

THE BECKLEY FOUNDATION DRUG POLICY PROGRAMME

A DRUGSCOPE BRIEFING PAPER



Drug consumption rooms

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SUMMARY

The defining characteristic of Drug Consumption Rooms (DCRs) is that they are legally sanctioned environments where people can take illegal drugs. Their purpose is to reduce drug-related harms. The underlying assumption is that if problem drug users are provided with safe private environments within which to administer drugs there will be a reduction in unsafe public drug use. Drug Consumption Rooms have developed in their modern form since the mid-1980s. For most of this period they have operated in a handful of countries in Western Europe, but in the last few years new facilities have opened in Australia and Canada, and some more rigorous evaluations of their impact have been produced. While the benefits of DCRs should not be exaggerated – and they raise issues of ethical and legal principle that cannot be resolved easily – evidence is emerging that these facilities can make a positive contribution to reducing drug-related harms where they have the support of local services and communities.

BACKGROUND

Drug Consumption Rooms have recently been defined as ‘legally sanctioned low threshold facilities which allow the hygienic consumption of pre-obtained drugs under professional supervision in a non-judgemental environment’ (Kimber J et al, 2003). They have been variously designated as ‘safe injecting rooms’, ‘supervised injecting centres’ and ‘medically supervised injecting centres’. While these terms adequately describe *some* DCRs, they describe *only some* DCRs, and are misleading if applied in a general way, not least because drugs are smoked as well as injected in some of these facilities.

It is important to distinguish DCRs from the sorts of ‘shooting galleries’ that have (like so-called ‘crack houses’) been run for the profit of drug dealers. Equally, DCRs should not be confused with medical facilities for the safe administration of *prescribed* drugs (i.e. heroin maintenance clinics). By contrast, the defining characteristics of DCRs are

- i that they are *legal* facilities for the purpose of facilitating use of *illegal* drugs;
- ii that their *purpose* is the reduction of drug-related *harm*.

Summing up, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) explains: ‘The aim of consumption rooms is to reach and address the problems of specific, high-risk populations of drug users, 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’ (EMCDDA, 2004). Defenders of DCRs place a particular emphasis on their potential to engage some of the most chaotic and problematic drug users and to act as a gateway into welfare and drug treatment services.

HISTORY

Until relatively recently DCRs were an exclusively Western European phenomenon. The first DCR – in the modern sense – was established in Berne, Switzerland in 1986. This was at a time of growing concern about the spread of HIV/AIDs, rises in drug related deaths and the growth of public drug scenes in a number of European cities. It was during this period that ‘harm reduction’ approaches began to emerge – including needle and syringe exchanges – in a policy landscape dominated by detoxification and drug free residential programmes.

BOX 1

Recent verdicts on DCRS

One recent commentator has usefully summarised the message from all the available evidence, as follows: ‘There is good evidence that, when developed in consultation with the wider community, a range of operational models for DCRs is possible, and these can serve differing populations and local needs. Data concerning the number of visits they receive provides evidence of the amount of injecting that is transferred to a safer environment, probably decreasing nuisance and in which skilled personnel with access to emergency equipment are in attendance. Consumption rooms also have a demonstrated capacity to attract more marginalised and vulnerable drug users. There are indications that they are likely to have an impact on overdose deaths and may reduce risk behaviours for blood borne viruses. However, these cannot yet be well-quantified. Beyond this, they can provide access to a range of drug treatment, health and social care services. As yet, the cost-effectiveness of consumption rooms is uncertain. Whilst they show promise, further research is required to clarify their overall impact and value for money’ (Hunt N, 2003).

Another evaluation concludes: ‘the evidence-base, while currently limited in terms of impact or economic studies is growing and improving in rigour. The available evidence suggests that DCRs are engaging the targeted client groups, reducing public nuisance associated with open drug scenes, are reasonably well accepted in their local communities, successfully managing drug overdose, contributing to stabilization or improvements in health and risk behaviours and interfacing between relevant health and social welfare services. Further, there is recent evidence of a community level reduction on overdose deaths in several German cities’ (Kimber J, Dolan K, Van Beek I, Hedrich D and Zurhold H, 2003).

In the 1980s and 1990s, DCRs were established in Germany, Spain, Switzerland and the Netherlands, and in the early 2000s, Australia and Canada. By 2003, there were approximately 60 facilities operating internationally. At the time of writing there were plans to establish facilities in Luxembourg and Norway. The implementation of DCRs was also being actively considered in Austria, Denmark, France, Italy and Ireland (Kimber et al 2003). Even in more resistant Western European countries, like the UK, they are now considered a serious option and are part of the mainstream debate about drug policy. In the UK Parliament, the report of the influential Home Affairs Select Committee, which has a membership drawn from all the main political parties, concluded that ‘there is a strong case for bringing heroin use above ground, so that those who wish to be helped can at least indulge their habit at minimum risk to their own health and that of the public. The obvious first step is the introduction of safe injecting houses’ (HASC, 2001, para 184).

Internationally, the most interesting development since 2000, has been the establishment of DCRs outside Western Europe; specifically, in the Kings Cross area of Sydney, Australia in 2001 and the East Side of Vancouver, Canada in 2003. The Australian facility has been the subject of a thorough 18 month evaluation, which builds on the existing evidence-base from Europe (itself usefully reviewed by the EMCDDA in a recent report). The political background to the establishment of the DCR in Vancouver, Canada is testimony both to the growing recognition of the potential of DCRs in different parts of the world, and the political sensitivity and caution that surrounds introduction of these facilities. Significantly, Canada describes the DCR in Vancouver as a ‘supervised injection site scientific research pilot project’. Evidently, the jury is still out.

Finally, the nature and the legitimising purposes of DCRs have varied from time to time, and place to place. The term DCR covers a whole multitude of things, from clinic-like facilities to much more informal environments. These facilities may be integrated into existing social service facilities (for example, for homeless people) or they may exist as separate services exclusively for drug users. Most DCRs offer other services. These vary, but can include needle and syringe exchange, access to basic medical care, laundry and shower facilities, café areas and – in some cases – access to emergency accommodation. Some are exclusively for safe injecting, others also provide for drug inhalation (in the Netherlands, drug smokers are the main target group). In some countries the principal driving force behind the establishment of DCRs was health of users, in others it was public order and nuisance. Some consumption rooms target particular client groups (for example, female sex workers) and others do not. In short, the message is that, while all DCRs provide controlled environments for using illegal drugs and aim to reduce harm, they work differently and have

developed for different reasons and in different ways in different countries.

BOX 2

EMCDDA, European report on drug consumption rooms

Some key statistics based on data drawn from 15 key studies on DCRs

- Clients in a range of surveys have identified hygienic consumption conditions, medical supervision and the availability of emergency care as important reasons to use DCRs.
- The typical user of DCRs is older than 30 and with a history of problem drug use – mainly heroin and/or cocaine – going back 10 years or more. Between 70% and 90% are men, except in facilities targeting sex workers.
- A high proportion of users are homeless or in unstable accommodation. A recent survey of German DCRs found that 5% of clients lived de facto on the streets. In DCRs near Madrid the rate of homelessness is 42%, while in the Can Tunis area of Barcelona it is 60%.
- Lifetime rates for imprisonment are high amongst DCR clients. Swiss studies estimate that between 50% and 75% of users of these facilities have been in prison, the figure is 38% in Spain.
- A study in Germany in 2002 reported that 50% of DCR clients had experienced drug free treatment and 43% substitution treatment. For one third of all interviewees a consumption room had been the ‘entry point’ into the drugs help system.
- Staff at DCRs report that a majority of clients adopt hygienic practices after information about basic hygiene rules have been provided consistently over a period of several months.
- A time-series analysis conducted for the German Federal Ministry of Health has concluded that there has been a statistically significant relationship in four German cities between the establishment of DCRs and a reduction in drug-related deaths.

THE ISSUES

There are three broad areas of controversy about DCRs.

- 1 There is an issue of *principle*. How do policy makers justify providing a service that enables people to engage legitimately in activities that are both harmful and illegal?
- 2 There is an issue about *messages*. Do DCRs legitimise drug use, encourage more people to use hard drugs or – at the local level – increase drug-related problems in the areas where they are situated?
- 3 There is an issue of *effectiveness*. Do DCRs reduce drug related harms and, even if they do, are they the most appropriate and cost effective way of reducing these harms?

ISSUES OF PRINCIPLE

The Annual Report of the International Narcotics Control Board (INCB) 2003 comments that ‘the Board on numerous occasions [has] expressed its concerns regarding the operation of drug injection rooms, where persons can inject drugs acquired with impunity on the illicit market. The Board reiterates its view that such sites are contrary to the fundamental provisions of the international drug control treaties, which oblige State parties to ensure that drugs are used only for medical and scientific purposes’ (INCB, 2004).

Two general points should be noted about this position. First, if the INCB’s claim is that *enabling users to take illegal drugs more safely* is inherently ‘contrary to the fundamental provisions of the international drug control treaties’, then this applies as much to needle and syringe exchange as it does to DCRs. The consequences of consistently applying a principle that ruled out all harm reduction practices that facilitate the use of prohibited drugs would be profound, particularly for the spread of HIV/AIDS and other blood-borne viruses. Second, the UNODC has not supported the INCB’s view that DCRs are contrary to the ‘fundamental provisions’ of the UN drug control treaties. Surprisingly, perhaps, the UNODC has no official position on DCRs. It has tended to take a case by case approach to harm reduction initiatives. But it has said in a legal opinion prepared for the INCB, that it is supportive of ‘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' (UNODC, 2002).

Those jurisdictions that have introduced DCRs have argued that they are not contrary to the provisions of the UN conventions of 1961, 1971 and 1988. Prior to the establishment of DCRs in Germany, an inquiry was carried out by the Chief Public Prosecutor at the Frankfurt am Main Higher Regional Court. It concluded that DCRs were compatible with the Conventions so long as such facilities did not permit the sale, acquisition or passing on of drugs and that they were genuinely hygienic and risk-reducing with adequate care and control (discussed in EMCDDA 2004). More recently, an analysis of the legal situation carried out by the Swiss Institute of Comparative Law concluded: 'The texts of the relevant international conventions do not provide any guidance on the question of whether or not public injecting rooms are in fact conducive to the rehabilitation and social integration of drug addicts in the short term and to the reduction of human suffering and the elimination of financial incentives for illicit trafficking in the long term. The actual practice of the State Parties in this respect could provide some guidance, if it is substantially uniform. If not, it must be concluded that State Parties retain the freedom to make their own policy choices on the tolerance of Fixer-Stubli (DCRs)' (Institut Suisse de Droit Comparee, 2000). The legal status of DCRs has remained contentious, but – at the very least – it is fair to say that the INCB's claim that these facilities are 'contrary to international law' is hugely controversial.

On the general issue of principle, Justice Wood, in the course of an inquiry into police corruption in Australia in 2002, concluded that: 'at present, publicly funded programs operate to provide syringes and needles to drug users with the clear understanding that they will be used to administer prohibited drugs. In these circumstances to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour' (cited in EMCDDA, 2004). This is a strong argument, but there is no escaping the fact that DCRs raise some fundamental ethical issues that are likely to be resolved differently in different jurisdictions.

ISSUES ABOUT MESSAGES AND PUBLIC ORDER

It is implausible to suggest that the establishment of DCRs will encourage people to start using hard drugs or escalate their drug use. The evidence on predictive factors of hard drug use strongly indicates social and psychological factors as the main criteria. The EMCDDA review has concluded that 'there is little evidence that by providing better conditions for drug consumption they [DCRs] perpetuate drug use in clients who would otherwise discontinue using drugs such as heroin or cocaine, nor that they undermine treatment goals' (EMCDDA, 2004). Nor do the majority of DCRs anyway provide a service accessible to people who do not *already* have dependency drug use problems. Generally, entry is restricted to *regular dependent users of heroin or cocaine, or those with a clear history of such behaviour*, with some services also excluding people who are being prescribed substitutes such as methadone. People under 18 are excluded from most DCRs – although some will admit 16 and 17-year-olds on the basis of a careful assessment – and drug users will generally not be allowed into the DCR with a child. Some services also exclude pregnant women.

Another concern about DCRs is that they could attract more drug dealers and problem users to the particular areas of towns and cities where they are located, with a generally negative impact on residents and local business. This raises serious issues about the management of DCRs, and the need for close co-operation with the local community and other service providers. The available evidence suggests that when DCRs are properly managed, and there is co-operation with the police, they are not linked to an increase in public order problems – on the contrary, they can have a key role to play in reducing them. Some services admit *only local residents*. Many issue user cards or codes, which restrict access and are revocable if users behave in unacceptable ways (conditions may range from bans on loitering to requirements to have regular health tests or training in safe use). Generally, DCRs do not advertise and there are strict prohibitions on drug dealing, sharing, the use of alcohol and other substances and violence. Other rules include the prohibition of assisted injecting and a range of safety requirements (such as not walking about the DCR with syringes).

The development of DCRs in some countries has actually arisen out of community concerns about the nuisance associated with public drug injecting and a desire to get drug use off the streets (notably in the Netherlands). The recent evaluation of the DCR in Sydney, Australia found that public support was initially high and increased even further following the opening of the DCR. After 18 months, over three quarters of local residents (78%) supported the DCR, along with 63% of businesses. This compared to 68% and 58% respectively

prior to the launch of the DCR. Respondents also said that they saw fewer incidents of public injecting and that they felt that there was less of a problem with discarded needles and syringes.

The evidence on the impact of DCRs on local communities is largely positive and reassuring. But DCRs are likely to be a source of tensions and troubles for local communities if they are introduced without proper consultation, lack clear and enforceable rules and/or are badly managed. DCRs can bring benefits to local communities, particularly by reducing public drug use and helping to remove discarded needles and other paraphernalia from local environments. But it is vitally important that there is consultation with local stakeholders, or DCRs can end up being blamed for public order problems later on.

ISSUES ABOUT EFFECTIVENESS, HEALTH AND WELFARE

The primary objectives of DCRs have been listed as health, safety and public order. As argued in the previous section, DCRs can benefit the community by reducing problems associated with drug use and, in the longer term, by helping to engage problem drug users in treatment programmes that are demonstrably effective in cutting drug-related crime and other social problems.

The other potential benefits of DCRs have been identified as:

- reducing overdose deaths;
- preventing blood-borne infections (HIV, Hepatitis B and Hepatitis C);
- preventing damage to veins and other routine health problems among injecting drug users;
- getting some of the most chaotic and hard to reach drug users into contact with drug treatment and other services;
- providing social contact and support for highly vulnerable people, who will often be homeless, marginalised and lacking in access to basic social care and health services.

So, is there evidence that existing DCRs are actually effective in delivering these benefits?

A detailed assessment of the research on DCRs is provided in the recent EMCDDA review of the evidence-base (EMCDDA, 2004). It concludes that there is evidence that DCRs are *reaching their target populations* and having a *positive impact on health, public order and crime* (see box 2). The evaluation of the DCR in Sydney, Australia concluded with very similar messages (MSIC Evaluation Committee, 2003 – see box 3).

- 1 **Reaching target populations.** The available European evidence shows that the majority of users of DCRs are older, longer-term user, who are disproportionately drawn from some of the most problematic and marginalised sections of the population (such as long term addicts, street injectors, homeless drug users and drug using sex workers). A significant proportion of users of DCRs had no previous contact with treatment services, but, either simultaneously with or following their involvement with the DCRs, many were in touch with other drug and welfare services, such as needle exchanges and shelters for the homeless. The evaluation of the Medical Supervised Injection Centre (MSIC) in Sydney, Australia concluded that it had made service contact with its target population, including many who had no prior treatment for drug dependence.
- 2 **Health.** DCRs can be effective at engaging some extremely marginalised people with services. As well as the benefits of supervised drug consumption and hygienic conditions, drug users access other services through DCRs, such as needle exchange, low-threshold medical care and psycho-social counselling. Referrals are also made to drug treatment and health service providers.
- 3 **Public order and crime.** The EMCDDA survey concludes that DCRs can improve local environments by reducing public nuisance and public drug use, but that impact on public order problems is likely to be greatest where there is local support and political consensus. There is a shortage of hard evidence that DCRs result in a decrease (or an increase) in the numbers of improperly discarded needles or syringes. However, the evaluation of the Sydney MSIC found that syringe counts were generally lower after it opened, and local residents and businesses reported sighting fewer public injections and syringes in 2002 compared to 2000. There is no evidence to suggest that DCRs are associated with increases in acquisitive crime. There is only limited data on the impact on drug dealing. In general, DCR rules appear to be properly enforced and respected by users. Small-scale drug dealing does take place in the vicinity of DCRs, but this is unsurprising given that most DCRs are typically located in close proximity to the existing drug market.

The evidence on the effectiveness of DCRs as a means of reducing a range of drug-related harms is promising, but it is less conclusive than supporters of DCRs might have wished. The 18 month evaluation of the DCR in Sydney, Australia could demonstrate only comparatively modest benefits (see box 3). In particular, there was no measurable change in the numbers of heroin overdoses in the community, and only a small decrease in the frequency of health and other problems relating to drug injecting among the relevant population. It has since been observed that ‘the number of overdoses in the Kings

BOX 3**Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre (MSIC)****Some key statistics**

- During the 18 month trial 3,810 individuals registered to use the MSIC. Around two thirds had been in treatment at some time, and about one quarter in the previous 12 months.
- 73% were male, the average age was 31 and the average period they had been injecting was 12 years.
- Heroin accounted for 61% of visits, cocaine for 30%.
- Additional health care services were provided to clients in approximately one in four visits.
- 1,385 referrals for further assistance were made on behalf of 577 clients, 43% were for drug treatment, 32% for primary health-care and 25% for social welfare services. 20% were confirmed to have resulted in the client making contact with the relevant agency.
- 409 drug-overdose related incidents requiring clinical management occurred at the MSIC, a rate of 7.2 overdoses per 1000 visits.
- Following the opening of the MSIC, there were reductions in opioid overdose ambulance attendances in the Kings Cross Area, but these had already been falling, and it was not possible to distinguish the role of the MSIC from the effect of a continued reduction in heroin availability.
- There was no evidence that the operation of the MSIC affected the number of heroin overdose deaths in the Kings Cross area. But, on the basis of clinical and epidemiological data on heroin overdose outcomes, at least four deaths per year are estimated to have been prevented by clinical intervention of staff at the MSIC.
- There was a small decrease in the frequency of injecting-related problems among MSIC clients.
- Nearly half of MSIC clients reported that their injecting practices had become less risky.
- The frequency of public injection among MSIC clients decreased.
- In 2002, 9% said that they injected more frequently and 22% less frequently since using the facility.
- Kings Cross residents and businesses reported sighting fewer episodes of public injecting and syringes discarded in public places.
- Syringe counts in Kings Cross were generally lower after the MSIC opened than before.

MSIC Evaluation Committee (2003), *Final report on the evaluation of the Sydney Medically Supervised Injecting Centre*, Sydney.

Cross area had started to decline prior to the establishment of the MSIC due to the reduced supply of heroin to Australia at that time. While there were further reductions in the number of opioid overdose ambulance attendances in the area following the opening of the centre, the evaluators state that 'it is not possible to distinguish the role of the MSIC in reducing demand for ambulance services from the effect of the continued reduction in the availability of heroin' (Alcohol and other Drugs Council of Australia, 2003). Generally, evaluation of the Sydney DCR was seriously hampered because of the problems of disentangling the independent impact of the Australian heroin drought.

CONCLUSION: CAUTION AND CONTENTION

The claims that can be made for DCRs on the basis of the available evidence should not be exaggerated. Taken in isolation from other policy and service initiatives they can have, at most, a limited impact. But the evidence from both Europe and Australia shows that DCRs can have an important role to play in tackling the whole range of harms that were identified in the first Beckley report, including crime and public nuisance, drug-related deaths, health and social problems and the damage inflicted on local urban environments by public drug scenes. A number of considerations need to be taken into account by policy-makers considering the introduction of DCRs.

- 1 **Principle.** There is no escaping the fact that DCRs facilitate behaviour that is both illegal and damaging. This poses some inescapable ethical dilemmas that cannot be resolved by a simple cost benefit analysis. Even jurisdictions that have DCRs typically prohibit some problem drug users from using them. For example, under 18s are usually prohibited, although this is unlikely to prevent these young people from using drugs, and will mean that they do so in less safe and hygienic environments. In short, there is an ethically fraught balance to be struck between facilitating damaging patterns of drug use amongst often vulnerable and troubled people, and working to reduce the harm associated with that drug use. Different communities will strike this balance differently.
 - 2 **Local law.** The paradoxical character of DCRs – that they are legal facilities for the purpose of facilitating illegal activities – may mean that they are in direct conflict with existing law in some jurisdictions. In the UK, for example, Section 8 of the Misuse of Drugs Act 1971, as amended by the Criminal Justice and Police Act 2001, would appear to make it a criminal offence for anyone concerned in the management of a DCR to ‘knowingly permit or suffer’ the ‘administering or using of a controlled drug which is unlawfully in any persons possession at or immediately before the time when it is administered or used’. The UK Government has recently announced that it will delay implementation of the amended version of this legal requirement for at least two years. This arguably removes the legal impediment within the UK – at least, for the time being – but similar issues are likely to arise in other jurisdictions.
 - 3 **Public acceptability.** Unless there is public support – especially at local level – DCRs are unlikely to operate successfully. Where harm reduction is not well-established as a response to drug use, the introduction of DCRs may be impractical as a first step. At present, in many countries DCRs are likely to fail what MacCoun and Reuter have called the ‘political standard’ for drug policy. To be politically viable, projected changes should not ‘offend fundamental values’ and, where they are to some degree in conflict with common beliefs and practices, it is important that the net gains have a high degree of certainty (MacCoun R J and Reuter P, 2001). This is not yet true of DCRs. The case for DCRs is strongest in those countries where harm reduction is already well-established.
 - 4 **Variations in drug problems.** The appropriateness of DCRs will obviously depend on the nature of drug problems in particular jurisdictions and localities. Where problem drug use is primarily associated with the oral consumption of drugs like methamphetamine and ecstasy, for example, there will not be any obvious case for introducing DCRs.
 - 5 **Opportunity costs.** Although the evidence suggests that there are demonstrable benefits from DCRs, it is important to also take account of the opportunity costs. Where resources are scarce (political as well as economic), then alternative investments may have a greater impact on health, safety, crime and public nuisance. For example, in countries that have not got needle and syringe or substitute prescribing programmes, then introducing such initiatives may be a more cost-effective investment of scarce harm reduction resources than the establishment of a DCR. In some countries that do have well-developed harm reduction programmes there is ongoing debate about whether investment in DCRs is as effective a way of engaging the most chaotic and vulnerable drug users in treatment and other services as investment in drug services within the criminal justice system. It is not enough to prove that DCRs can reduce drug-related harm, it is also necessary to demonstrate that they are the best use of the available resources.
- In many parts of the world, DCRs will not be a viable option at the present time - economically, legally, politically or cultural. All commentators agree that the viability and effectiveness of DCRs will depend on local contexts and circumstances. These include co-operation between relevant services (police, housing, health services, treatment providers, etc), high levels of support from the community and the particular nature of local drug problems. Even in appropriate contexts, it is important that the claims made for DCRs are not exaggerated. They cannot prevent public drug use; their impact on drug-related health and welfare problems may be only limited; and they do not address many of the wider problems caused by drug markets and drug dealing.
- A review of the evidence-base has concluded that DCRs ‘show promise and require cautious expansion with evaluation in ways that are adapted to local settings’ (Hunt N, 2003). In conclusion, evidence is now emerging that DCRs can be an effective way of reducing drug-related harms as part of a holistic approach to drug policy if they have the support of relevant agencies and from the local community. If problem drug users are provided with safe private environments within which to administer drugs then it is a reasonable supposition that there will be a reduction in unsafe public drug use. The available evidence appears to confirm this.

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USEFUL WEBSITES

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