaids and rubbish bins are available... (Parliament of New South Wales, 1998)

Whereas, the Sydney MSIC is an example of a 'specialised' service from which referrals may be made to other, external services, 'integrated services' will typically have a variable range of additional treatment, health and welfare services directly available. 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.

Although, for the sake of completion, 'informal' services are listed above, these are not discussed further as it has been assumed that informal, tolerated services are outside the scope of this report.

Semi-official injecting centres have been documented in countries including the Netherlands, Switzerland, and the UK, dating back as far as the 1960s. These are better characterised as areas for tolerated drug use and are distinct from contemporary DCRs with their emphasis on supervised consumption, injecting hygiene and distributing sterile injecting equipment.



**Stage 1**

The Waiting Room and Assessment Area is where clients are assessed for eligibility to use the service. The assessment aims to:

- establish that the client is an existing injecting drug user, not aged under 18 years, not pregnant or accompanied by a child and not intoxicated
- collect clients' demographic information and medical history including previous drug overdose and treatment information .

**Stage 2**

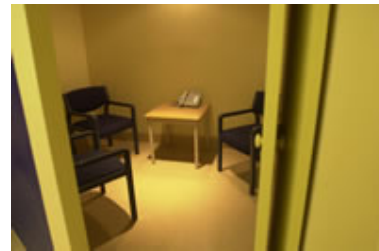
The Injecting Room is a clinical environment with two trained staff, including a registered nurse, always on duty. It has eight open booths that can seat two people, allowing staff to supervise at all times. In the Injecting Room clients are given clean needle, advised on safer injecting practices and provided with first aid and other clinical services. There are waste bins for used needles and a Resuscitation room to manage drug overdoses.



**Injecting Room**

**Stage 3**

The After Care Area is where the clients remain under observation until they are ready to leave. Counsellors and social welfare staff are on hand to link clients with other services including housing, legal, social welfare drug treatment and rehabilitation.



**After Care Area**

**Exit**

Clients may leave the MSIC from the rear, on Kellett St. This door also allows ambulance access to the centre



**Exit into Kellett Street**

Figure 1. Sydney Medically Supervised Injecting Centre (Source: <http://www.sydneymxic.com/whatwedo.htm>)

The following summary outlines the services provided in each country with comment on aspects of provision within this.



### 3 Switzerland

#### *History and provision*

Switzerland is credited as being the site of the first contemporary DCR, established in 1986 within Berne. By 2003, 12 DCRs were operating in seven cities:

- Basle – 2
- Berne – 1
- Biel – 1
- Geneva – 1
- Schaffhausen – 1
- Solothurn – 1
- Zurich – 5.

#### *Objectives*

An assessment of the legality of DCRs (Schultz, 1989) gives one indication of the objectives of DCRs in Switzerland, stating that they do not violate Swiss drugs legislation if they “improve the hygienic conditions under which consumption takes place and provide medical supervision and no dealing takes place” (Hedrich, 2004: 15). In the late 1980s a prominent open drug scene developed in Zurich and, although there was concern about the large number of drug related deaths and a high prevalence of HIV among drug users, the objective of reducing public nuisance was considered to be as important as improving users’ health (Eastus, 2000).

#### *Target population*

Within Swiss DCRs, the target population has been defined as *Schwerstabhängige* (heavily addicted persons) who do not accept/take up other offers of help; long-term, hard-core injecting drug users (Eastus, 2000).

#### *Permitted modes of drug use*

Although the main emphasis within DCRs in Switzerland is on injecting, since 2001 several facilities have been expanded to accommodate areas for drug inhalation (smoking). One-third of services now include provision for inhalation as well as injecting. A service visited by IWG members in 2005 also incorporated a hygienic stainless steel shelf that was provided for people to sniff powdered drugs (which can include heroin and cocaine). This was

provided because a) it allowed targeted promotion of sniffing as a safer alternative to injecting b) it contributed to reducing neighbourhood nuisance among those people who would use this route of administration.

### *Residency/restrictions*

DCRs have often been concerned to avoid a 'honeypot' effect whereby people beyond the local population are drawn into the locality of services and increase problems of nuisance within the area. In Switzerland, drug 'tourists' were perceived to be further exacerbating problems within Switzerland's open drug scenes – notably Zurich's 'needle park'. Consequently, services often have restrictions on eligibility based on residency or nationality. In Switzerland, most services control entry by the use of identity documents.

In Zurich, the service visited by IWG members is situated next to a police 'relocation centre'. People from outside of Zurich who use drugs in public spaces in the city are taken to the relocation centre for 24 hours and then returned to their city of origin. In this way, a policy of tolerance and social support is complemented by policies that minimise 'honeypot' effects.

### *Access arrangements*

In order to gain access to services, systems usually have user passes, access cards or other registration arrangements. It is exceptional for services to allow free, unverified entry.

## **4 Germany**

### *History and provision*

Discussions concerning supervised injecting facilities in Germany began in the early 1990s and a legal appraisal in 1994 of their operation in Frankfurt led to their official introduction. By 2003, Germany had 25 supervised consumption facilities across 14 cities. Hanover and Saarbrücken have one DCR each. Frankfurt and Hamburg are the only two cities with more than one DCR. Nine cities have integrated consumption rooms into existing drugs services – Münster, Wuppertal, Essen, Cologne, Aachen, Dortmund, Bochum, Bonn and Bielefeld. In Berlin, a mobile consumption room became operational in October 2003, and two further fixed services are planned.

## *Objectives*

The introduction of DCRs in Germany arose in response to open drug scenes in Hamburg and Frankfurt that were associated with unhygienic injecting, rapidly rising overdose emergencies and complaints about nuisance by residents and police. As such, DCRs in Germany developed to address this combination of health and public order problems.

## *Target population*

German DCRs target 'schwer erreichbare Betäubungsmittelabhängige' (hard-to-reach drug addicts) (Hedrich, 2004: 10) with a particular emphasis on drug injectors in open drug scenes.

## *Permitted modes of drug use*

Just under half of all DCRs in Germany are exclusively for people who inject. The remainder have provision for both injecting and inhalation.

## *Residency/restrictions*

Restrictions on who can attend vary across the country. Services in Frankfurt and some services in North Rhine-Westphalia place restrictions and require evidence of local residency demonstrated by identity documents.

## *Access arrangements*

Some services in North Rhine-Westphalia limit use to a specified number of clients and issue user cards to ensure that users are local residents. Where consumption facilities are distant from drug markets, the cards also provide a guarantee of immunity from prosecution for drug possession on the way to the service.

German DCRs are legally required to meet minimum standards (see box below). Points of note are the necessity of providing a range of ancillary services including abstinence-oriented treatment and the requirement to exclude first time or occasional users. Although stand-alone services can be quite successful at referring people to further services, integrated services would seem likely to have an in-built advantage in promoting engagement with other health and welfare services. In addition, decisions about the degree to which other services are directly available are likely to

have a considerable impact on the range and extent of outcomes. Besides general drug treatment, including opioid substitution and abstinence-oriented approaches, options exist to promote services in line with other priorities such as hepatitis B immunisation and hepatitis C testing.

Decisions about whether to include new or occasional injectors involve difficult judgements. Recent evidence of the high incidence rate for hepatitis C infection among injecting drug users in the UK (Judd *et al.*, 2005) means that early engagement may provide opportunities for health promotion and early intervention among novice injectors. On the other hand, there is a risk of consolidating an identity as an injecting drug user and reinforcing inclusion within social networks of injectors for people whose injecting may otherwise be relatively transient. Existing research does not comment usefully on the impact of DCRs on people's injecting 'careers' and this remains an area that warrants further research. For practitioners, judgements about whether someone who is demonstrably unable to inject properly but intent on doing so is an especially challenging ethical dilemma; its management would require clear guidance within any service.

**Legally required minimum standards of consumption rooms in Germany**

German narcotics law (§ 10a BtMG) sets out 10 minimum standards to ensure the safety of drug users and adequate supervision of the consumption of drugs. Statutory orders at Lander level must meet these standards, which are related to health, public order and administrative issues:

- 1 appropriate equipment of the premises;
- 2 arrangements to ensure immediate provision of medical emergency care;
- 3 medical counselling and assistance for the purpose of risk minimisation in the use of narcotic drugs brought by the drug-addicted person;
- 4 referral of these persons to abstinence-oriented follow-up counselling and therapy services;
- 5 measures to prevent criminal offences under the Narcotics Act from being committed in drug consumption rooms, other than the possession of drugs for personal use in insignificant quantities;
- 6 cooperation with local authorities responsible for public order and safety required to prevent, to the greatest possible extent, any criminal offences from being committed in the immediate surroundings of the drug consumption rooms;
- 7 a precise definition of the group of persons entitled to use drug consumption rooms, specifically as regards their age, the type of narcotic drug they may bring with them and consumption patterns; obvious first-time or occasional users are to be excluded from using these rooms;
- 8 documentation and evaluation of the work done in consumption rooms;

9 continuous presence of a sufficient number of reliable staff whose professional training qualifies them to comply with the requirements mentioned in numbers 1 to 7; and

10 appointment of a qualified person who shall be responsible for compliance with the requirements mentioned in numbers 1 to 9 (...).

(Hedrich, 2004: 17).

## 5 The Netherlands

### *History and provision*

In the Netherlands, DCRs were first set up in 1990 within a church-operated service – Pauluskerk – in Rotterdam but did not become a regular part of the services until 1994. Official consumption rooms became feasible after legal guidelines were issued in 1996.

By 2004, 22 rooms existed in 12 cities: Amsterdam (3), Apeldoorn (1), Arnhem (2), den Hertogenbosch (1), Deventer (1), Eindhoven (2), Groningen (1), Heerlen (1), Maastricht (1), Rotterdam (7), Utrecht (1) and Venlo (1).

### *Objectives*

Although they have health and social welfare objectives, DCRs in the Netherlands have a particular emphasis on nuisance reduction and are highly targeted towards homeless and transient sub-populations such as immigrants and sex workers. The declining number of people who inject – indicated by the rising average age among treatment and survey samples – coupled with relatively low rates of overdose mean that, although there is consideration for health and welfare, the Netherlands places more emphasis than any other country on nuisance reduction. Typically services have 25–30 registered attenders who are from among the most marginalised drug users in each locality.

### *Target population*

Target populations within the Netherlands have been variously defined as: ‘problematic street drug users’, i.e. long-term addicts, characterised by use on the street, disorderly behaviour and poor physical state (Schatz and Wolf, 2002); ‘chronic hard drug users that are not motivated for treatment’ (NDM, 2002: 92); and ‘adult street drug users with a reputation for nuisance’ (Wolf *et al.*, 2003).

### *Permitted modes of drug use*

Consistent with their declining rates of injecting, all Dutch services accommodate both people who use injection and those who use inhalation although, in common with services elsewhere, considerable efforts are made to separate people who inject from those who primarily inhale/smoke with distinct injecting and smoking rooms. There are no services that are exclusively for injecting. Some services discourage the more intensive form of use of crack cocaine by 'piping' and instead promote crack 'chasing', which gives a more prolonged and moderated experience that may be more economical and less hazardous to health (personal communication – Theo van Dam).

The IWG's visits to DCRs in Holland, Germany and Switzerland clarified the strenuous efforts that are generally made to deter people who smoke heroin or cocaine from beginning to inject. This transition was reported rarely and, where it happens, was usually subject to considerable concern, with careful assessment and educational input from staff – sometimes over a period of several weeks (see Solai *et al.* (2006) for further discussion of how potential injectors can be managed ethically within DCRs). DCRs appear to present uniquely high quality opportunities to promote transitions away from injecting (see Hunt *et al.* 1999 for an extended discussion). Any implementation in the UK might usefully consider whether or how this objective might best be enabled.

In the course of their visits to DCRs that permitted smoking of heroin and crack, IWG members were struck by the effectiveness of services for engaging black drug users and other visible minorities. A large proportion of service users appeared to come from minority ethnic groups and this may have relevance to debates within the UK about effective strategies for engaging a) stimulant users; and b) members of black and other minority ethnic communities.

### *Residency/restrictions*

The Netherlands has experienced considerable problems with drug 'tourism'. The majority of services serve a limited target group of 'chronic addicts' from a specific local area; the user must register with the municipality or local drugs agency and be a legal resident of the Netherlands. One consumption room is reserved for people who originate from outside of the Netherlands. Entry criteria

for this service are: long-term addiction; use on the streets resulting in disorderly behaviour; and poor physical state (personal communication – Eberhard Schatz).

### *Access arrangements*

The official registration process includes checks by police; contracts for use of the rooms are closed and admission permits ('user cards') issued. The total number of user cards per consumption room is limited to prevent overcrowding. If users do not make use of the room for several weeks, their user card is revoked.

## **6 Spain**

### *History and provision*

Spain has just three services serving population centres in Madrid, Barcelona and Bilbao. Uniquely, the Madrid service, which was established near a large open drugs scene in 2000, is continuously open 24 hours a day. In Barcelona, the service was initially provided within a mobile service for four hours daily on weekdays but has now been replaced with a fixed site service. Spanish DCRs have been developed on an integrated model with other health and social services.

### *Objectives*

Spain's DCRs were developed in response to high rates of overdose and poor access to healthcare more generally. The timing of their development corresponds with a widespread shift towards harm reduction approaches across Spain that was heralded by high rates of HIV. However, this is not cited as a specific driver for the development of services.

### *Target population*

Socially excluded injecting drug users, high-risk groups, homeless drug users (Hedrich, 2004).

### *Permitted modes of drug use*

Injecting only.

### *Residency/restrictions*

None.

## *Access arrangements*

The client registration system is the same as in other health services: at their first visit, clients are allocated a unique number by which they can be identified at subsequent visits.

## **7 Australia**

### *History and provision*

Australia has a single specialised DCR that was established in 2001 under legislation that enabled the service to be set up as part of a scientific study – Sydney’s MSIC. Although DCRs have been considered in other cities, such as Melbourne (Fry and Testro, 2000), no other services are currently available. Nevertheless, Sydney’s service has recently received an extension, permitting it to continue to operate now that its original evaluation is complete.

### *Objectives*

The Sydney MSIC was established in the Kings Cross area of Sydney, which had a quasi-open drug scene characterised by public injecting and the use of short let hotel rooms, which people used for administering injections – a form of illegal shooting gallery. Additionally, Australia’s DCR was established as a response to rapidly escalating rates of heroin overdose and concern about rates of hepatitis C among Australian injecting drug users (IDUs).

### *Target population*

The Sydney MSIC targets drug users who inject in public places and/or alone; hidden intravenous drug users, i.e. those not in contact with services; and injecting drug users in the Kings Cross area (Kimber and van Beek, 2002).

Eligibility criteria require that clients should:

- be 18 years of age or over,
- have injected illicit drugs previously,
- not be known to be or obviously pregnant,
- not be accompanied by children and,
- not be intoxicated (alcohol or other drugs).

(Sydney MSIC, 2002)



### *Permitted modes of drug use*

Heroin in Australia is in the white, hydrochloride form and is poorly suited for smoking. Injecting is very much the predominant form of heroin use and amphetamine/speed is also mainly injected, although smokable methamphetamine is occasionally available. Consequently, as its name suggests, the Sydney MSIC only accommodates injecting.

### *Residency/restrictions*

None. However, the MSIC evaluation examined whether drug users were attracted to the service from other areas.

### *Access arrangements*

Clients are registered anonymously and receive a user code to identify them at subsequent visits.

## **8 Canada**

### *History and provision*

Canada has a supervised injecting site (SIS) delivered from two premises within Vancouver, which operate on the basis of an exemption from the Canadian Controlled Drugs and Substances Act. In common with the Sydney MSIC, this operates as a scientific research pilot project.

### *Objectives*

Vancouver's SIS was developed as part of the city's 'four pillars' approach to drug related harm and, in particular, the high rates of HIV infection and hepatitis C in Vancouver (associated with the rapid influx of cocaine into the city's drug scene) and high levels of overdose. Vancouver's Lower Eastside – the location of the SIS – also has an open drug scene and correspondingly high levels of public nuisance.

### *Target population*

Marginalised drug users who cannot be reached by traditional means (City of Vancouver, 2003).

Eligibility criteria are that participants:

- have a previous history of injection drug use,

- are willing to sign a user agreement, release and consent form,
  - are willing to adhere to the SIS code of conduct,
  - are not accompanied by children under their care,
  - are not exhibiting aggressive behaviour, and
  - are not overtly intoxicated (alcohol and other drugs).
- (Vancouver Coastal Health, 2004)

### *Permitted modes of drug use*

Injecting.

### *Residency/restrictions*

No exclusion criteria.

### *Access arrangements*

Vancouver's SIS exists as a scientific research pilot project. Initial attendance includes assessment of eligibility and recruitment into the study. Subsequent access is permitted on presentation of the person's study identifier.

## **9 Norway**

After a two-year preparation process, Norway opened a DCR in Oslo on 2<sup>nd</sup> February 2005. It will be evaluated by personnel from Oslo University (personal communication – Joergen Kjaer) and the politics of its establishment have been described by Skretting (2006).

## **10 Luxembourg**

Luxembourg has recently opened a DCR. However, no evaluation data is expected until 2006.<sup>1</sup>

## **11 Discussion**

This paper has summarised the main features of existing DCRs around the world to allow consideration of the way in which models of delivery elsewhere might apply to the UK context, and to explore the implications of different types of service.

Any eventual provision should reflect need. An accompanying paper (Hunt, 2006, IWG Paper A) has assessed need in relation to the problems relating to both the health and well-being of IDUs and

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<sup>1</sup> See EMCDDA report at [http://eddra.emcdda.eu.int/eddra/plsql/ShowQuest?Prog\\_ID=4056](http://eddra.emcdda.eu.int/eddra/plsql/ShowQuest?Prog_ID=4056)

public nuisance dimensions that are typically addressed by DCRs. Within the UK, there is evidence of need – in the sense of capacity to benefit – in each of these main areas. This evidence is particularly robust with regard to overdose, blood-borne infections and other problems associated with injecting hygiene. The opportunities that DCRs provide for delivering detailed and individually tailored advice about risk reduction and injecting hygiene have no parallels within existing UK drug services. Given that many of the UK's most marginalised and problematic drug users remain out of contact with treatment services, there is also marked need with regard to the extent that DCRs might facilitate referral to drug treatment and other health and social services. Our understanding of need at the local level has many imperfections. Nevertheless, it appears that some parts of the UK have higher levels of injecting, drug related mortality and morbidity and street drug use – often associated with homelessness and poverty (for example Brighton or Camden), indicating that need is uneven.

Our understanding of the extent of public nuisance problems in the UK is more limited. However, research commissioned by JRF (Taylor *et al.*, 2005; Hunt *et al.*, forthcoming) provides evidence that public injecting is commonplace and has considerable community impact.

Furthermore, we have some indications of the likely level of 'want' or demand for DCRs among UK needle exchange users from a sample of 398 needle exchange clients from Glasgow, Leeds and London, in which 21% said they would make 'occasional' use of a 'safer injecting room', 24% thought they would do so 'often' and 32% thought they would 'always' use one, if available (Hunt *et al.* forthcoming). This suggests that DCRs are likely to be used by a substantial proportion of the target population.

Currently, we have less understanding of how utilisation might be influenced either by different models of service provision or different rules for service users. The introduction of DCRs elsewhere has sometimes been preceded by studies that have investigated the likely impact of different rules and conditions on uptake and potential impact (e.g. Fry and Testro, 2000). Similar work would be desirable in the UK should the decision to implement one or more DCRs be taken here.

As has already been noted, the cardinal choice to be made is between 'integrated' or 'specialised' models of DCR. Australia and Canada have opted for models that are based on isolated 'demonstration' projects involving specialised DCRs, whereas European services tend to be smaller and more likely to operate across multiple sites within any given city or town. Some European services are specialised, in the sense that they have a very specific target population, e.g. the Dutch service that exclusively targets a small number of non-Netherlands drug users. However, such services are quite distinct from the Canadian and Australian demonstration projects that have specifically been established under legislation as scientific studies. It therefore makes some sense to consider a basic choice between the Canadian/Australian and European models.

The main distinctions arise with regard to cost, context and integration. The Australian MSIC operating costs for one year between May 2001 and April 2002 were \$AUS 1,995,784 (MSIC Evaluation Committee, 2003: 214). The annual costs of the Canadian SIS trial is \$CAN 2.5m, although this also includes the evaluation expenses (City of Vancouver, 2003). Cost data on European services on an integrated model is less readily available. Nevertheless, the marginal cost of extending a service to include supervised consumption facilities seems likely to be much less than those arising from a specialised project that is developed from scratch, as some building and administration costs would be shared and there may also be opportunities for more efficient use of personnel. For example, funding for one of the services visited by IWG members in Frankfurt was originally just €500–600,000 per annum. It also seems noteworthy that the Frankfurt service was originally supported by the Chamber of Commerce, as it was generally recognised that the drug problem was intractable – and could only be temporarily displaced rather than eradicated – and that this approach was likely to be the least-worst option for business. This suggests that although conventional treatment funding routes through the NTA might be an obvious vehicle for funding, DCRs might also attract funding from other channels that are not routinely considered – especially in situations where anticipated reductions in nuisance might benefit business, e.g. in London with the forthcoming Olympic developments for 2012.

Within the UK, the national network of drug services providing a mixture of low-threshold and structured treatment in almost every

local authority area would seem to offer good prospects for integrating DCRs alongside existing services in a similar way to other European practice. It is also of note that, to promote staff retention and development and avoid 'burnout', measures have been put in place within the Sydney MSIC to enable staff to rotate through other clinical services (personal communication – Ingrid van Beek). Such measures may be easier within integrated services. Decisions that influence cost are of considerable significance as these directly shape the eventual cost-effectiveness of any health and public order gains that may be derived.

Regarding context, the Sydney and Vancouver services were developed in response to public health crises, particularly concerning overdose and, to a lesser extent, blood-borne infections, which were highly concentrated within a restricted area within major cities in which public nuisance was also high. These were accompanied by a high degree of public and media attention in each area, which resulted in each area being perceived as having a marked social problem. Although there are signs that some localities share aspects of these features within the UK there seem to be no clear parallels with these cities (the public debate within Camden involving community members and the local council may be something of an exception to this). In general, the problems with drug users' health and well-being in the UK appear to arise in a way that is much more distributed around the country, suggesting that it is important to consider models that might readily be adapted to the needs of a number of cities and larger towns around the country.

Under the auspices of the NTA, the UK has made substantial efforts to increase treatment participation in recent years, with considerable success. Nevertheless, efforts have targeted those who become involved in the criminal justice system and a large number of injecting and 'class A' drug users remain outside of treatment. These include marginalised and vulnerable drug users who do not offend or are otherwise outside of the criminal justice system. The health gains that may arise for this group purely from using DCRs without using any other services seem unlikely to be trivial. However, the further potential for DCRs to offer an important alternative route into treatment, general health and social services seems considerable and may be influenced by any eventual service model that is adopted.

In light of the encouraging evidence seen by the IWG during visits to European services, it seems particularly worthwhile to consider whether DCRs can make a useful contribution within efforts to engage stimulant users, black and minority ethnic drug users and the homeless; of which each group seemed well-represented within services visited by the IWG.

Evaluations that allow direct comparisons of the relative effectiveness of specialised DCRs compared to integrated services are not available and it is evident that the Sydney MSIC has been effective at generating many referrals into other services. Nevertheless, common sense suggests that such referrals could best be facilitated within integrated services where different services exist under one roof and there are heightened opportunities to encourage the use of services, such as substitute prescribing, structured counselling, day programmes or detoxification.

Taken together, the issues relating to cost, context and integration point to the desirability of 'integrated' models of DCR within any UK implementation. These would be likely to have lower unit costs, and correspondingly greater cost-effectiveness, along with good prospects for integration within existing local services.

Two further issues, arising directly out of the UK context, warrant specific discussion – mobile services and homeless hostel provision. Internationally, there have been occasional examples of mobile DCRs within Berlin and, transiently, in Spain. In Cardiff, Wales, there is currently consideration given to providing a mobile DCR in order to enhance drug users' health and reduce public injecting (BBC 2004). Not only do mobile services avoid some of the costs of fixed sites but also they may be a way of reducing some of the potential problems with planning permission that can arise. This is a specific consideration in Cardiff, where community resistance is anticipated (personal communication – Carl Chapple). Mobile services therefore warrant consideration, with regard both to costs and effectiveness, but also as a possible way of managing community concerns – anticipated to be the subject of a later report.

Part of the debate concerning DCRs in the UK has particularly involved services in hostels for the homeless. Legal and ethical

issues have repeatedly arisen for staff working in these settings as their client group includes many injecting drug users. A dilemma arises because confusion about the interpretation of section 8 of the Misuse of Drugs Act means that staff sometimes require hostel residents to go into public settings to inject where risk and nuisance is increased, even though they feel that their duty of care would oblige them to provide a degree of supervision for clients who are injecting. Kevin Flemen (personal correspondence) has described a model for hostel provision in the UK in which: the client uses in his/her room; a worker is on-site and monitors the risk of overdose; workers are competent to offer harm reduction advice and information; and emergency call facilities exist. Given that many IDUs reside in hostel settings and that this dilemma commonly arises for hostel staff, there is a case for more extensive consideration of ways in which hostel services might be included within any UK provision and the operational and practice issues which such proposals imply.

## **12 Conclusions**

Anticipating an eventual evaluation, the discussion here points to the importance of the two main dimensions within the 'realistic evaluation' paradigm – context and mechanism (Pawson and Tilley, 1997). The needs analysis (Hunt, 2006) and issues specific to the UK identified within this report – notably questions concerning mobile and hostel provision – point to variations in the context within which any UK service might be provided. This has corresponding implications for the mechanisms by which UK DCRs would work and the outcomes that could be expected.

It seems simplistic and short-sighted to suppose that a single demonstration project similar to that within Vancouver or Sydney would be well-suited to the UK – the context is different. In many respects it would probably be poorly suited to local needs and likely to incur costs and forego opportunities that a more fine-grained 'integrated' approach that adapts different features of models elsewhere could offer.

Rather than a single, spectacular demonstration project, a needed and more culturally sensitive approach to understanding what would work best in the UK seems to require a mixed programme of more modest provision across a range of contexts, with clearly

articulated mechanisms by which diverse objectives would be expected. Within such an approach, it will be critical to link this to local needs, which are increasingly being expressed through partnerships and proposals that explore the possible contribution of DCRs to local problems.



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