



European Monitoring Centre  
for Drugs and Drug Addiction

# European report on drug consumption rooms

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## Introduction

Morbidity and mortality associated with drug dependence affect a sizeable number of European citizens and constitute major problems for public health in Europe. According to current estimates, the prevalence of problem drug use <sup>(1)</sup> in the European Union (EU) Member States and Norway varies between two and nine cases per 1 000 of the population aged 15–64, indicating a large population at risk for serious health consequences. Most of the more than 8 000 acute drug-related deaths reported annually in the EU and Norway are due to injecting heroin use, and the numbers are rising (EMCDDA, 2003). Risks related to injecting drug use are the transmission of blood-borne infections, in particular human immunodeficiency virus (HIV) and hepatitis B and C, fatal and non-fatal overdoses and other morbidity, i.e. bacterial infections.

Drug users who congregate in public areas or open drug scenes are often homeless and marginalised, and lack access to social and health care services. Studies suggest that severe health risks are linked to street-based injecting (Klee, 1995; Best et al., 2000). Owing to their visibility, this group is subject to continuous police attention and public hostility, which, as users try to avoid detection, increases their vulnerability to injection-related complications, blood-borne infections and their risk to die from a drug overdose. Drug dealing and drug use in public affect cities with some neighbourhoods experiencing considerable nuisance, and create a feeling of lack of public order and safety (Renn and Lange, 1996).

The serious health and public order problems associated with drug use, especially drug injecting in public places, have led in recent years to the establishment of drug consumption rooms in several countries. Here confirmed drug users are allowed to consume drugs in hygienic conditions and without fear of arrest. The establishment of drug consumption rooms is controversial and has led to disagreement between the International Narcotics Control Board (INCB) and some UN Member States on the one hand and other UN Member States on the other hand, about the interpretation of the international drug conventions <sup>(2)</sup>, in particular in relation to the basic provision of the conventions, obliging States to limit the use of narcotic drugs strictly to medical and scientific purposes.

This report does not address this debate; nor does it offer comment on the position of consumption rooms in respect of international drug control treaties. It aims to provide a descriptive analysis of historical background, operational frameworks and outcomes of such services that can serve as a basis for a more informed discussion. The report is part of the remit of the EMCDDA to monitor drug use-related health consequences and efforts to reduce these, guided by the second target of the European Union Drugs Strategy 2000–04, which is the substantial reduction over five years of the incidence of infectious diseases and the number of drug-related deaths.

Chapter 1 gives an overview of objectives, target groups and functioning of consumption rooms. Chapter 2 describes the historical background and the driving forces that contributed to the setting up of such services, and outlines expected benefits and risks. Chapters 3 to 5 describe who uses these facilities and what outcomes have been documented with regard to individual and public health as well as public order and safety. The final chapter summarises the findings and conclusions of the report.

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<sup>(1)</sup> Problem drug use is defined as injecting drug use or long-duration/regular use of opiates, cocaine and/or amphetamines; see also EMCDDA (2001).

<sup>(2)</sup> Namely the Single Convention on Narcotic Drugs, 1954, the amendment to this Convention by the 1972 Protocol, the Convention on Psychotropic Substances, 1971, and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

# 1 What are consumption rooms?

## 1.1 Definition

Consumption rooms are protected places for the hygienic consumption of preobtained drugs in a non-judgemental environment and under the supervision of trained staff (Akzept, 2000). They constitute a highly specialised drugs service within a wider network of services for drug users, embedded in comprehensive local strategies to reach and fulfil a diverse range of individual and community needs that arise from drug use. Consumption rooms are official services, funded from local or regional budgets or by churches. They are distinct from illegal ‘shooting galleries’, which are run for profit by drug dealers, as well as from consumption facilities provided within the framework of drug prescription programmes, where drugs are supplied to users (Kimber et al., 2003a).

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.

## 1.2 Objectives

Consumption rooms have health and public order and safety objectives (Box 1). They are intended to reduce drug use-related health risks, e.g. transmission of infectious diseases and overdose-related deaths, and to increase the access of specific target populations of drug users to health, welfare and drug treatment services. They also aim to create an acceptable situation for the public with regard to order and safety concerns that arise from open drug scenes<sup>(3)</sup> while providing a sheltered and dignified environment for drug consumption. In order to achieve health and public order objectives, services must be able to reach as many members of the target group as possible.

### Box 1: Main objectives of consumption rooms

- To reach as much of the target population as possible (Chapter 3)
- Health objectives (Chapter 4):
  - to provide a safe environment that enables lower-risk, more hygienic drug consumption (short-term objective)
  - to reduce mortality and morbidity in the target population (medium-term objective)
  - to stabilise and promote the health of service users (long-term objective)
- Public order and safety/crime objectives (Chapter 5)
  - to reduce public drug use and associated nuisance
  - to avoid increases of crime in and around the facilities.

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<sup>(3)</sup> Drug use and dealing in public spaces.



### 1.2.1 Balance between objectives

Public health and public order objectives play a role in all consumption rooms; however, the emphasis given to one or the other differs depending on which groups were the main promoters of the facilities.

In the Netherlands, the majority of the current facilities seem to have originated from initiatives by neighbourhood residents and police, supported by local authorities, and are predominantly directed at reducing public nuisance: 'Local policy makers and drug care professionals are usually those who determine the admission criteria, often in cooperation with police, public prosecutors and neighbourhood residents' (Wolf et al., 2003). Other Dutch facilities, established at the initiative of social or drugs services, often in cooperation with drug users' interest groups, focus more clearly on objectives related to the health of drug users (see Trautmann, 1995; Schlusemann, 1998; Linssen, 1999; Schatz and Wolf, 2002).

In Switzerland, public order and public health objectives are considered to be of equal importance (Eastus, 2000).

The legal frameworks at national and Lander level in Germany (narcotics law and statutory orders) emphasise the health-related aims of the rooms. However, federal law requires that the services cooperate closely with the authorities responsible for public order, and in most Landers the reduction of public nuisance is explicitly defined as one objective of consumption rooms (BtMG-ÄndG, 2000; Landesverordnungen, 2000–02).

The specific characteristics of the facilities in Madrid and Barcelona are that they are located in suburban settings with large open drug scenes. Concern about the health of drug users visiting such areas to buy and use drugs was the main reason for the establishment of the facilities, but they also aim 'to lessen the social impact of intravenous consumption in public' (Ministerio del Interior, 2002, p. 76). A scientific trial of a medically supervised injecting centre (MSIC) in Sydney, Australia, has examined the success of the facility in meeting health and public order objectives (MSIC Evaluation Committee, 2001).

### 1.3 Target groups

Consumption rooms target limited and well-defined groups of problem drug users (Table 1). 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, and who often lack, in addition to health care, food, hygienic facilities for drug consumption and access to drugs services. Some consumption rooms target specific groups such as female sex workers or illegal immigrants.

**Table 1: Definition of target groups**

Switzerland	' <i>Schwerstabhängige</i> ' (heavily addicted persons) who do not accept/take up other offers of help; long-term, hard-core injecting drug users (Eastus, 2000)
The Netherlands	'Problematic street drug users': 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, p. 92)
	'Adult street drug users with a reputation for nuisance' (Wolf et al., 2003)

Germany	' <i>Schwer erreichbare Betäubungsmittelabhängige</i> ' (hard-to-reach drug addicts) (BtMG-ÄndG, 2000), especially drug injectors in open drug scenes
Spain	Socially excluded injecting drug users, high-risk groups, homeless drug users (Alvarez Vara, Antidrug Agency of the Autonomous Government of Madrid, personal communication, September 2002)
Australia	Drug users who inject in public places and/or alone; hidden intravenous drug users, i.e. those not in contact with services; injecting drug users in the Kings Cross area (Kimber and van Beek, 2002)

General criteria for allowing drug users to access supervised consumption areas are that clients are regular, addicted users of heroin or cocaine and over 18 years old. Addicted non-injectors who want to make their first injection are often also excluded from using the services. Based on individual assessments, 16- or 17-year-olds are admitted in some services. Drug users accompanied by a child are not permitted to enter the drug consumption areas. Admission policies with regard to clients in substitution treatment vary. In some services, pregnant women are excluded (MSIC Sydney); in others they receive special counselling (e.g. all services in Zurich).

Use of the facility is sometimes restricted to local residents, to avoid attracting more drug users to the area. This is the case in the Netherlands, and to an increasing extent also in Switzerland and Germany. To control this, either access permits (user cards) are issued to service users once they have been confirmed to belong to the target group or identity documents are checked every time a user enters the facility. A 'user card' system, with information transmitted to the police, to check if criminal proceedings are pending, is common in the Netherlands. Different systems of client assessment and registration and of service monitoring are in place (Table 2), with Swiss and German services emphasising the confidentiality of use of the rooms. In Australia and Spain, residency restrictions are not in place.

**Table 2: Specific inclusion/exclusion criteria**

	Residency restrictions	User passes, access cards, registration systems
Switzerland	Most services: control of identity documents	Some services
The Netherlands	Majority of services: 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 (except at one consumption room that is reserved for illegal immigrants)	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
Germany	Services in Frankfurt and some services in North Rhine-Westphalia: control of place of residence via identity documents	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 should guarantee non-

		prosecution for drug possession on the way
Spain	None	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
Australia	None	Clients are registered anonymously and receive a user code to identify them at subsequent visits

#### 1.4 How do consumption rooms operate?

Three distinct types of consumption rooms have been identified in an analysis in the Netherlands: integrated, specialised and informal consumption rooms (Linssen et al., 2001; Wolf et al., 2003) (Box 2). 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. They aim to reach those who for various reasons are not in contact with traditional drug care services and provide besides supervision of drug consumption a range of other services to their clients, including needle exchanges and wound and abscess clinics. They have strong referral networks with neighbouring drugs and social services, methadone programmes and with shelters for the homeless.

#### Box 2: Examples of functioning of consumption rooms

##### Typical injecting room

A description of a typical injecting room, based on observations in Switzerland, is as follows: ‘... [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).

##### Integrated facilities

Integrated facilities combine an injecting room and other services. All integrated facilities in the Netherlands that were studied by Wolf et al. (2003) had roughly the same layout. “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. Areas where drugs may be taken are found elsewhere on the premises.” (l.c., p. 655).

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 are available at most integrated facilities in the Netherlands. In addition to the common room and the drug-taking 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 or a room for individual seclusion (especially for cocaine users). Most Dutch consumption rooms are licensed to provide facilities for a very limited group of local homeless addicts.

### **Specialised consumption rooms**

In a specialised consumption room in Frankfurt, more than 1 900 drug injections are supervised every week (data from 2001). The facility is located near the train station, in close vicinity to a range of other drugs services. It is part of a major non-governmental organisation that runs a range of other agencies, including a shelter, counselling services and a methadone maintenance treatment programme. The service follows a three-step admission procedure. Front-desk staff determine whether potential clients meet the general admission criteria. The clients then have to read and sign a declaration that they are of age and not in a substitution programme, following which they are made familiar with the house rules. If the consumption room is full, clients are registered anonymously and remain in the waiting area, where they can have soft drinks or water. When a place becomes free, they receive sterile equipment at a counter and can enter the consumption room, usually for about 30 minutes. Inside the room, a staff member makes clients aware of health risks and dangerous modes of consumption, observes them during the consumption and provides advice on injecting hygiene and techniques. Other staff members are available to provide immediate care in case an emergency occurs. After consumption, clients clean up after themselves and leave the consumption area. Staff are available to provide information and referrals; medical services are provided in a separate area of the facility at specific times.

Integrated and specialised facilities are also common in other countries, whereas so-called 'informal' consumption rooms, run by current or former drug users but tolerated by the police, and mostly restricted to drug smoking/inhalation, have so far been described only for the Netherlands (Linssen et al., 2001; Wolf et al., 2003).

Among the services usually available at integrated and specialised facilities are needle and syringe programmes, basic medical care, counselling and referral. Many centres also include café areas, where clients can get soft drinks and sometimes meals, or laundry and shower facilities (see section 4.3.1). In integrated facilities, clients can enrol for addiction treatment or benefit from emergency accommodation that is available at the facility, whereas specialised facilities rely on referrals to other local care agencies.

Consumption rooms do not advertise their services and staff members are not allowed to help clients inject. House rules typically prohibit drug dealing, sharing of drugs between clients, aggressive behaviour and the use of alcohol and sometimes other substances (e.g. tobacco smoking) and set down basic hygiene requirements and safety procedures ('do not walk around while carrying a syringe'). Additional limitations may also be imposed, e.g. 'no drug cocktails that include medicaments' or 'no injections into neck or groin veins'. In most facilities, clients are not allowed to help each other to inject.

Many services are restricted to the target group of drug injectors. Services that provide areas for drug inhalation usually allow smoking, chasing the dragon, free-basing and snorting<sup>(4)</sup>. However, some limitations with regard to the types of substances that can be consumed might be in place (e.g. the consumption of certain medicaments or crack cocaine may be forbidden). In the Netherlands, consumption rooms are mainly directed at smokers. The availability of

<sup>(4)</sup> 'Chasing the dragon' refers to the ingestion of heroin by inhaling the vapours that are produced when the drug is heated, typically on tin-foil above a flame (Strang et al., 1997). 'Free-basing' is inhaling crack cocaine via a heated pipe. Snorting is nasal inhalation.

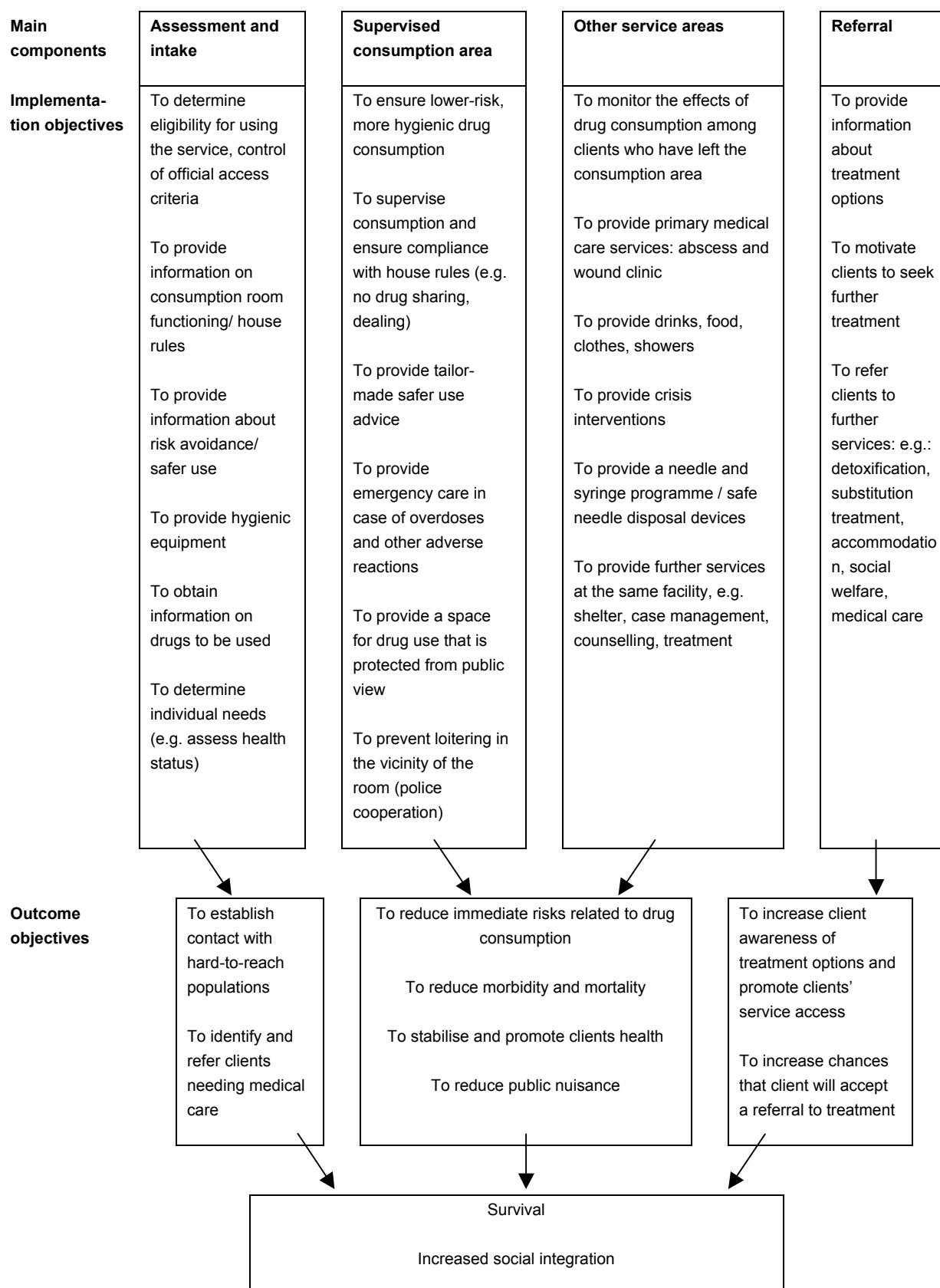
places for non-injecting drug use has recently been expanded in Switzerland (Spreyermann and Willen, 2002, 2003). Depending on the modes of drug consumption allowed, the way in which facilities are furnished can vary widely (Wolf et al., 2003), and the atmosphere may vary from almost like a living room (in the case of drug smoking) to a more clinical, hospital-like environment (to meet hygiene standards for injecting), for example the MSIC facility in Sydney (van Beek, 2003).

In many services, when potential clients enter, staff members carry out a visual check of the drugs to be used and assess the physical condition of the users to ensure that they are not intoxicated or otherwise in a physical condition that increases the risk of overdose.

In the Netherlands, it is common for service users to sign 'user contracts' that oblige them to fulfil specific obligations such as undergoing regular health checks, participating in safer use training and not loitering outside the facility. 'User cards' are instrumental as they can be withdrawn if clients fail to meet their obligations. There are systems in place in all rooms to punish violations of the house rules, usually by temporary exclusion from the use of the rooms.

An example of a logic model of a consumption room, describing the different components of the room and what these are designed to achieve (see Rush and Ogborne, 1991), is shown in Figure 1 below.

**Figure 1: Service model for a hypothetical consumption room with public health and public order objectives**



Adapted from Marsden et al. (2000), Box 2

## 2 When, how and why did consumption rooms come into being?

Consumption rooms developed in cities where – despite the availability of a variety of treatment options, including methadone substitution, as well as a range of harm reduction services such as outreach and needle and syringe programmes – public drug use persisted and there remained serious concern about infectious diseases, drug-related deaths and/or public nuisance.

### 2.1 History

#### 2.1.1 Chronology and expansion

Unofficial or semiofficial initiatives of tolerated drug use at addiction counselling centres or youth services were reported from the Netherlands in the early 1970s (the Prinsenhof and the HUK Amsterdam) and from Switzerland ('*Fixerraum-experiment*' at the AJZ in Zurich) in the early 1980s (Stöver, 1991; Herwig-Lempp et al., 1993; de Jong and Weber, 1999; Dolan et al., 2000). In England, similar developments occurred in the late 1960s and early 1970s (Malinowski, 2002). These initiatives were fundamentally different from supervised drug consumption rooms in that supervision of consumption or distribution of hygienic equipment was not their main objective. They attracted large numbers of drug users, but also dealers, and problems with regard to the management of ambience and behaviour arose. These experimental initiatives were stopped – either by the agencies themselves or after police intervention – after a relatively short period of time.

#### 2.1.2 Switzerland

The first supervised consumption room of the current type was opened in June 1986 in Berne, Switzerland, and was followed by the introduction of consumption rooms in Basle, Lucerne and St Gallen. The early history of Swiss supervised consumption rooms has been described by several authors (e.g. Forster, 1991; Frey, 1991; Fuchs, 1991; Linder, 1991; Hämmig, 1992a).

The first consumption room was officially tolerated in July 1988, as a result of the discussions of a working group comprising judges and the General Prosecutor (Hämmig, 1992b). A legal assessment of such services was commissioned by the Swiss Federal Office for Public Health (FOPH) from a law professor at the University of Berne. The appraisal (Schultz, 1989) concluded that the establishment of state-controlled consumption rooms does not violate Swiss national drugs legislation as long as the rooms improve the hygienic conditions under which consumption takes place and provide medical supervision and no drug dealing takes place. In accordance with this assessment, injecting rooms obtained the status of medical institutions and were thus exempt from police intervention.

A further analysis of the legality of state-controlled public injecting rooms under public international law, and more particularly under the three relevant international drug control treaties<sup>(5)</sup>, again commissioned by the FOPH, was carried out by the Swiss Institute of Comparative Law and submitted in January 2000. It concludes:

The texts of the relevant international conventions do not provide any guidance on the question whether or not public injecting rooms are in fact conducive to the rehabilitation and social reintegration of drug addicts in the short term and to the

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<sup>(5)</sup> See footnote 2.

reduction of human suffering and the elimination of financial incentives for illicit traffic 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 [sic] of *Fixer-Stübli*. State Parties are not obliged by the conventions to prosecute and punish the possession and consumption of drugs (other than those psychotropic substances that are listed in Schedule I to the 1971 Convention) by addicts in *Fixer-Stübli*. This conclusion is subject to the caveat that activities which counteract the object and purpose of the conventions must not be tolerated [sic], but that is simply to restate the question of the underlying socio-medical utility of public injecting rooms.

(Institut Suisse de Droit Comparée, 2000, p. 7)

The number of consumption rooms in Switzerland increased following the closure of open drug scenes (e.g. Platzspitz in Zurich) in the early 1990s. In 2003, 12 consumption rooms were in operation in seven Swiss cities: Basle (2), Berne (1), Biel (1), Geneva (1), Schaffhausen (1), Solothurn (1) and Zurich (5); facilities in Lucerne and Olten were closed in 1994 and 2003 respectively (Figure 2). Since the end of 2001, several facilities for drug injectors have been expanded to include areas for drug inhalation.

### 2.1.3 Germany

Initiatives to establish supervised injecting facilities started in Hamburg and Frankfurt in the early 1990s (Stöver, 1991; Klee, 1997) including the examination of their legal admissibility (Böllinger, 1991; Michaelis, 1991). In 1993, an analysis of the question of whether the operation of consumption rooms constitutes a criminal offence under German narcotics law (BtMG) and the relevant articles of the German penal legislation and whether such services are contrary to the relevant UN conventions of 1961, 1971 and 1988 was carried out by the Chief Public Prosecutor at the Frankfurt am Main Higher Regional Court, Headquarters of the Campaigns Against Drug Abuse (ZfB) (Körner, 1993, 1994). The assessment, commissioned by the health authorities of the city of Frankfurt, concluded that the operation of such facilities was not a punishable offence either under any current German laws or according to UN conventions, provided that the sale, acquisition or passing on of drugs/narcotic substances are not tolerated and that hygienic, stress-free and risk-reduced drug consumption is ensured through adequate care and control (Körner, 1993, p. 16). Based on this legal appraisal that defined strict implementation rules, the operation of consumption rooms in Frankfurt was tolerated in 1994 by the responsible health and law enforcement authorities through a local multiagency coordination group.

The issue of the legal admissibility of the rooms remained however in other parts of Germany controversial. The city of Hamburg launched a legal initiative in June 1995, proposing an amendment to § 29 I BtMG that would exempt consumption of drugs in publicly recognised drugs services from being a criminal offence (Körner, 1995, p. 459). This proposal, directed at adapting the legal provisions for the crime of 'providing an opportunity for the consumption of drugs' so as to allow drugs services to reach active drug users more easily, was not successful.

In December 1999, the German Parliament (Bundestag) adopted an amendment of the Narcotics Act in order to provide a legal basis for drug consumption rooms. In February 2000, the Council of the Federal States (Bundesrat) consented to the amendment, which came into force on 1 April 2000. As drugs policies differ widely between federal states, a nationwide legalisation of consumption rooms was not possible. As a compromise, the amendment (§ 10a BtMG) leaves it to the discretion of individual states whether or not to issue such rooms with a licence. A catalogue of minimum standards is defined in the law, with the aim also of guaranteeing compliance with international conventions (Box 3).



### **Box 3: 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 (...).

(BtMGÄndGes of 28.03.2000; Federal Ministry of Health and Social Security, 2003).

By 2003, the necessary ordinances, regulating licensing procedures and prerequisites for admission of drug users to the rooms had been adopted in 6 of the 16 federal states: Hamburg (2000), North Rhine-Westphalia (2000), Saarland (2001), Hesse (2001), Lower Saxony (2002) and Berlin (2002) (see Landesverordnungen 2000–02).

In Frankfurt, most of the five current services, which have a total capacity of 37 places for supervised injecting, were created between December 1994 and August 1996. Service development in Hamburg started also in 1994 and followed a decentralisation concept (see Box 5); by May 1999 about 39 places for injection and 15 places for inhalation, distributed over eight services, were available. In 2002, one service in Hamburg was closed. The political decision to close a further room in the centre of Hamburg was announced in 2003. Hamburg and Frankfurt are still the only German cities with more than one consumption room.

Further consumption rooms were opened in Hannover in 1997 and in Saarbrücken in 1999. After the German federal drugs law was amended in spring 2000, defining the conditions under which drug consumption rooms could be implemented (3. BtMG-ÄndG of 1 April 2000), nine cities in North Rhine-Westphalia (Münster, Wuppertal, Essen, Cologne, Aachen, Dortmund, Bochum, Bonn and Bielefeld) integrated consumption rooms into existing drugs services between 2001 and 2003; in Berlin, a mobile consumption room became operational in October 2003, and two further fixed services are planned. In 2003, a total of 25 consumption facilities operated in 14 German cities (Figure 2).

#### **2.1.4 The Netherlands**

In 1990, a church-operated social institution in Rotterdam began to allow drug users to consume drugs on its premises (Pauluskerk), although it was not until 1994 that this first

'gebruikersruimten' (= user room) became a regular part of the services provided (Schatz and Wolf, 2002).

The establishment of official consumption rooms became feasible after the College van Procureur-generaal issued legal guidelines on 1 October 1996 (College van Procureur-generaal, 1996). These guidelines clarified that the possession of drugs in consumption rooms is tolerated, provided the facilities fit into the local drug policy framework defined by the local triumvirate of mayor, police and public prosecutor (de Jong and Weber, 1999; Zurhold et al., 2001). Local regulations in districts where consumption rooms operate (Gemeentewet, art. 172, art. 174, art. 174a, art. 175, art. 176; Schatz and Wolf, 2002) define public order criteria: specific cooperation bodies that include representatives of local residents, local businesses and service providers are set up and additional police surveillance is often put in place.

Following the clarification of the legal status of the room by the General Prosecutor, the city of Rotterdam started to formally support consumption rooms as part of its nuisance reduction policy, and facilities in other cities followed (Barendregt et al., 2002; van der Poel et al., 2003).

User rooms in the Netherlands have a limited number of registered clients from a well-defined target group. Mostly, the rooms service between 25 and 30 local homeless drug users (Zurhold et al., 2001). However, some facilities have wider access criteria or target specific transient subpopulations (e.g. immigrants, sex workers). At the time of writing, there are known to be in existence 22 rooms 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).

### **2.1.5 Spain**

In May 2000, a supervised injecting room was established in Villa de Vallecas, near Madrid, which has a large drugs market and open drugs scene. It is situated in a prefabricated building of about 200 m<sup>2</sup>, and its services are integrated with a range of other survival services for marginalised drug users of the open scene. The implementation of the service is based on the local public health regulations. The service offers 10 places for injecting drug use and is the only supervised injecting facility that is permanently open, day and night, seven days a week. A much smaller facility was set up in Barcelona in September 2001 as part of the already existing mobile services targeting drug users in an area called Can Tunis. The facility, with a maximum of five injecting places, was located in a small bus and available for only four hours on weekdays. When it was closed in November 2003, another facility was opened in Barcelona in the centre of the old city. In the same month, a further injecting room was opened in the city of Bilbao.

### **2.1.6 Australia and Canada**

A medically supervised injecting centre (MSIC) with 16 places was established in the Kings Cross area of Sydney, New South Wales (NSW), Australia, in May 2001, following several years of intensive discussions of the public health and order problems arising from the large illicit drugs market in this area and the role of supervised injecting facilities in tackling these. The MSIC operates as a scientific trial, based on legislation that was adopted at the Parliament's Drug Summit in May 1999 (Drug Summit Legislative Response Act 1999, Parliament of NSW). However, as a result of delays in the approval of the licence application and a legal challenge by the local chamber of commerce, the MSIC did not open until May 2001. Representatives of the licensing authorities (NSW Health and Police Services) randomly monitored compliance of the service with the licence conditions every 3–6 months, and a team of researchers from the University of NSW were commissioned by the government to independently evaluate the relevant impacts of the MSIC, reporting regularly to a Government Monitoring Committee, which includes political, health, police and community representatives. In October 2002, the trial period was extended for additional 12 months to allow for the consideration of the report by

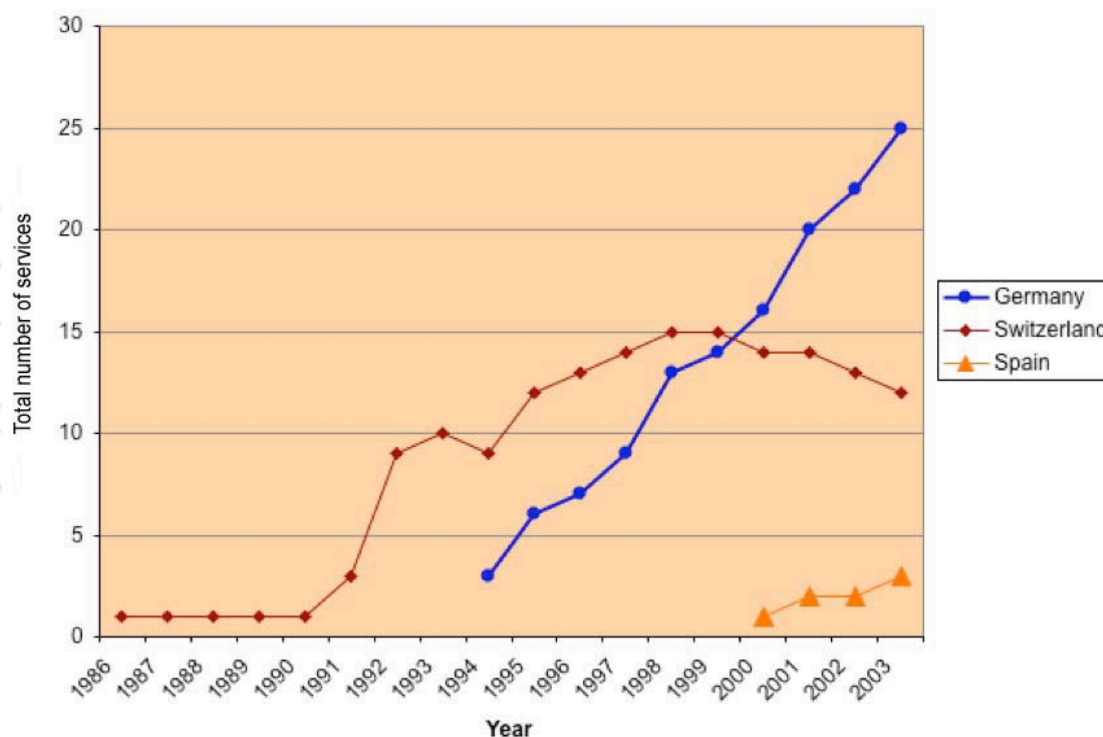
Parliament (MSIC Evaluation Committee, 2003). On the basis of the outcomes of the evaluation, the MSIC continues to operate.

In June 2003, Health Canada approved the establishment of a supervised injecting site (SIS) in Vancouver. The service, which became operational in September 2003, operates on the basis of an exemption under Section 56 of the Canadian Controlled Drugs and Substances Act (Health Canada, 2002) as a scientific research pilot project.

### 2.1.7 Current availability

Supervised drug consumption facilities operate in 36 cities in four European countries: Germany, the Netherlands, Switzerland and Spain. Figure 2 shows the number of operational consumption rooms in Switzerland, Germany and Spain for the period 1986 to 2003.

**Figure 2: Development of number of supervised drug consumption rooms in Switzerland, Germany and Spain between 1986 and 2003**



Sources: For Switzerland: Benninghoff et al., 2003; Spreyermann & Willen, 2003; R Hämmig (personal communication). For Germany: Poschadel et al., 2003. For Spain: Ministerio del Interior, 2002; Anoro et al., 2003b; El Correo Español y El Diario Vasco 02/12/2003. Consumption rooms in the Netherlands not included because of lack of data.

At the end of 2003, the total number of consumption rooms in Europe was 62. Cities with large drug markets and drug-using populations (e.g. Hamburg, Frankfurt, Rotterdam, Amsterdam, Basle and Zurich) have more than one facility in order to meet the greater demand. Further officially sanctioned injecting centres exist in Sydney, Australia, and in Vancouver, Canada.

The primary mode of drug consumption in Dutch consumption rooms is smoking or chasing (which is also allowed in an increasing number of rooms in Germany and Switzerland), while in all other countries injecting is predominant. Smoking, chasing or snorting of drugs is not allowed in the Spanish, Australian and Canadian facilities (Table 3).

**Table 3: Availability of official drug consumption rooms in Europe end of 2003**

Country	Number of supervised consumption facilities	Number of cities with supervised injecting facilities	Number of consumption facilities for injectors only	Number of facilities with injecting and inhalation areas
Switzerland	12	7	4	8
Germany	25	14	11	13
The Netherlands	22	12	0	22
Spain	3	3	3	0
Total	62	36	18	43

The number of places provided by each consumption room varies between 3 and 16 in Germany and between 5 and 12 in Switzerland; even in facilities that offer places for inhalation and injection, the majority of places are usually reserved for injectors. On average, the Dutch facilities surveyed by Wolf and colleagues in 2000/01 had 10 or 11 places for smokers and three to six places for injectors (Wolf et al., 2003); however one room provides 30 places. The consumption rooms in Madrid and Barcelona have 10 and five injecting places, respectively, and the MSIC in Sydney has 16 places, in eight injecting booths for two.

Further consumption rooms are planned to be opened in Berlin (where the statutory order was adopted in December 2002) and Luxembourg (based on the law of 27 April 2001). Since 2001, the legal framework in Portugal (Council of Ministers Resolution 39/2001 of 9 April 2001, para II.4) allows the licensing of such facilities; however, there are currently no plans to establish consumption rooms in Portugal. In Norway, the Parliament requested in June 2003 that the government provide legal authority for a pilot injection room project. Consumption rooms have been proposed or are in the process of being established in several other European cities (Kimber et al., 2003a).

Box 4 gives an overview of the terminology under which consumption rooms were set up.

#### **Box 4: Terminology**

The names that are or have been used for the facilities often reflect the policy discourse and historical contexts under which they were established.

##### **Switzerland**

Initially, consumption rooms were called '*Fixerstübli*' (literally 'IDUs' living room'), reflecting the emphasis on sheltering consumption from public view. The term '*Gassenzimmer*' (street room) illustrates that street outreach has moved indoors. Nowadays, the terms *injection room* and *inhalation room* are also in use in Switzerland.

##### **Germany**

The term '*Gesundheitsraum*' (health room) was used when the first facilities were established, reflecting the public health objective of the facilities as a symbolic 'safe card' against the dominance of public order objectives. Today, the more neutral term '*Konsumraum*' (consumption room) is more common.

### The Netherlands

The name for consumption rooms used here, '*gebruikersruimten*' (users' rooms), emphasises the social aspect of the rooms as meeting places.

### Spain

The terms '*dispositivo asistencial de venupunción*' (DAVE) (facility for assisted injection) and '*espaço de venopunción higiénica asistida* (EVA) (facility for hygienic assisted injection) are used, reflecting the health-related objectives of the facilities.

### Australia and Canada

The consumption facility in Sydney is a '*medically supervised injecting centre*' (MSIC), emphasising a clinical service model that was considered appropriate in the specific local circumstances in Kings Cross.

The consumption room in Vancouver is named '*supervised injection site*' (SIS).

## 2.2 Driving forces

In the mid-1980s, services for drug users in many countries in Europe were focused on inpatient detoxification followed by drug-free residential treatment, although in a number of countries (e.g. Denmark, Spain, Italy, the Netherlands and the United Kingdom) outpatient counselling and some form of substitution treatment were also available.

The emergence of the HIV epidemic among injecting drug users, and the realisation of its health and economic consequences, raised questions about drug policy priorities and the need to prevent acquired immunodeficiency syndrome (AIDS) among drug-injecting populations. Towards the middle of the 1980s it became apparent that large groups of drug users were not being reached by existing services, as reflected by, for example, increasing numbers of drug-related deaths and emerging public drug scenes.

Responses to drug use, which in some countries were strict and exclusively based on abstinence from drugs, were broadened by the introduction of two important measures: the expansion of substitution treatment and outreach health education including needle and syringe programmes (although this was a progressive process from the mid-1980s to 2000 and varied between countries). Outreach, a community-centred initiative aimed at contacting individuals from particular target populations whose needs are not effectively addressed by other services or traditional health education channels (Hartnoll et al., 1989), developed into an important means of bringing prevention messages and clean injecting equipment to those at risk of drug-related health damage. It also plays an important role as source of referral to drug treatment (Coyle et al., 1998; EMCDDA, 1999). Drugs policy changed to increase the emphasis on survival, and low-threshold facilities were established, as other ways of reaching addicts had failed. The new objectives were to reach drug addicts, to reduce risk behaviour and to facilitate access to services (e.g. Hämmig, 1995, for Switzerland).

However, outreach workers, especially those in cities with centralised, large illicit drug markets, where open drug scenes emerged (as was the case in Berne, Zurich, Hamburg and Frankfurt in the mid-1980s and early 1990s), were soon faced with two dilemmas:

- The provision of clean injecting equipment and education about hygienic injection was not sufficient to enable drug users in open drug scenes to inject hygienically.
- They were increasingly becoming called upon to provide emergency aid to the victims of overdoses. However, despite becoming better trained and equipped to provide such services 'in the street', many clients of needle and syringe programmes (NSPs) died from drug overdoses in locations where nobody was present or those who were present failed to call the emergency services for fear of prosecution.

It became clear to outreach workers that an environment was needed in which drug users could put into practice educational messages and follow instructions about hygiene and safety, and where immediate medical intervention could be systematically provided in **all** emergencies. Consumption rooms were conceived as an attempt to resolve these problems.

### **2.2.1 Switzerland**

Historically, the three driving forces behind the establishment of the first consumption rooms in Switzerland in the second half of the 1980s were public nuisance created by large open drug scenes, large numbers of drug-related deaths and a high prevalence and incidence of HIV infection among drug users. The objective of reducing public nuisance was considered to be as important as improving users' health (Eastus, 2000).

A considerable open drug scene began to emerge at the end of the 1980s in a park in the heart of Zurich (Platzspitz), and in the early 1990s resulted in a public health and order crisis that was resolved by the Federal Government formally adopting harm reduction as one pillar of federal Swiss drug policy in February 1991 (Geense, 1997). This formal commitment of the federal government to an approach to drug problems consisting of prevention, treatment, repression and harm reduction allowed it to experiment with new approaches to reducing drug-related problems, including formalisation of existing, tolerated '*Fixerstübl*' and opening of new facilities of this type. After the open drug scene in Zurich was broken up by police at the end of 1992, six consumption rooms were established to provide an alternative space where addicts could use drugs.

### **2.2.2 Germany**

The establishment of consumption rooms in Germany was preceded by several years of discussions and weighing up of the conflicting interests of health and drugs services, local residents and businesses, and the police. The dilemmas arising at local level from the need to provide necessary health and addiction care services to drug addicts while at the same time reducing the negative effects of public drug use on local residents have been described for the cities of Frankfurt and Hamburg (Hartnoll and Hedrich, 1996; Renn and Lange, 1996; Zurhold et al., 2001).

Factors that contributed to creating the necessary political support for consumption rooms included public discussion of drug-related problems at community level, complaints by residents of areas affected by public drug use, demands by drugs services and sometimes by the police for the establishment of this type of facility and legal considerations. An analysis of the complex structures and processes of local decision-making on consumption rooms in four German cities (Schütze, 1999) pointed to the relevance of local multiagency networking and the existence of a non-public coordination forum of key actors from prosecution, law enforcement and health, who were empowered to negotiate, and to take and implement decisions.

### **2.2.3 The Netherlands**

Official support for the establishment of 'user rooms' emerged after 1996, when local authorities began to believe that consumption rooms could be instrumental in reducing health risks for users and drug-related nuisance, in gaining knowledge about drug scenes, in motivating users to receive regular care and in enabling the authorities to keep in contact with drug users (NDM, 2001, 2002; van der Poel et al., 2003). For example, the city of Rotterdam formally supported the establishment of consumption rooms as part of an anti-nuisance policy introduced in 1996 (Quadt, 1996; Municipal Health Service Rotterdam, 1997).

The rooms aim to improve the management of drug addicts who are considered 'problematic' in that they do not want to seek treatment and cause nuisance ('*overlast*'<sup>(6)</sup>) to other citizens by using and dealing drugs in the street.

In Amsterdam, an 'adoption model' introduced in 1998 targeted a small but problematic group of so-called 'chronic addicts' – about 400 out of a total 6 000–7 000 drug users in the city. The objectives of the model were to help addicts to lead more normal lives and to reduce the '*overlast*' they caused to citizens. Amsterdam drugs services were asked to 'adopt' a small number of chronic addicts and to provide them with a number of key services. One of these key services was the provision of 'a protected area where they can use drugs' (Schlusemann, 1998).

Consumption rooms in the Netherlands work in close cooperation with the local police and the '*meld-and regelpunten overlast*' (nuisance reporting centres), where members of the public can lodge their complaints. Neighbourhood committees are integral to the success of the programme. The Dutch consumption room approach has been criticised for its bias towards maintaining public order (Linssen, 1999).

#### 2.2.4 Spain

The health care needs of drug users in open drug scenes, in particular their high incidence of drug overdoses and lack of access to health and social service networks, have been identified as the main driving forces behind the establishment of drug consumption facilities in Madrid and Barcelona (Anoro et al., 2001, 2003a, 2003b; Alvarez Vara, Antidrug Agency of the Autonomous Government of Madrid, personal communication, September 2002). The services are fully integrated in a wide range of further health and social services that existed either before the service of supervised drug injection was established (Barcelona) or were established at the same time (Madrid).

#### 2.2.5 Australia and Canada

The Kings Cross area in Sydney is the location of one of the largest illicit drug markets in New South Wales (NSW), and has been associated with prostitution, gambling and drug use since the 1960s. Rooms rented out by commercial sex establishments and hotels on a short-term basis to street-based sex workers for the purpose of casual sex were also rented out for the purpose of injecting drugs (as illegal shooting galleries) (MSIC Evaluation Committee, 2003). These rooms have been described as 'informal semisupervised injecting rooms' as clean equipment was provided and ambulance services alerted when customers had overdosed (van Beek, 2003). An official inquiry into police corruption in the mid-1990s (Wood, 1997) revealed that many of these establishments were also involved in supplying drugs, sometimes with the complicity of the local police (Dolan et al., 2000).

The report on the inquiry acknowledged, however, the potential public health benefits of facilities that allow safe, hygienic injecting and recommended the establishment of licensed supervised injecting rooms, staffed by health professionals:

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

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<sup>(6)</sup> The Dutch term '*overlast*' refers to objective (verifiable, observable) nuisance as well as to nuisance that is subjectively perceived. Although no unambiguous, widely used definition of the term is available, the concept 'nuisance' was successfully mapped for the Dutch context in a research project commissioned by a ministerial working group in 1995, which identified several clusters of behaviours and perceptions. However, measurement and monitoring of nuisance pose considerable challenges (Garretsen et al., 1996).

public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour.

(Report by Justice Wood, quoted from van Beek, 2002)

The report initiated a process of public debate that resulted in the scientific trial of a medically supervised injecting centre in Kings Cross, which opened in May 2001.

In response to large street-based heroin markets and associated risks of infectious disease and overdose deaths in many Canadian communities, health and policy authorities called for the establishment of supervised injection sites, especially in major cities (Kerr and Palepu, 2001; Palepu et al., 2001; Wood et al., 2001; Fischer et al., 2002; Fry, 2002). Backed by studies on the potential public health and community impacts of such facilities (Wood et al., 2003; Kerr et al., 2003; Fry, 2003) and following intensive national debate, a supervised injection site scientific research pilot project began in September 2003 in Vancouver's Downtown East Side.

## 2.3 Expected benefits and risks of consumption rooms

Typically, the establishment of supervised consumption facilities in a neighbourhood is preceded by long periods of discussions, during which the divergent interests of public and individual health, public order and safety, local residents and businesses, law enforcement and local administration, and to some extent also drug users' interest groups, are weighed against each other. In none of the cities in which rooms have been established was the decision to do so easy or quick. However, the intensive discussions – often in the framework of coordination schemes established by local authorities – did lead to more realistic expectations of consumption rooms on the part of all involved, but especially among the key actors, i.e. police and social services (e.g. Klein, 2002 for Frankfurt). In their analysis of the dynamics of drug policy-making in metropolitan areas, Kübler and Wälti (2001) conclude that local policy coordination schemes effectively started a collective learning process, during which the various actors mutually adjusted their practices in order to reduce counterproductive effects of formerly uncoordinated activities (Kübler and Wälti, 2001, p. 50).

Going beyond the common reaction of the opponents of such services that the rooms would 'send the wrong message', police and health experts in the cities accepted the facilities as a pragmatic solution and as one part of a comprehensive demand reduction strategy, extending existing services and approaches to tackle serious problems of health and public order.

The expected benefits and risks related to the three main objectives of consumption rooms are described below.

### 2.3.1 First objective: To reach as much of the target population as possible

Target populations are typically defined as high-risk problem drug users, especially regular or long-term users of heroin and cocaine, drug injectors, drug-using sex workers, street users and other marginalised, often not in treatment, groups. To achieve their public health and order objectives, services must be used. They should thus:

- attract the target population and be run so that supervised consumption is acceptable to drug users and clients continue to attend regularly;
- provide sufficient capacity at local level, in the right places and at the right times, to achieve coverage of the target population.

Potential risks include:

- People other than the intended target group might use the service and new people could be recruited into drug use.



- Service policy may make it difficult for clients such as more marginalised or chaotic users to attend on a regular basis, reducing the impact of the room.

### **2.3.2 Immediate health objective: To provide a safe environment that enables lower-risk, more hygienic drug consumption**

Expected benefits are reductions in the immediate harms that can arise from drug consumption, especially those related to hurried drug injecting in public places. To achieve this, consumption rooms seek to ensure that:

- drugs are consumed under hygienic conditions and safer use is facilitated;
- rapid care is available in the event of emergencies.

Effects that might be considered risks include:

- Better conditions for drug use could increase levels of drug use or encourage riskier patterns of use.

### **2.3.3 Medium term health objective: To reduce morbidity and mortality**

Expected benefits to be achieved through health promotion and safe use education at consumption rooms are:

- sustainable improvements in knowledge and risk awareness among clients;
- reduced high-risk behaviour beyond the consumption room setting itself;
- reduced exposure to and transmission of drug-related infectious diseases;
- reduction in overdoses.

Safer use and management of drug emergencies at consumption rooms should contribute to a reduction in overdose-related deaths in the community.

The following might be considered a possible risk:

- Consumption rooms increase morbidity and mortality by 'condoning' injecting.

### **2.3.4 Long term health objective: To stabilise and promote the health of service users**

Expected benefits of consumption rooms are that they:

- increase access to and use of basic medical care and counselling through on-site services;
- improve drug treatment uptake and promote longer term improvements in clients' health and social functioning through referral to other services.

The following might be considered to be possible risks:

- Clients use the consumption rooms only and are still 'not reached' by medical, counselling and treatment services.
- Consumption rooms may foster service dependence and hold clients back from starting treatment by making drug use more 'comfortable'.
- They might counteract the effects of treatment (e.g. allowing clients in oral methadone treatment to use the rooms for injection).

### **2.3.5 Public order objective: To reduce public drug use and associated nuisance**

Expected benefits

- reduced drug use in public, especially drug injection;
- reduced level of nuisance in neighbourhoods with visible drug scenes

## Possible risks

- Pull effect – consumption rooms might attract increasing numbers of drug users from other neighbourhoods or cities.

### 2.3.6 Public safety objective: to prevent increased crime in and around consumption rooms

Consumption rooms have been considered as potential ‘magnet’ for drug users and dealers, resulting in more public nuisance and crime.

The rooms therefore aim to prevent:

- increases in acquisitive crime in the neighbourhood;
- increases in drug-dealing in the neighbourhood;
- drug dealing and other criminal activity inside the rooms.

Table 4 provides an overview of objectives and related benefits and risks of consumption rooms. Not all consumption rooms pursue all objectives.

**Table 4: Objectives and expected benefits and risks**

Objective	Expected benefits	Expected risks
To reach as much of the target population as possible	The services attract the target population and are run so that supervised consumption is acceptable to drug users and clients continue to attend regularly; sufficient capacity is provided at local level, in the right places and at the right times, to achieve coverage of the target population.	People other than the intended target group use the service and new people are recruited into drug use. Service policy makes it difficult for clients such as more marginalised or chaotic users to attend on a regular basis, reducing the impact of the room.
To provide a safe environment that enables lower-risk, more hygienic drug consumption	Immediate harms that can arise from drug consumption, especially those related to hurried drug injecting in public places are reduced by ensuring that drugs are consumed under hygienic conditions and safer use is facilitated; and that rapid care is available in the event of emergencies.	Better conditions for drug use increase levels of drug use or encourage riskier patterns of use.
To reduce morbidity and mortality among the target population	Health promotion and safe use education at consumption rooms result in sustainable improvements in knowledge and risk awareness among clients; reduced high-risk behaviour beyond the consumption room setting itself; reduced exposure to and transmission of drug-related infectious diseases; reduction in overdoses. Safer use and management of drug emergencies at consumption rooms contribute to a reduction in overdose-related deaths in the community.	Consumption rooms increase morbidity and mortality by ‘condoning’ injecting.
To stabilise and promote the health of service users	Clients’ access to and use of basic medical care and counselling is increased through on-site services; uptake of drug treatment is improved; longer term improvements in clients’ health and social functioning are promoted through referral to other services.	Clients use the consumption rooms only and are still ‘not reached’ by medical, counselling and treatment services. Consumption rooms foster service dependence and hold clients back from starting treatment by making drug use more ‘comfortable’. They counteract the effects of treatment (e.g. allowing clients in oral methadone treatment to use the rooms for injection).

To reduce public drug use and associated nuisance	Reduced drug use in public, especially drug injection; reduced level of nuisance in neighbourhoods with visible drug scenes.	Pull effect – consumption rooms attract increasing numbers of drug users from other neighbourhoods or cities.
To prevent increased crime in and around consumption rooms	Cooperation agreements with the police prevent increases in acquisitive crime and drug-dealing in the neighbourhood.  Drug dealing and other criminal activity inside the rooms is prevented by staff.	Consumption rooms are feared to be potential 'magnets' for drug users and dealers, resulting in more public nuisance and crime.

## 2.4 Availability of studies on consumption rooms

Studies of consumption rooms that are reviewed in this report were identified by searching databases, journals and conference proceedings. A network of international experts on drug consumption rooms <sup>(7)</sup> helped to access grey publications. Existing bibliographies <sup>(8)</sup> served as basis for the bibliographic search, which focused on new publications after January 2001. However, a number of key studies from earlier dates have also been included in this report.

### 2.4.1 Early studies

At the end of the 1990s, several publications on the functioning of consumption rooms as well as on their role within a broader framework of services were available. These included, for example, two monographs in German that brought together articles by Swiss and German experts on legal and policy issues and on practice standards emerging from the still very 'young' services (Stöver, 1991; Klee, 1997). A first comparative analysis of consumption rooms in the Netherlands, Germany and Switzerland was published by the NIAD Institut in Utrecht (de Jong, 1996). A significant step in terms of wider accessibility of information was the publication – in English – of guidelines for the operation and use of consumption rooms that had been developed at an international conference (Akzept, 2000).

In Sydney, Australia, a Committee of the New South Wales Parliament began with an inquiry into the costs and benefits of safe injecting rooms in July 1997. An extensive report, based on hearings involving national and international experts, researchers and policy-makers, study visits to European consumption rooms and an analysis of published studies, was presented seven months later (Parliament of New South Wales, 1998).

Between 1998 and 2000, available evidence on the effects of the rooms was reviewed in several papers (e.g. Weber and Schneider, 1998; de Jong and Weber, 1999; Dolan et al., 2000). The number of sources considered in these reviews was, however, limited, and most authors referred to the same studies, conducted during the early years of operation of the consumption rooms in Berne, Zurich, Basle, Lucerne, Frankfurt and Hannover (Hämmig, 1991, 1992a,b, 1995; Sozialamt der Stadt Zürich, 1993, 1995; Ronco and Spuhler, 1994; Ronco et al.,

<sup>(7)</sup> Members of the expert group: Carlos Alvarez Vara (Madrid), Christopher Eastus (FOPH Berne), Jo Kimber (University of New South Wales), Eberhard Schatz (AMOC Amsterdam), Heino Stöver (University of Bremen), Luis Torralba (City of Barcelona), Ingrid van Beek (MSIC Sydney), Theo van Dam (LSD Drug Users Union), Carmen Vecino (City of Barcelona), Judit Wolf (Trimbos Instituut) and Heike Zurhold (ZIS, Universität Hamburg).

<sup>(8)</sup> Online-bibliographies on consumption rooms were available at the websites of Archido, Bremen ([www.archido.de](http://www.archido.de)), the Lindesmith Library ([www.lindesmith.org](http://www.lindesmith.org)) and the Australian Drug Foundation ([www.adf.org.au](http://www.adf.org.au)).

1994; Kemmesies, 1995; Geense, 1997; Jacob et al., 1999; Minder Nejedly and Bürki, 1999). Furthermore, access by international researchers to research results was limited by the fact that most studies were published in German (except for Kemmesies, 1995 (translated into English in 1999); Geense, 1997; and some studies by Hämmig). Several of the studies were internal reports to funders, analysing service monitoring data and the results of quantitative and qualitative surveys of clients and staff. The reviews concluded that the rooms contributed to improved public and client health and reductions in public nuisance but stressed the limitations of the evidence and called for further and more comprehensive evaluation studies into the impact of such services.

#### **2.4.2 Further and more recent studies**

In 1999/2000, Kimber et al. conducted an international survey of 39 supervised consumption rooms in Germany, the Netherlands, Spain and Switzerland (Kimber et al., 2001), which provided a systematic overview of differences and common elements of service delivery across services. Also in 2001, the results of a European Commission-funded project, presenting evaluation data from three drug consumption rooms in Hamburg and four in Rotterdam, were published (Zurhold et al., 2001). Further Rotterdam data were later published by van der Poel et al. (2003).

In the Netherlands, a literature review, commissioned by the Social Addiction Policy Development Centre at the Trimbos Instituut, included five evaluation studies of consumption rooms that had been conducted in Rotterdam, Venlo, Arnhem and Apeldoorn between 1997 and 1999 (Linssen et al., 2001). These studies had used a follow-up research design, assessing the effects of the rooms on client health, referrals to further addiction care and public nuisance (Warner, 1997; Biesma and Bielemann, 1998a,b,c; Biesma & Bielemann, 1999). Further studies applying the same design were conducted by Biesma et al. (2000) in Apeldoorn, and Meijer et al. (2001) in Groningen. Following the literature review, a handbook on the operation of consumption rooms and a detailed description of the functioning of the rooms, both based on a full telephone survey of official rooms in the Netherlands as well as visits to several services, were published by the same group of authors at the Trimbos Instituut (Linssen et al., 2002; Wolf et al., 2003).

The most comprehensive study carried out so far was a survey of all 19 consumption rooms that were in operation in Germany in 2001. The study was commissioned by the Ministry for Health and conducted in 2002 (Poschadel et al., 2003). In the framework of this study, operational data from the 19 rooms were analysed to check their performance. Surveys of clients, staff and police as well as direct observations were performed to identify weaknesses and best practice, and compliance with the legal minimum standards was checked. In addition, the researchers carried out an analysis of data on drug-related deaths in four cities, in order to determine whether the rooms had had any effect on the number of deaths.

Service monitoring data are made available through annual activity reports from all facilities in Germany. Some of these reports present detailed analyses of the data on utilisation and client characteristics (e.g. IDH 2000, 2001; AIDS Hilfe, 2002; MFJFG NRW, 2002; INDRO, 2003), the results of cross-sectional client surveys or in-depth analyses of emergency data (Happel, 1997, 2000; Happel and Steinmetz, 2001). At city level, capacities, opening hours and coordination of consumption room services have been assessed in Hamburg and Frankfurt, both of which have several rooms (Gessenharter et al., 1999; Baumgärtner, 2000; BAGS, 2001; Drogenreferat der Stadt Frankfurt, 2002; Prinzleve and Martens, 2003).

A number of in-depth evaluation studies of consumption rooms have recently been published in Switzerland. In particular, the rooms in Biel (Benninghoff and Dubois-Arber, 2002; Spreyermann & Willen, 2002), Geneva (Benninghoff et al., 2003; Groupe Sida Genève, 2003), Berne (Reyes Fuentes, 2003), Zurich (Spreyermann and Willen, 2003) and Olten (Willen, 2002) have been evaluated. Complex research designs were applied, including a combination of qualitative and

quantitative methods: interviews, observations, focus group discussions, quantitative surveys among staff and clients, the analysis of service monitoring data and secondary data analysis (e.g. crime, police interventions, syringes found in public places). A particular feature of the Swiss studies is that they apply research instruments that have been used to examine risk behaviour in other local studies with low-threshold client populations in the context of the evaluation of the Swiss AIDS prevention strategy throughout the 1990s, which allow the analysis of trends in risk behaviour over time.

Data from consumption rooms in Spain are still scarce, partly because the rooms have only recently been established. So far, service monitoring data have been documented for DAVE Madrid by the implementing agency and its medical coordinator (Agencia Antidroga, 2000; Díaz-Gutiérrez, 2001; Ministerio del Interior, 2002). To date, no evaluation of the facility in Can Tunis in Barcelona, which is run by a non-governmental organisation in charge of a range of other projects in the same area, has been conducted. However, a number of conference presentations (Anoro et al., 2001, 2003a; ABD, 2002) and a description of the functioning of the service and its problematic situation in the local policy and funding context are available (Anoro et al., 2003b).

The scientific trial of a medically supervised injecting centre in Sydney, conducted between May 2001 and October 2002, included process, outcome and economic evaluations (MSIC Evaluation Committee, 2001), the results of which were published in a comprehensive report in summer 2003 (MSIC Evaluation Committee, 2003).

### **2.4.3 Methodological challenges**

To measure the impact of consumption rooms on health and social integration is a challenging and limited exercise: firstly, consumption rooms are not the only means by which changes in these areas could have been achieved (problem of causality); and, secondly, the length of time required for possible effects to become apparent is necessarily longer than the observation period. Researchers have tried to overcome these barriers by using a variety of different evaluation tools, which has allowed them to gain an insight into the functioning and effects of consumption rooms (Benninghoff et al., 2003, p. 15). As with all analyses of the health impact at community level, the level of coverage of the target behaviour plays an important role.

With regard to measuring the effects of the services on public nuisance, the choice of indicators and research methods will depend on the definition of 'public nuisance' applied, which might differ between countries or even between cities. A further challenge in designing research in this area is to define, within the specific local context, which variables the operation of a consumption room can be expected to influence and which other aspects of nuisance, e.g. those related to local drug markets, are not expected to be influenced by the facility itself, and how the level of local cooperation between health and police actors might influence any results in this area.

Methodological limitations of indicators used to measure the outcome and impact of the operation of consumption rooms have been discussed in several recent studies (see for example MSIC Evaluation Committee, 2003 or Benninghoff et al., 2003). The indicators for which data are presented in this report are summarised in Table 5 below. Their limitations are briefly addressed in the relevant parts of the report.

**Table 5: Indicators per objective**

Objective	Indicators
To reach as much of the target population as possible	Profile of service users; levels and patterns of use of consumption rooms; location and opening hours; coverage of target populations at city level
<i>Immediate health objective:</i> To provide a safe environment that enables lower-risk, more hygienic drug consumption	House rules on hygiene and safety; supervision and 'tailor-made' risk reduction advice; emergencies: types and outcomes; levels and patterns of drug use
<i>Medium-term health objective:</i> To reduce morbidity and mortality among the target population	Client knowledge of risks (overdose, infections); changes in risk-taking behaviour; incidence of infectious diseases; drug overdoses and deaths
<i>Long-term health objective:</i> To stabilise and promote client health	Availability of other services on-site; use of on-site services: e.g. medical care; client self-reports regarding health and satisfaction with services; referrals to treatment and other services
<i>Public order objective:</i> To reduce public drug use and associated nuisance	Client self-reports on locations for drug consumption; neighbourhood surveys on public drug use and nuisance; police reports and observations; discarded syringes; data on clients' area of residence
<i>Public safety/crime objective:</i> To prevent increased crime in and around consumption rooms	Local crime surveys; police crime statistics and observations; reports and observations from consumption room staff; client surveys/interviews

## 3 Reaching the target group

### First objective: to reach as much of the target population as possible

Target populations are typically defined as high-risk problem drug users, especially regular or long-term users of heroin and cocaine, drug injectors, drug-using sex workers, street users and other marginalised, often not in treatment, groups. To achieve their public health and order objectives, services must be used. They should thus:

- attract the target population and be run so that supervised consumption is acceptable to drug users and clients continue to attend regularly;
- provide sufficient capacity at local level, in the right places and at the right times, to achieve coverage of the target population.

Potential risks include:

- People other than the intended target group might use the service and new people could be recruited into drug use.
- Service policy may make it difficult for clients such as more marginalised or chaotic users to attend on a regular basis, reducing the impact of the room.

### 3.1 Characteristics of service users

The data presented in this chapter have been drawn from 15 key studies that are presented in more detail in Annex I, Tables A and B, and references to these studies are not included in the text. When additional sources were used or when data from these key studies were reported that are not contained in Tables A and B, the references are provided.

#### 3.1.1 Age, sex and drug use profile

The typical user of consumption rooms is older than 30 and has a history of problem drug use – mainly of heroin and/or cocaine – going back 10 or more years. Clients under 20 and recent drug users with a history of problem drug use of only one or two years' duration are uncommon, while the number of registered clients in their 40s, 50s and even 60s has increased in recent years (IDH, 2000, 2001; Drogennotdienst, 2002). Cross-sectional client surveys conducted in 1990, 1995 and 2001 at the longest established injecting room, the Fixerstübli in Berne, clearly document that its client population is ageing: the average age of service users increased from 26 in 1990 to 30 in 1995 and to 33 in 2001. Also, in 1990, 50 % of clients were 25 years or younger, but this figure had fallen to less than 15 % by 2001. The data also show that, over time, those who use the facility are increasingly characterised by heavy injecting drug use, poorer socioeconomic conditions, and - despite a wide range of treatment offers - continuous use of illicit drugs (Minder Nejedly and Bürki, 1999; Reyes Fuentes, 2003).

Most service users, 70–90 %, are men, except in those consumption rooms (Hamburg and Rotterdam) that specifically target the population of drug-using sex workers.

Studies from consumption rooms in Berne, Biel, Geneva, Frankfurt and Sydney have also found that the majority of consumption room users are 'frequent injectors' of heroin and/or cocaine (several times per week to several times per day). In the Netherlands, consumption room clients are also typically 'frequent drug users', but most clients inhale/smoke drugs.

There are many public injectors among those who use consumption rooms. In the month prior to registering at the MSIC in Sydney, 39 % of clients had injected in a public place; and among those registering at the injecting room in Geneva, 20 % reported they had made their last injection in a public location.

Admission criteria for consumption rooms usually explicitly exclude experimental or intermittent users. This in itself makes it unlikely that consumption rooms attract and inadvertently initiate naive users. Occasionally, however, difficult situations can arise. In their evaluation of the injecting room in Geneva, Benninghoff et al. (2003) reported that 4 out of 736 clients who registered with the service during the first year of its operation indicated they had had their first injection at the facility. In eight other cases this was suspected but not confirmed. In Berne, seven (4.5%) of the 154 clients surveyed in 1995 and four (2.7%) of the 147 clients surveyed in 2001 indicated they had had their first injection at a low-threshold service with consumption room. Service policy is to discourage clients from injecting for the first time and send them away; some services would however not withhold hygienic facilities if a user remains determined to inject.

### **3.1.2 Housing**

A significant minority of drug users who come to consumption rooms to use drugs have no permanent address and live in temporary accommodation or emergency shelters. Studies conducted in German cities found that between 19 % and 27 % of clients live in unstable accommodation. A recent survey of all German consumption rooms found that 5 % of clients live 'de facto' in the street. In Geneva and in Biel, Switzerland, recent studies found that 8 % and 11 % of injecting room clients, respectively, were without fixed accommodation. The percentage of consumption room users in Berne without accommodation of their own and who lived with friends or parents or in shelters increased from 8 % in 1990 to 33 % in 2001.

Homelessness is very high among the marginalised target populations of the injecting rooms near Madrid (42 %) and in the Can Tunis area of Barcelona (60 %; Anoro et al., 2003b). As homelessness is one of the main criteria for admission to consumption rooms in the Netherlands, the proportion of Dutch consumption room clients who have no fixed abode is usually high, for example 30 of 67 consumption room pass-holders surveyed in Rotterdam had no permanent address.

Out of 3 810 clients who registered with the supervised injecting centre in Sydney during the 18-months trial, 11 % reported living in unstable accommodation.

### **3.1.3 Sources of income**

Unemployment and dependence on social welfare payments are common among consumption room users. Clients in Frankfurt, Hamburg, Rotterdam, Geneva and Sydney, only one-quarter or fewer reported having income from permanent employment. In Berne, the rates of permanent or temporary employment decreased and dependence on social welfare payments and invalidity pensions increased between the beginning of the 1990s and 2001.

### **3.1.4 Imprisonment**

Many consumption room clients have been in prison. Lifetime prevalence of imprisonment was between 50 % and 75 % in Swiss studies (Geneva, Biel, Berne) and 38 % among clients of an injecting room in Spain.

In Sydney, 26 % of the registered users of the supervised injecting centre had been imprisoned in the 12 months before registration. Client surveys at injecting rooms in Biel and Geneva found rates of recent imprisonment (in the previous two years) of 38 % and 20 % respectively.

### **3.1.5 Place of residence**

Information on the place of residence of service users has been collected in several studies. In one of the first German studies, 63 % of service users at a consumption room in Frankfurt in 1995 were found to be local (Happel, 1997). During the second half of the 1990s, admission



policies in many German and Swiss rooms increasingly excluded non-locals from using the services (see section 5.1.2). In Lucerne (Ronco and Spuhler, 1994), Geneva (Benninghoff et al., 2003) and Hannover (Jacob et al., 1999), researchers found that about 80 % of service users were resident in the city or its surroundings. However, at the same time, in Lucerne intensive police activity had targeted non-locals and discouraged them from staying in the city, and in Geneva a special 'drug task force' had, since March 2002, been reinforcing existing interdiction measures against non-locals. Even higher rates of local users were found in other studies: of 441 clients registered at a consumption room in Biel, 93 % were local residents (including those in temporary accommodation) of the city or canton. Among MSIC users, 42 % were resident in its local area and a further 36 % in other parts of the city. Both groups together accounted for 91 % of all consumption visits (MSIC Evaluation Committee, 2003).

### 3.1.6 Previous treatment experience

Half of drug users registering at the consumption room near Madrid reported having been in treatment before (Agencia Antidroga, 2000). Among consumption room clients interviewed in Germany in 2002, 50 % had experienced drug-free treatment and 43 % substitution treatment (including many who had experienced both types of treatment), but 15 % had never been in any type of addiction treatment. For one-third of all interviewees, a consumption room had been the 'entry point' into the drugs help system (Poschadel et al., 2003, p. 118).

Among 3 810 registered clients in Sydney, two-thirds had already been in treatment for their addiction at least once, and about one-quarter reported having entered treatment in the previous year (mainly methadone maintenance treatment; MISC Evaluation, 2003, Table 2.6).

### 3.1.7 Current contact with other drugs services

The proportion of consumption room clients who are currently in substitution treatment varies according to national and local admission policies. Most German services do not allow clients who are in substitution treatment to use the consumption areas. In an interview survey conducted in 18 consumption rooms in Germany, 11 % of 168 clients reported that they were currently in methadone treatment (Poschadel et al., 2003), while a study conducted in one consumption room without access limitations found that 40 % of clients were in substitution treatment (Jacob et al., 1999). In Switzerland, being in substitution treatment does not exclude clients from using consumption rooms, and client surveys in Geneva and Biel have found rates of users in current treatment of 72 % and 80 % respectively (for comparison, the national coverage level of substitution treatment among heroin users in Switzerland is estimated to be around 60 %; Zobel et al., 2003). In local studies, for example among users of low-threshold services, rates of clients in substitution treatment can be even higher<sup>(9)</sup>. In Sydney, too, clients receiving substitution treatment are eligible to use the injecting centre (Kimber and van Beek, 2002).

Close cooperation with other services and client referrals are an essential part of the service policy of consumption rooms, in particular of the so-called 'specialised' services, and the parallel use of social and health care services in addition to consumption room facilities is reported by between 31 % and 88 % of clients (see Tables A and B, Annex I). The main complementary services are low-threshold facilities that provide needle and syringe programmes, medical care and social and counselling services, as well as shelter accommodation. Often, these services are located in close vicinity to the consumption rooms.

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<sup>(9)</sup> In the context of a service satisfaction study among 505 clients of all six low-threshold services in Zurich, conducted in summer 2003, 70% of respondents were currently in substitution treatment (R. Vogt and R. Blättler, ADH Zürich, personal communication, October 2003).

## 3.2 Utilisation and coverage

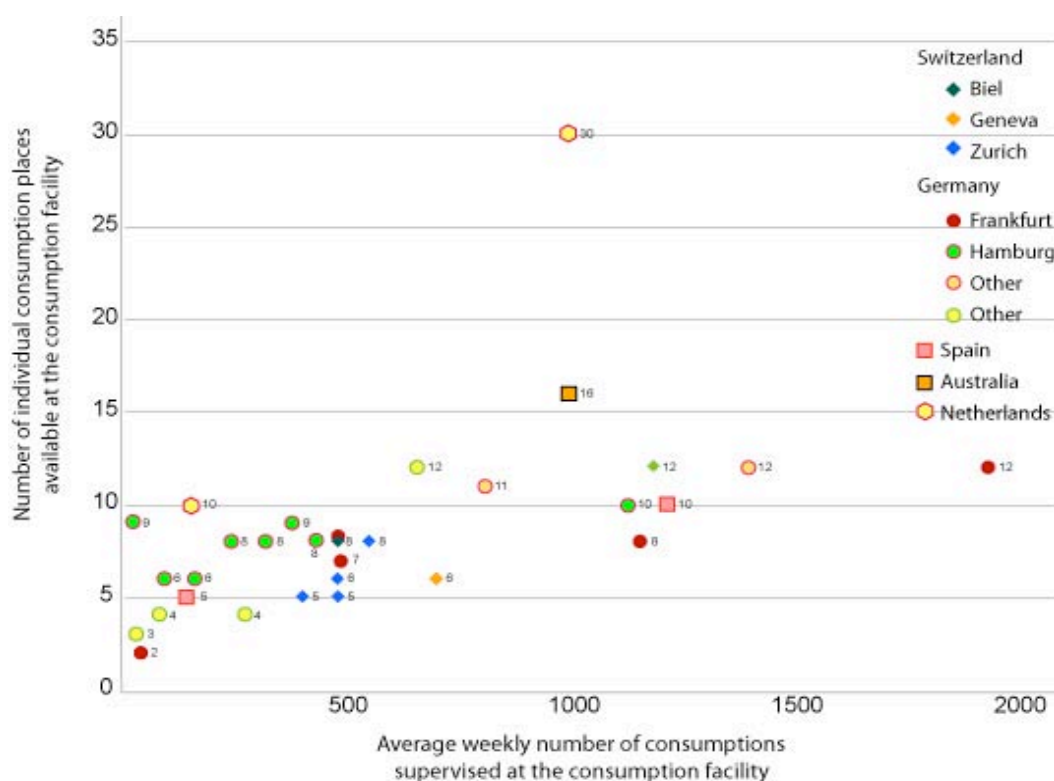
### 3.2.1 Drugs used in consumption rooms and route of administration

Heroin and cocaine are the main drugs used in consumption rooms, including as mixtures, and the main mode of drug consumption is injecting, except in the Netherlands, where most service users smoke drugs. All Dutch facilities have separate areas for those who inhale and those who inject. In recent years, inhalation rooms have also been established in Switzerland and Germany, as additional facilities on the same premises as injecting rooms, to respond to changing local drug use patterns, to promote less risky forms of consumption among injectors and to reduce health risks among those who inhale (see pilot studies: Willen, 2002; Spreyermann and Willen, 2003). In facilities in Germany and Switzerland that allow both routes of administration, injecting is still by far the predominant mode of consumption. Only in one facility for sex workers is drug inhalation predominant.

### 3.2.2 Utilisation

The average weekly number of supervised consumptions varies from fewer than 50 in small services in decentralised locations to nearly 2 000 in large facilities located near illicit drug markets. Data on the weekly average number of supervised consumptions at selected rooms are given in Figure 3.

**Figure 3: Capacity and utilisation of selected consumption rooms**



Sources: **Germany**: Data on weekly average consumptions for 18 consumption rooms in Germany: Poschadel et al., 2003 (Reporting Year: 2001) and for Saarbrücken (estimate for Year 2000): Kimber et al. 2001. **Switzerland**: For five rooms in Zürich (Year 2002), and for the facilities in Biel (Year 2001/2002) and Geneva (Year 2002): Spreyermann and Willen 2002 and 2003; Benninghoff et al., 2003. For the MISC **Sydney** (est. based on last six months of trial period, Year 2002): MSIC Evaluation Committee, 2003. For **Amsterdam**: AMOC/DHV, 1999 (est. average number of visits, registered in 1998) and **Rotterdam** (est. based on average number of 150 daily users reported by Wolf et al., 2003). For the rooms in **Madrid**: Ministerio del Interior, 2002 (est. based on first six months in 2002) and **Barcelona**: ABD, 2002.

Patterns of service utilisation also vary. Client monitoring systems for some consumption rooms, such as the services in Sydney and Madrid, reveal a high client turnover and low rates of regular use.

During the 18-month trial period, 3 810 drug users registered with the service in Sydney and made a total of 56 861 visits – an average of 15 visits per client (range 1–646). The average number of injections supervised per week increased from 468 in the first six months of the trial to 852 in months 7–12 and reached 1 049 during months 13–18 of the trial <sup>(10)</sup> (MSIC Evaluation Committee, 2003). Analysis of the patterns of service attendance during the 18 months of operation revealed that 62 registered clients never used the facility and that, of the remaining 3 748 users, one-third (1 274, 34 %) visited only once, 41 % made 2–10 visits and only one-quarter (937) attended the service on 11 or more occasions. Frequent injectors and those who were engaged in sex work in the month prior to registration were more likely to be in the latter group (MSIC Evaluation Committee, 2003; Kimber et al., 2003b).

The consumption room near Madrid (DAVE) reached 5 086 different drug users during its first 26 months of operation from May 2000 to June 2002 and provided supervision for a total of 80 671 drug injections, an average of 15 injections per client (Ministerio del Interior, 2002). Further information on clients' patterns of service attendance was not available.

Possible reasons put forward for a low rate of regular use include specific aspects of service management, ambience and house rules, a large transient population and high rate of user turnover in the local drugs scene.

Regular, frequent use of consumption rooms seems to be more common in Germany, Switzerland and the Netherlands.

A quantitative analysis of service monitoring data collected during one week each month between May and September 1998 at a consumption room in Frankfurt found that 500–600 different drug users visited this service each week (Happel, 2000). During this period, the average weekly number of injections supervised at the facility was 2 650 <sup>(11)</sup>, which implies that, on average, clients used the facility five times per week. These results confirm the information collected in an earlier study through interviews with drug users in Frankfurt (Kemmesies, 1995), in which respondents reported that they used consumption rooms on average on five occasions each week.

The use of all low-threshold drugs services with consumption rooms in Zurich (Kontakt- und Anlaufstellen, K&As) is monitored annually. The results of the 2001 and 2002 surveys, based on clients sampled over one week ( $n = 159$  and  $158$  respectively), show that frequency of utilisation of K&As was on average higher than five times per week (R. Blättler, ADH Zurich, personal communication, August 2003).

Data from interview surveys of clients contribute to a further description of patterns of service attendance and confirm considerable rates of regular service utilisation in Germany and Switzerland. In a study conducted in 1997, 63 % of injecting room users in Frankfurt reported using the service more than once a week, with 34 % claiming to be daily visitors (Happel, 2000). In a recent study of a non-random sample of 168 consumption room users at 18 German consumption rooms, 84 % claimed to use the facilities more than once a week, including 51 % who said they used the rooms at least once a day (Poschadel et al., 2003, p. 117).

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<sup>(10)</sup> Recalculated from Chapter 2.3.3 of the final report, plus data from 6-month and 12-month evaluations.

<sup>(11)</sup> The total number of consumptions from May to September 1998 at this consumption room was 95 474 (Poschadel et al., 2003, p. 232).

The service policy of consumption rooms affects their patterns of utilisation. For example, in the Netherlands, where the principal aim of the rooms is to reduce public nuisance (Barendregt et al., 2002; Wolf et al., 2003), many facilities admit only a small number of drug users who satisfy specific criteria (e.g. homelessness), have a large number of consumption places which are available for long hours including at weekends, and do not impose time limits on their clients because they aim to achieve high coverage of the target behaviour drug use in public'. As a result of this policy, many Dutch consumption rooms have very high rates of regular users. For example in a survey of 67 pass-holders at consumption rooms in Rotterdam, respondents reported that they had, on average, visited their consumption room on six days in the week before the study (median 7 days for each of the four facilities) and twice within the preceding 24 hours (van der Poel et al., 2003). The stringent selection criteria with regard to the rooms' target group, the obligation of card-holders not to consume drugs in public and an effective protection of neighbourhood interests through influential local residents' committees and nuisance registers, complemented by increased police surveillance near the rooms, all contribute to this high rate of regular use.

Benninghoff and Dubois-Arber (2002) conducted a full client survey at a drugs service with a consumption room in Biel during one week in 2002. A total of 86 clients participated in the survey (response rate < 86 %), of whom 16 used only the café, 21 the inhalation room, 31 the injecting room and 18 both consumption rooms. The majority of the 49 clients who used the injecting room were found to be regular visitors, with 9 out of 10 users visiting at least once per week, including 43 % who were daily visitors. About half of the clients reported that the injection room had been the location they most frequently used drugs during the past six months; the others reported that their main place of consumption was their own home.

### 3.2.3 Location and opening hours

In an interview study of 168 service users, Poschadel et al. (2003) found that, in addition to the provision of safe and hygienic conditions for drug consumption (see section 4.1), one of the main reasons for using consumption rooms (reported by 27 % of interviewees) was the closeness of the facilities to the places of drug purchase. A smaller group said that they used the service because there was nowhere else for them to go to consume drugs: 5 % because they were homeless and 8 % because they did not want to confront their family members at home with their drug use.

In an analysis of the number of visits made to three consumption rooms in Frankfurt during their first months of operation, Kemmesies (1995) found that the distance of the facilities from the drug market was an important factor that determined levels of use.

While in Hamburg the decentralised consumption rooms seem to be underused, the capacity and opening hours of the few services close to the drug market appear to be insufficient to meet the demand (see Figure 6 below and Box 5).

#### **Box 5: Decentralisation consumption rooms – experiences from Hamburg**

In 1990, the area around the main train station in Hamburg (district St Georg) had become a large illicit drug market. In order to reduce the health- and nuisance-related problems caused by the open drug scene in the area, three consumption rooms were integrated into drugs services located outside the district between 1994 and 1997. In addition, at the end of 1997, a further consumption room (with seven places for drug injecting) was established in St Georg itself to service a local population of drug users, especially ageing drug users in poor health, who had been identified as a group that was difficult to dislocate.

The 'decentralisation' of drug services, even if this meant locating them in areas where there had never been any demand for such a service, was an important factor in making the establishment of consumption rooms in Hamburg politically acceptable (Zurhold, 2002). In most cases, use of the decentralised facilities remained low, the illicit drug market continued in the St

Georg district and problems associated with public drug scenes persisted. By April 1998, these problems had reached a critical level among residents and local businesses, and the Senate announced its decision to establish an additional four or five decentralised consumption rooms. At the same time, a mediation process to determine whether expansion of existing consumption capacity in St Georg would be desirable, useful or necessary was launched.

The mediation involved about 25 institutions and organisations as well as citizens and interest groups from the area (e.g. local policy-makers, residents, representatives of drugs services and of the police). All participants agreed that there was an urgent need for action with regard to the open drug scene at the main train station/St Georg, but no consensus could be reached, as each group had very different and sometimes conflicting priorities, which led to their selective perception of the highly complex and dynamic situation. The mediator's proposal to the Senate was a stepwise expansion of capacity in the existing service combined with an increase in active attempts by staff to direct drug users to services outside the district. The effects of this measure should be evaluated and ultimately, if not successful, a further consumption room be opened within walking distance of the service in St Georg. The mediator also proposed the establishment of local committees at all consumption rooms in the city to enable residents to voice their fears and problems, and to participate in decision-making (Gessenharter et al., 1999).

The proposal was only partly implemented by an expansion of evening opening hours of the consumption room in St Georg while at the same time closing the service on Saturdays. The effects of both changes on the local area as well on the use of six 'decentralised' consumption rooms were monitored (Baumgärtner, 2000). It was found that the clients made intensive use of the facility during the expanded opening hours between 20.00 and 22.00 hours, and that a higher percentage of female drug users and of drug users with a high frequency of drug use used the facility in the evening. Closing the service on Saturdays did not increase the levels of use of 'decentralised' rooms; instead those who were formerly 'Saturday visitors' shifted to drug use in private settings and in public.

The effects of further extending the opening hours until midnight (introduced in 2003 on demand by local residents) on the number of drug users in the public space were examined using survey and observational methods (Prinzleve and Martens, 2003). The results showed that, during the expanded hours of service, there was a large reduction in the number of users consuming drugs in public. This positive effect outweighed the degree to which evening services attracted drug users into the area.

Dutch services are open for eight to nine hours each day, including at weekends, and usually no waiting is necessary at those services that target a limited number of homeless drug users (Wolf et al., 2003). However, some larger services report problems related to overcrowding (van der Poel et al., 2003).

Extended opening hours in the evening can attract specific target populations into the consumption rooms. A study in Hamburg (Baumgärtner, 2000) found that the percentage of female users and of very frequent injectors could be increased in one service by allowing it to open for a longer time in the evening. More female drug users attend if the facility is located near the places of sex trade (see also Box 5 above).

A dramatic increase in the average weekly number of injections at DAVE (Madrid), which has 10 places, was achieved when daily opening hours were extended from 14 to 24 hours in January 2001. During 2000, the weekly average number of injections was 160; during 2001, this number steadily increased, reaching 1 130 during the first half of 2002. In addition to increasing opening hours, the range of services was expanded, including the provision of an emergency centre that offers medical and social services and referrals, as well as overnight accommodation for 50 drug users (Ministerio del Interior, 2002).

Newly established consumption rooms in Germany, Switzerland and Australia were quickly accepted by clients and achieved high use levels after only six months of operation, or even

sooner (Kemmesies, 1995; Sozialamt der Stadt Zürich, 1995; Happel, 1997; Spreyermann and Willen, 2002; MSIC, 2003). In contrast to the rapid acceptance and uptake of such facilities in these countries, Wolf et al. (2003, p. 652) found that in the Netherlands:

... a new facility opening its doors may not be immediately swarmed with clients. It takes some time for new facilities to enrol clients for several reasons. Some users want nothing to do with care services, they feel such facilities may thwart their efforts to cut back on drugs, or they might not wish to conform to the rules and demands that the facility makes on them.

Thus, how extensively the rooms are used depends largely on their location and their service policy, in particular opening hours and access criteria. Whereas rooms in Switzerland, Germany and especially in the Netherlands report high rates of regular service users, the services in Sydney and Madrid have a high client turnover.

### 3.2.4 Coverage of target populations: some examples from city level

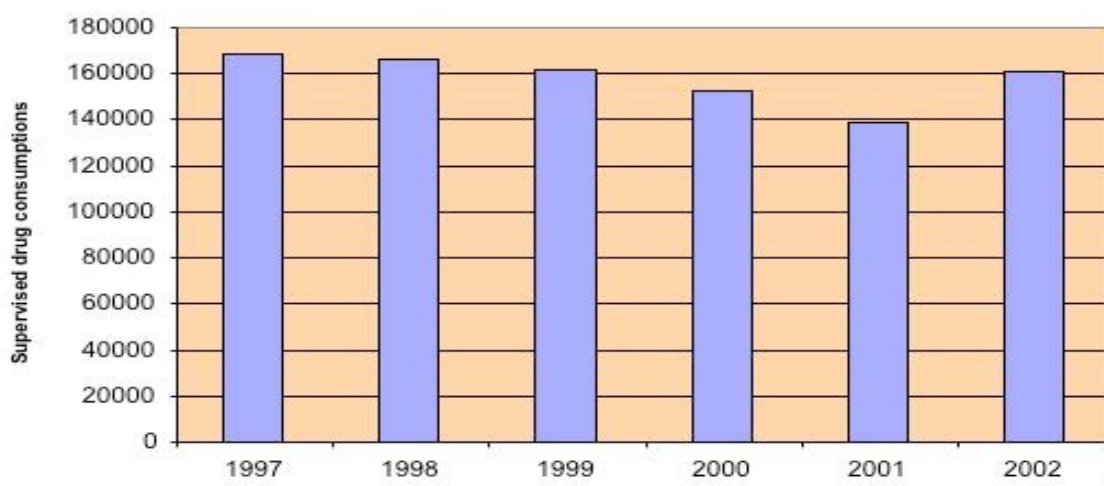
In the early 1990s, the cities of Frankfurt, Hamburg and Zurich were confronted with large open drug scenes. In all three cities, consumption rooms were introduced as part of a wider local response to the public health and order problems arising from this situation.

#### *Zurich*

After closing down the large, centralised public drug scene in Zurich in 1992, three consumption rooms were opened to provide alternative locations for drug injecting. However, an evaluation study conducted in 1993 and 1994 found that the capacity of the three rooms did not meet the demand and, in particular, was insufficient to achieve a significant reduction in public nuisance (Sozialamt der Stadt Zürich, 1995). Following an increase in the number of rooms to six in 1995, public drug consumption in the city has successfully been reduced. The number of supervised consumptions was stable around 3 000 per week during the period 1997–99 (Spreyermann and Willen, 2003) but declined in 2000 when one of the services was closed. New facilities for drug inhalation were opened in 2001 and 2002.

In 2002, the five consumption rooms in Zurich provided 36 places for drug injecting and inhalation and operated seven days a week for a total of about 250 coordinated weekly opening hours, hosting about 3 100 consumptions per week (see Figure 4). A service evaluation study conducted in 2002 found that, on average, clients use consumption rooms more than five times per week (R. Blättler, ADH Zurich, personal communication August 2003).

**Figure 4: Total number of supervised drug consumptions in all consumptions rooms in Zurich, 1997 - 2002**



Source: Spreyermann and Willen, 2003, p. 19.

### Frankfurt

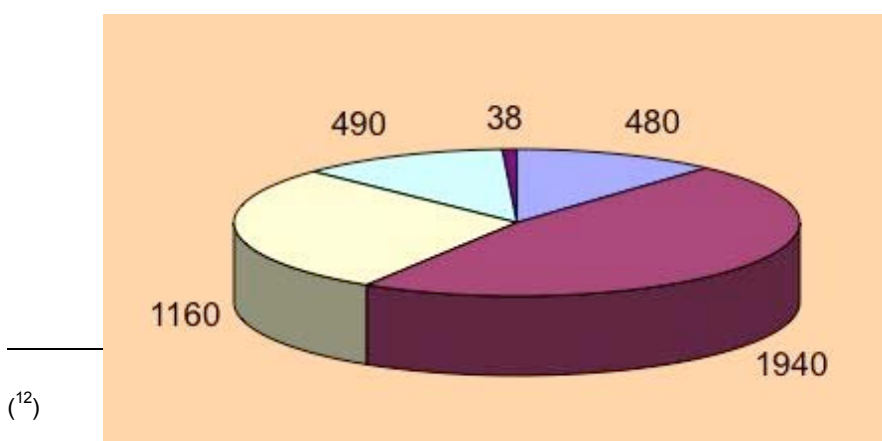
In Frankfurt, a wide range of services for drug users, including outreach health education, shelters and methadone maintenance treatment, were introduced in the early 1990s as the result of a new local policy programme (Stadt Frankfurt am Main, 1991). The primary target group of the consumption rooms was a population of 300–400 highly problematic street injectors (of a total estimated number of 6 000–8 000 drug users who obtained their supply of drugs in Frankfurt) who continued to inject in public around the train station and in a nearby public park despite the availability of various drugs services. Between December 1994, when the first consumption room was opened, and August 1996, capacity was gradually increased while the effect of the rooms on the open drug scene was monitored.

In his study of the first months of operation of three injecting rooms in Frankfurt in 1994/95, Kemmesies (1995) found that there were queues during busy periods, and cocaine injectors in particular were not willing to wait and continued to use in public. The study concluded that the existing capacity of 22 places open for a total of 100 hours per week was insufficient to tackle public drug use effectively.

A significant reduction in the visible drug scene in Frankfurt was achieved only when a fourth consumption room was established in August 1996, increasing the number of available places to 35, and opening hours of all four rooms together were extended to a total of about 300 hours per week. Service delivery was coordinated so that capacity during periods of high demand was increased and supervised injecting possibilities available daily between 6.00 o'clock in the morning and midnight. A recent study found that this expansion of service provision and coverage coincided with a reduction in drug-related deaths in Frankfurt (see section 4.2).

One room is integrated into an emergency shelter for 70 drug users and the other three are located in the train station area at varying distances from the places where drugs are sold (Körner, 1995). The rooms admit only drug injectors. All four rooms are open from Monday to Saturday and three are also open on Sundays <sup>(12)</sup>; increased capacity is provided during times of high demand, e.g. in the evenings (until midnight). In 2001, a total of about 4 100 injections were supervised each week in the four rooms. The distribution of the consumptions across the five facilities in Frankfurt is presented in Figure 5 below. This capacity is considered to be sufficient to meet demand by the local target population of problematic, long-term injectors (R. Ernst, Head of Drogenreferat Frankfurt/M, personal communication, June 2002).

**Figure 5: Weekly average number of supervised injections in consumption rooms in Frankfurt, 2001**



<sup>(12)</sup>

290 per week. In 1998, meless in Frankfurt. Its reported in 2001 was 38

Source: Poschadel et al., 2003



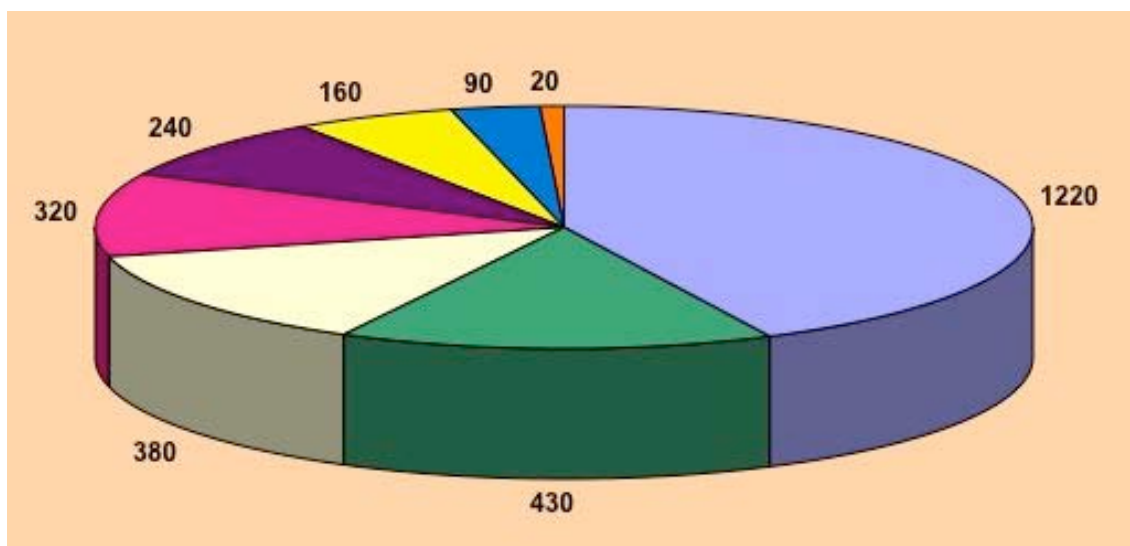


### Hamburg

In Hamburg, police estimate the total number of drug users to be between 7 000 and 8 000 (Zurhold et al., 2001). Since 1994, eight consumption rooms have been established, providing a total of 58 places for supervised drug injection and inhalation for a total of 300 hours per week. The city follows a policy of 'decentralisation' of the drug scene via consumption rooms (see Box 5). Hamburg has considerably more consumption places than Frankfurt and Zurich, and a lower overall rate of consumptions per available place: about 2 860 <sup>(13)</sup> supervised consumptions take place each week. The distribution of the consumptions across the eight facilities in Hamburg is presented in Figure 6 below.

The use of 'decentralised' rooms is low, whereas services close to the illicit drug market cannot meet the existing demand and public nuisance problems resulting from open drug scenes persists. One decentralised service was closed in 2002. The political decision to shut down a further service in Hamburg was announced in summer 2003.

**Figure 6: Weekly average number of supervised consumptions in consumption rooms in Hamburg, 2000/2001**



Source: Poschadel et al., 2003.

A contact café with consumption room was opened in Biel, Switzerland, in August 2001 after the authorities had closed a 'scene' restaurant, where about 20–40 drug users met daily. The room aimed to prevent the emergence of an open drug scene in the city. When the consumption facility was planned, it was assumed that 10–20 % of an estimated target population of 600 drug users would use it and five places for drug injecting and four inhalation places were made available for 42 hours per week. During its first year of operation however, a total number of 515 individual drug users registered with the service and the average weekly number of consumptions was 480. A client survey conducted as part of the evaluation study found that a high proportion of clients were regular users of the service (Spreyermann and Willen, 2002).

<sup>(13)</sup> Based on annual data for 2001 from consumption rooms C to H and data for 2000 for consumption rooms A and B, reported in Poschadel et al. (2003).

### 3.3 Conclusions on reaching the target population

Consumption rooms reach a population of often older, long-term users some of whom have had no previous treatment contact. Services appear particularly successful in attracting groups that are difficult to reach. No evidence was found to suggest that naive users are initiated into injecting as a result of the presence of consumption rooms.

Service users' sociodemographic data and drug use profile are similar across countries. Data show that the rooms reach the intended target groups of long-term addicts, street injectors, homeless drug users and drug-using sex workers and are thus facilitating contact with the most problematic and marginalised drug users. Demographic information also shows that these services can be successful in reaching long-term drug users with no previous contact with treatment services.

Many of those who use consumption rooms are simultaneously in contact with other low threshold drug and help services (i.e. shelters and needle and syringe programmes). This reflects the potential role of consumption facilities as integrated parts of a wider service network that reaches and maintains contact with this hard-to-reach population. It might also reflect a more general service dependence among the ageing population of problem drug users that uses these facilities.

Service utilisation is influenced by the accessibility of the service and its sensitivity to the life situation and needs of drug users. Given the profiles of the service users, it appears highly likely that many of the supervised consumptions would have taken place in public if the services had not been available.

Even in cities with large populations of drug users, the consumption room capacity required to satisfy the demand of the target population so that drug injecting in public is significantly reduced and open drug scenes are prevented is not huge. However, capacity should be adjusted to the needs and limitations of the target population (e.g. many older drug users are in poor physical condition, which restricts their mobility): services should be located near places of drug purchase, at day-care centres and at overnight shelters for drug users, and they should be open in the evenings and at weekends.

## 4 Health

Consumption rooms have three objectives with regard to the reduction of health risks: they aim to provide safe and hygienic drug consumption opportunities (immediate objective), to reduce mortality and morbidity among the target population (medium-term objective) and to stabilise and promote the health of their clients (long-term objective).

### 4.1 Hygiene and safety conditions

**Immediate health objective: To provide a safe environment that enables lower-risk, more hygienic drug consumption**

Expected benefits are reductions in the immediate harms that can arise from drug consumption, especially those related to hurried drug injecting in public places. To achieve this, consumption rooms seek to ensure that:

- drugs are consumed under hygienic conditions and safer use is facilitated;
- rapid care is available in the event of emergencies.

Effects that might be considered risks include:

- Better conditions for drug use could increase levels of drug use or encourage riskier patterns of use.

#### 4.1.1 House rules and service standards

All consumption rooms have house rules (e.g. no alcohol use, no sharing of injection equipment, no injecting in the neck or groin, prohibition of certain substances or modes of consumption) and adhere to certain service standards. Drug users who want to use a consumption room have to comply with these rules and procedures, including meeting basic standards of hygienic and practising lower-risk injecting. The necessary consumption equipment, including sterile syringes and needles, water, filters, swabs, spoons/cookers, aluminium foil and further drug consumption paraphernalia, is provided, usually free of charge. After use, staff ensure that consumption equipment is safely disposed of and disinfects the consumption area and equipment that is going to be re-used, e.g. spoons<sup>(14)</sup>. Sufficient time for an unhurried consumption is allowed, usually at least 30 minutes<sup>(15)</sup>, with several services not limiting the time a user can spend in the consumption area.

All drug consumptions are supervised with regard to respect for hygiene and overdose risks. Supervising staff provide safer use advice (Box 6) but are not allowed to assist clients to use drugs. The direct observation of high-risk behaviour allows staff to give advice that is geared to the individual client and risk situation. The opportunity to convey 'tailor-made' risk education messages to individual users depending on risks observed is considered to be a particular advantage of consumption rooms. Tailor-made messages have been discussed by several authors as a means of promoting behavioural changes towards lower-risk drug use (Geense, 1997; Happel and Steinmetz, 2001; Dubois-Arber et al., 1999; Zurhold et al., 2001; van Beek, 2003; Spreyermann and Willen 2003; Benninghoff et al., 2003).

<sup>(14)</sup> One study reported disagreement about hygienic requirements for spoons used at consumption rooms. While the local infectious disease prevention unit recommended sterilisation of the spoons, the experts of the advisory committee based on a risk assessment of the disinfectant in use, considered disinfection to be sufficient (Benninghoff et al., 2003, p. 28).

<sup>(15)</sup> Services that supervise mainly heroin injections report that clients spent on average half an hour in the consumption area. Rooms that supervise mainly cocaine injections report shorter consumption times of about 15 minutes.

### **Box 6: Safer use education**

Safer use education can include advice on:

- basic hygiene rules, e.g. 'washing hands';
- choice of syringe and needle types;
- vein selection, site rotation, use of peripheral veins;
- injection technique: angle of penetration, use of tourniquet;
- dosage;
- vein care.

A systematic effort to increase and maintain safer use knowledge among clients of consumption rooms is made by some Dutch services. Permission to use the facility is given on the basis of a contract between the service and the user that obliges the drug user to attend safer use training courses.

#### **4.1.2 Hygiene and safety as reasons for attendance**

Clients consider the hygienic consumption conditions, medical supervision and the availability of emergency care as important reasons to use consumption rooms (Minder Nejedly and Bürki, 1999; Zurhold et al., 2001; Benninghoff and Dubois-Arber, 2002; Poschadel et al., 2003; Reyes Fuentes, 2003). For example, 70 % of 168 interviewees in a client survey conducted in consumption rooms throughout Germany said that they were less afraid of suffering health damage from drug use when they used under supervision. Responding to an open question of what aspects of consumption rooms they appreciate most, about half (48 %) mentioned the hygienic conditions, one-third (36 %) the medical services, including the emergency aid, and 31 % the fact that they no longer had to use in public (Poschadel et al., 2003).

The facility to consume drugs in an atmosphere free from fear of being disturbed by police or other drug users and dealers, and thus to avoid the risks related to hurried consumption, is another important reason why drug users make use of consumption rooms (Ronco and Spuhler 1994; Kemmesies, 1995; Geense, 1997; Happel, 2000; Benninghoff et al., 2003; Poschadel et al., 2003; Reyes Fuentes, 2003). For most consumption room users in Berne surveyed in 1990, 1995 and 2001 (59 %, 86 % and 71 % respectively), the ability to 'inject in peace' was a main reason for using the service. Between 40 % and 47 % of clients surveyed specified as a reason the fact that they 'don't have to fear the police' (Reyes Fuentes, 2003). The protected environment was considered by 47 % of consumption room users in Germany as a positive aspect (Poschadel et al., 2003, p. 119).

#### **4.1.3 Emergencies and outcomes**

##### *Types of emergencies*

The main types of emergencies occurring in consumption rooms are drug overdoses (mainly heroin overdoses with symptom respiratory depression) and epileptic seizures. Allergic reactions to drugs are very rare. Cocaine-related emergencies (main symptoms: hyperventilation, panic attacks and restlessness) are often registered separately from opiate overdoses, but only few services keep systematic records of the severity of overdoses and other emergencies, using established medical schemes.

Most emergencies that occur at consumption rooms are related to heroin: four out of five overdoses recorded during the 18-month trial of a MSIC in Sydney were heroin related, and 15 % were due to cocaine (MSIC Evaluation Committee, 2003). Similar patterns are reported from Germany: in 2000, out of more than 300 emergencies occurring at a major consumption room in Frankfurt, 81 % were heroin overdoses with different levels of respiratory depression, 14 % epileptic seizures and 5 % cocaine-related emergencies (IDH, 2001). In 2001, the

emergency staff of another, smaller room attended 119 emergencies inside and outside the service, with 73 % of victims suffering respiratory depression, mostly after combined use of heroin with crack and/or alcohol, and 18 % seizures, often triggered by mixtures of tablets, crack and/or alcohol (AIDS Hilfe, 2002).

### *Emergency rates*

Emergency rates at consumption rooms vary considerably. Very low emergency rates were reported from injecting rooms in Switzerland and Spain: in 1993–94 the three rooms in Zurich recorded 0.5 emergencies per 1 000 injections (Sozialamt der Stadt Zürich, 1995), and recent studies of the injecting rooms in Biel and Geneva found rates of 0.9 and 1.8 per 1 000 injections respectively (Spreyermann and Willen, 2002; Benninghoff et al., 2003). The injecting centre DAVE (Madrid) documented 1.3 emergencies per 1 000 supervised injections during its first two years of operation (C. Alvarez Vara, Antidrug Agency of the Autonomous Government of Madrid, personal communication, February 2003).

In Germany, the number of emergencies registered in consumption rooms over the period 1995–2001 ranged from 1.6 to 3.5 per 1 000 supervised consumptions (including consumptions by injection and inhalation), with an increasing trend. Rates reported from most services oscillate around 3 per 1 000, and rates above 4 per 1 000 are rare (Poschadel et al., 2003). However, in 2002, one German service reported 6.8 emergencies per 1 000 supervised consumptions (INDRO, 2003).

The MSIC in Sydney recorded seven drug overdose-related incidents requiring clinical management per 1 000 injections during its 18-month trial phase (MSIC Evaluation Committee, 2003).

Drug inhalation carries a much lower risk of overdose than does injecting, and inhalation rooms report very few incidents requiring emergency intervention. For example, at an inhalation room in Switzerland, an emergency rate of one overdose per 8 000 inhalations was reported (Spreyermann and Willen, 2002). Reliable data on emergencies in consumption rooms in the Netherlands are not available<sup>(16)</sup>; however, most drug consumptions are inhalations and overdoses are likely to be rare.

Consumption rooms are frequently located near open drug scenes, and staff of the facilities also provide emergency aid outside their premises. This is particularly true of the emergency team of the injecting room DAVE near Madrid, which attends four times more cases in the open drug scene than inside the facility (Díaz-Gutierrez, 2001; C. Alvarez Vara, Antidrug Agency of the Autonomous Government of Madrid, personal communication, February 2003).

An in-depth analysis of emergencies that occurred outside one consumption facility (including a survey of the victims) showed that emergencies in the street tended to be more severe than those inside the room, usually because the victims had also consumed alcohol or opiates and the CNS depressant effects of these had aggravated the emergency (Happel and Steinmetz, 2001). The 'external' emergencies attended by the emergency staff of this facility resulted in an ambulance call-out more often than those that occurred inside the service (56 % vs. 43 %), suggesting that overdoses caused by drug consumption in public tend to be more severe than those occurring in consumption rooms (Happel, 1997).

### *Outcomes of emergencies*

Depending on staffing and other resources on site, emergencies are dealt with by the staff of the consumption rooms alone or with the assistance of an ambulance team.

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<sup>(16)</sup> From a major Dutch facility with approximately 1 000 consumptions weekly, an overdose rate of one per year was reported (Zurhold et al., 2001, p. 157).

Some injecting centres have a fully equipped medical emergency room and a doctor or nurse present at all times (Sydney, Madrid); most services in Germany and in Switzerland operate without the permanent presence of a doctor, but their staff includes nurses as well as other professionals trained in first aid. Staff of the consumption room in Sydney dealt with 98 % of emergencies without external help (MSIC Evaluation Committee, 2003). At services which do not have a doctor present at all times, ambulance attendance is requested in 50–70 % of emergencies (Happel, 1997; Jacob et al., 1999; AIDS Hilfe, 2002; Spreyermann and Willen, 2002), and instructions at several such services define a low threshold for ambulance calls. However, quite often the emergency situation is already solved by the time the ambulance arrives (IDH, 2001; AIDS Hilfe, 2002).

An important reason for staff to call an ambulance is that only doctors are allowed to administer the opiate antagonist naloxone, a medication that reverses narcotic depression resulting from severe opiate overdose<sup>(17)</sup>. An analysis of emergencies, ambulance calls and interventions at a German consumption room showed that an ambulance was called in 71 % of emergencies and that naloxone was administered in 59 % of the cases attended by an ambulance – or 42 % of all emergencies (Happel and Steinmetz, 2001). At the MSIC in Sydney, where naloxone is administered by qualified staff on-site, it was required in 25 % of the 329 heroin-related overdoses that occurred during the 18-month trial (MSIC Evaluation Committee, 2003).

At a large consumption room in Germany, ambulance attendance call-out rates following an emergency increased from less than 50 % in 1998 to 71 % in 2002. According to the manager of the service, the reasons for the increase include an increase in the number of clients in poor health (which makes them vulnerable to overdose), more ambiguous emergencies due to cocaine-related toxicity and a rising number of psychiatric symptoms. Because of these increasingly complex patterns of emergencies, fewer members of staff are willing to deal with emergencies without external support (J. Steinmetz, consumption room Manager, personal communication, December 2002).

Of those who suffer an emergency at a consumption room, a small number have to be hospitalised for further observation. Injecting facilities in Frankfurt and Sydney report that 2.2–8.4 % of emergencies result in hospitalisation (Table 6).

One death has been reported from a supervised consumption facility. In December 2002, a drug user died from anaphylactic shock<sup>(18)</sup> at a German consumption room (INDRO, 2003; Gerlach and Schneider, 2003).

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<sup>(17)</sup> In Germany, the distribution of naloxone to peers of drug users, combined with training in first aid, has recently been piloted (see Korporal and Dangel-Vogelsang, 2002).

<sup>(18)</sup> An anaphylactic shock is a severe systemic reaction in a susceptible individual upon exposure to a specific antigen (such as wasp venom or penicillin) following previous sensitisation. It is a medical emergency characterised by respiratory symptoms, fainting, itching, urticaria, swelling of the throat or other mucous membranes and a sudden decline in blood pressure. Source: <http://www.hon.ch/Library/Theme/Allergy/Glossary/shock.html>.

**Table 6: Hospitalisation after emergencies at three major injecting rooms**

Name, Location / Source	Number of injections supervised during observation period	Number of emergencies	Number of hospitalisations	Percentage of emergencies that resulted in hospitalisation
Konsumraum Frankfurt, January 1999 to July 2000 (IDH, 2000, 2001; Happel and Steinmetz, 2001)	214 682 <sup>(1)</sup>	641 <sup>(2)</sup>	33	5.1 %
La Strada Frankfurt, January to December 2001 (AIDS Hilfe, 2002)	25 596	119 <sup>(3)</sup>	10	8.4 %
MSIC Sydney, May 2001 to October 2002 (MSIC Evaluation Committee, 2003)	56 861	409 <sup>(4)</sup>	9	2.2 %

(1) Poschadel et al. (2003).

(2) Includes 103 emergencies outside the facility.

(3) Includes 16 emergencies outside the facility.

(4) Drug overdose-related clinical incidents.

#### 4.1.4 Effects on the level of drug use

Some surveys among consumption room clients have included questions about the perceived effect of the consumption rooms on the level of drug use. One study in Switzerland (Geense, 1997) found, among a small sample of 15 consumption room users, two who claimed that attending a low-threshold facility with an injecting room had helped them to control their consumption, or even reduce it. However, five of the interviewed drug addicts said that they had increased their use of drugs since they had begun to use the facility.

In a more recent Swiss study, Benninghoff et al. (2003) interviewed 17 service users in Geneva; two attributed a reduction and three an increase in their drug use to the supervised facility.

In a follow-up study of 60 drug users registered at a newly established consumption room in Groningen, levels of drug taking reported upon registration and after a period of up to four months of service use were compared. The authors found reductions in the levels of heroin and cocaine use, whereas polydrug use remained unchanged and the use of non-prescribed medicaments increased (Meijer et al., 2001).

Self-reported changes in the levels of drug use attributed to the use of a consumption room were examined among 67 admission pass-holders of four consumption rooms in Rotterdam. While 12 % of respondents ( $n = 8$ ) reported that they used drugs less often, 16 % ( $n = 11$ ) stated that they smoked or injected more frequently since starting to use the facility (van der Poel et al., 2003).

Self-reported changes in the frequency of injecting were also examined among clients of the injecting room in Sydney in 2001 and 2002 ( $n = 152$  and  $199$  respectively): 10 % and 9 %, respectively, reported that they injected more frequently, whereas 16 % and 22 % respectively reported that they injected less frequently since starting to use the facility. Most of those reporting increased frequency of injection also reported cocaine injection while most of the MSIC participants reporting decreased frequency reported heroin injection (MSIC Evaluation Committee, 2003, section 5.3.2 & 5.4.3).

A reduction in their drug use was attributed to the use of consumption rooms by 5 % of 168 service users interviewed by Poschadel and colleagues in Germany in 2002 (Poschadel et al., 2003, p. 124).

#### 4.1.5 Conclusions with regard to hygiene and safety conditions

Consumption rooms achieve the immediate objective of providing a safe place for lower risk, more hygienic drug consumption without increasing the levels of drug use or risky patterns of consumption.

Direct benefits of supervised injecting appear to be a reduction in some of the risk behaviours related to injecting, in particular improvements in injecting practice, use of sterile equipment and lack of opportunity for sharing drugs. Other benefits are that, if medical emergencies should occur, immediate medical intervention is possible, and the consumption equipment used in the rooms is correctly disposed of. Client surveys consistently show that service users appreciate the hygienic conditions, safety and peace that the rooms provide.

Through direct observation of clients' risk-taking behaviour, safer use advice can be personalised. The observation of risks and experiences in the risk education of consumption room users could be useful in developing safer use messages for the wider population of drug users.

Trained staff respond quickly to emergencies, which can usually be managed at the service level without hospitalisation. Some evidence suggests that outcomes of emergencies occurring within consumption rooms are less severe than those taking place outside. Immediate medical emergency care reduces overdose morbidity and possibly also hospital admissions and therefore costs. There has been one death at a consumption room due to an allergic reaction, but there have been no reports of fatal overdoses.

Levels of drug taking can fluctuate for a variety of reasons, including changes in the availability of drugs on the illicit market. No causal evidence exists about the link between decreases and increases of drug consumption, reported by a minority of clients, and the operation of consumption rooms.

## 4.2 Do consumption rooms reduce morbidity and mortality?

### **Medium term health objective: To reduce morbidity and mortality**

Expected benefits to be achieved through health promotion and safe use education at consumption rooms are:

- sustainable improvements in knowledge and risk awareness among clients;
- reduced high-risk behaviour beyond the consumption room setting itself;
- reduced exposure to and transmission of drug-related infectious diseases;
- reduction in overdoses.

Safer use and management of drug emergencies at consumption rooms should contribute to a reduction in overdose-related deaths in the community.

The following might be considered a possible risk:

- Consumption rooms increase morbidity and mortality by 'condoning' injecting.



#### 4.2.1 Effects on risk-taking behaviour and infectious diseases

##### *Client self-reports and staff observations on risk behaviour*

Changes in drug use-related risk-taking behaviour among clients using supervised consumption facilities have been examined in a number of follow-up studies conducted in the Netherlands (see review by Linssen et al., 2001; Meijer et al., 2001). Further studies have compared risk taking in consumption room clients and drug users who do not use such a service (Benninghoff and Dubois-Arber 2002; MSIC Evaluation Committee, 2003) or analysed differences between cross-sectional samples of consumption room clients drawn from the same facility at different times (Ronco et al., 1996a; Minder Nejedly and Bürki, 1999; Reyes Fuentes, 2003). Several other studies have asked consumption room users whether they retrospectively attributed any changes in risk behaviour to their use of the services (Jacob et al., 1999; Zurhold et al., 2001; Poschadel et al., 2003; van der Poel et al., 2003). All studies relied on clients' self-reported risk behaviour as the data source.

Consumption room users in Arnhem (Linssen et al., 2001) were interviewed upon their registration and after 4–6 months of service use ( $n = 19$ ). The study found that, at the follow-up interview, clients had increased their knowledge about hygiene and safety of drug use and reported taking fewer health risks while using drugs, which they said was as an effect of the safer use education provided at the user room. A similar finding comes from a follow-up study among 60 registered users of the consumption room in Groningen, where the researchers examined clients' knowledge about injecting safety at registration and after up to four months of using the service. Although no reduction in the overall level of injecting was reported, knowledge about injecting safety had improved at follow-up, an effect that increased with the length of time for which the clients had used the service (Meijer et al., 2001).

Levels of self-reported risk behaviour were compared between a sample of 64 clients of low-threshold services in the city of Biel, who were surveyed in the context of a regular national cross-sectional study of low-threshold drugs services in 2000 (which was before a supervised injecting facility was established in the city), and a sample of 49 clients of the Biel injecting room, who were surveyed in 2002. The same questionnaire instrument, developed by the University Institute of Social and Preventive Medicine, Lausanne in the context of the evaluation of the national AIDS prevention strategy, was used (Dubois-Arber et al., 1999; Benninghoff et al., 2001; Benninghoff and Dubois-Arber, 2002). Sixteen per cent of the former sample compared with only 4 % of the latter reported having shared syringes during the previous six months. Levels of other injecting-related high-risk behaviour reported by injecting room users in 2002 were still high, with 33 %, 24 % and 15 % admitting sharing spoons, filters and water, respectively. In the 2000 survey of clients of low-threshold services these rates had been 49 %, 38 % and 25 %, respectively.

The same instrument was also used in a survey of clients of the consumption room in Geneva in May/June 2002, when the facility had been operating for five months. No significant differences were found in self-reported risk-behaviour of the 82 injecting room clients compared with drug users monitored in local surveys at low-threshold services in 1996 and 2000 (Benninghoff et al., 2003), except for the variable 'passing a used syringe to another drug user': while rates among low-threshold clients in 2000 ( $n = 59$ ) and 1996 ( $n = 53$ ) had been as high as 22 % and 18 % respectively, only 5 % of the 82 injecting room clients surveyed in 2002 had given a used syringe to another drug user during the past six months. The 2002-study also compared the consumption room users with a group of 18 drug users who did not use this type of facility despite its availability. The results suggested that levels of risk-taking with regard to injecting as well as of sexual risk-taking behaviour were higher among the consumption room users.

In cross-sectional surveys of injecting drug users in the Kings Cross area of Sydney, carried out in 2001 and 2002, MSIC users were more likely than MSIC non-users to exhibit a profile associated with problem drug use (i.e. a longer injection history and/or a higher frequency of injecting) and reported more frequent injecting-related problems such as abscesses, skin

infections and thrombosis. However, MSIC users were less likely to report problems related to bruising and scarring of veins, and nearly half of them reported that their injecting practices had improved since using the MSIC, resulting in less vein damage and soft-tissue injury and less blood loss during injection. MISC users were more likely than non-users to use new syringes/needles for all injections and less likely to share syringes or other equipment, but the differences were not statistically significant (MSIC Evaluation Committee, 2003).

Three cross-sectional surveys of clients at a consumption room in Berne, conducted in 1990, 1995 and 2001, show decreasing levels of risk behaviour: among the more recently interviewed clients, a higher percentage indicated that they had used sterile equipment at their first injection (1990: 77%; 1995: 91% and 2001: 96%) and an increasing proportion of clients said that they would never accept used injecting equipment (from 58% in 1990 to 75% in 1995). Furthermore, levels of resistance to condom use had decreased over time (Minder Nejedly and Bürki, 1999; Reyes Fuentes, 2003).

Among 105 clients of the consumption room in Hannover who were interviewed during the first year of operation of the service, 22 % attributed positive changes in injecting hygiene and 36 % a reduction in time spent in the open drug scene to the use of the consumption room (Jacob et al., 1999). In an interview survey of 67 registered consumption room users in Rotterdam, 90 % of interviewees reported positive changes in their drug use-related risk behaviour since visiting consumption rooms, in particular a decrease in drug use in public, improved hygiene and cleanliness and consuming less hurriedly and in a quieter environment, which reduces risks (Zurhold et al., 2001; van der Poel et al., 2003). The analysis suggests a 'dosage effect': the longer the 'exposure' to consumption rooms, the greater the reduction in high-risk behaviour.

Half of the consumption room users interviewed by Poschadel et al. (2003, p. 123) reported behavioural changes towards safer drug use which they attributed to the use of the consumption facility. The majority of this group (82.6 %) reported the systematic use of sterile syringes and other equipment.

Staff of consumption rooms report that a majority of clients consistently adopt hygienic practices after information about basic hygiene rules had been provided repeatedly over a period of several months (Benninghoff and Dubois-Arber, 2002; Benninghoff et al., 2003; Poschadel et al., 2003). In particular, tailor-made advice, based on direct observation of individual drug use behaviour and risks, helps clients to improve their injecting techniques and to reduce the direct harms of injecting (MSIC Evaluation Committee, 2003).

#### *Incidence and prevalence of infectious diseases*

The effect of the operation of a supervised consumption room on local incidence and prevalence of infectious diseases, i.e. HIV, HBV and HCV, was examined as part of the evaluation of the public health impact of the Sydney injecting centre. Notifications of newly diagnosed blood-borne virus infections reported in New South Wales were examined for Kings Cross and other geographical areas, and trends were compared over the trial period. However, a serious limitation of this indicator, which had already been raised in the evaluation protocol, was the low population prevalence of these infections in Australia, which made it unlikely that changes in the number of cases would be sufficient to detect any statistically significant trends (MSIC Evaluation Committee, 2001, p. 27). Data on HCV incidence among injecting drug users who were tested at a neighbouring drugs service during the trial period as well as data on reported HCV prevalence from surveys conducted between 1998 and 2002 among injecting drug users in the Kings Cross area were also analysed.

The evaluation study found that there was no evidence of an increase or decrease in the incidence of notifications of HIV, HBV and HCV in the locality of the injecting room that was attributable to the operation of the facility. HCV incidence remained stable among injecting drug users tested at the local drugs service. There was a trend towards increased HCV prevalence

among IDUs surveyed during the MSIC trial period that was consistent with national trends among injecting drug users (MSIC Evaluation Committee, 2003).

#### 4.2.2 Effects on overdose deaths in the community

Trained personnel who are able to give advice on dosage and application technique, house rules that exclude high-risk drug combinations (especially alcohol consumption) and which allow for unhurried conditions of drug consumption, as well as the availability of emergency services on-site or on call are expected to reduce the risk of fatal overdoses among drug users at supervised consumption rooms (see section 4.1).

Supervised drug consumption rooms are also expected to achieve a reduction in the number of drug-related deaths at community level. However, the impact of the facilities on drug-related deaths in their area depends on several factors, including the proportion of fatal overdoses in the community that are accounted for by the target population and the extent to which drug consumptions by the target population do in fact take place under supervision. Two recent studies in Germany and in Sydney (Australia) have examined the impact of consumption rooms on drug-related deaths in the community.

##### *Germany*

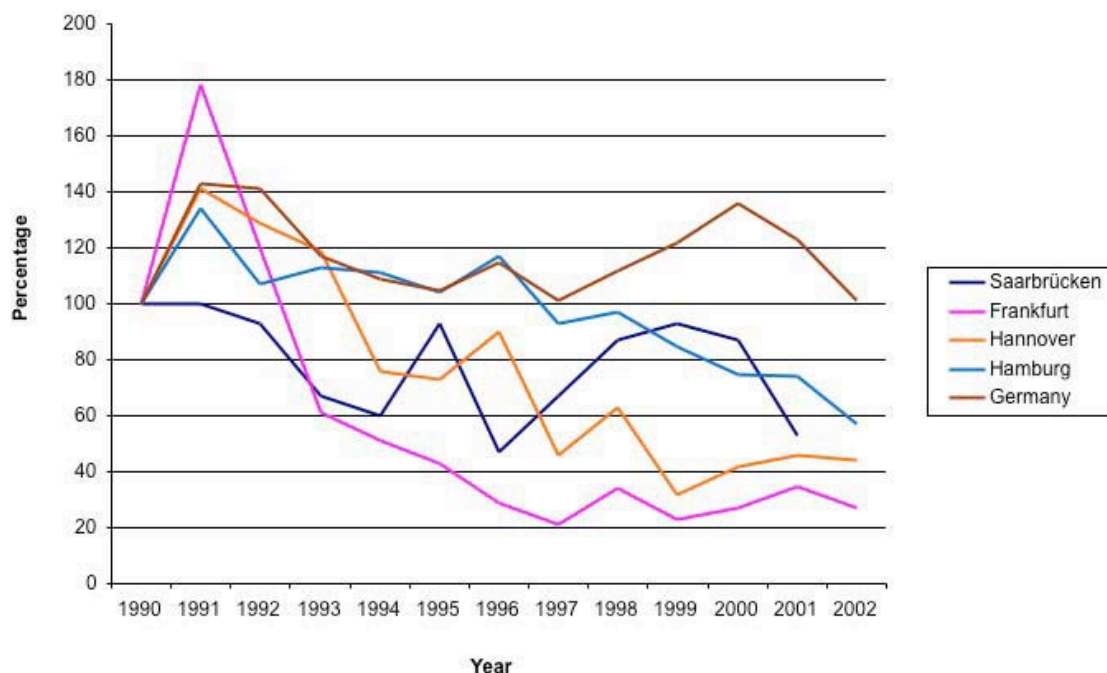
A full survey of consumption rooms in Germany, commissioned by the Federal Ministry for Health in 2001, included an analysis of the contribution of the rooms to the reduction in drug-related deaths at community level (Poschadel et al., 2003, pp. 140–54) through time-series analyses of police data on drug-related deaths. Monthly records of drug-related deaths for the period 1990–2001 were collected from four cities with consumption rooms: Saarbrücken, Hannover, Hamburg and Frankfurt. The methodological approach chosen was to apply a seasonal (12-month) ARIMA model to forecast the time series and to determine whether the opening of consumption rooms was reflected in any significant way in the data on drug-related deaths (Box 7).

#### **Box 7: ARIMA**

The acronym ARIMA stands for 'auto-regressive integrated moving average', a statistical method used to analyse time series. ARIMA models are also referred to as Box–Jenkins models (Box and Jenkins, 1976). Time series consist of a set of observations of some phenomenon taken at equally spaced time intervals. The purpose of time-series analyses is to model the mechanism that generates the observed data and, in turn, to forecast future values. The ARIMA model includes three parameters. Cyclic components can be integrated by using seasonal ARIMA models.

Trends in the development of drug-related deaths in Germany between 1990 (=100) and 2002 are shown in Figure 7 for the national level and for the four cities included in the time-series analysis.

**Figure 7: Trends in drug-related deaths in Germany between 1988 and 2002: national level, Frankfurt, Hamburg, Hannover and Saarbrücken (Indexed 1990 = 100%)**



Source: Bundeskriminalamt, 2003.

In the first half of the 1990s, the total number of drug-related deaths in Germany had shown a decreasing trend. Numbers fell from a the highest level ever of 2 125 drug-related deaths in 1991 (here indexed as 100) to 1 565 deaths in 1995. The trend reversed in 1996 with 1 712 deaths registered and further increases followed from 1998 until 2000, when 2.030 persons died from drug-use related causes in Germany. In 2001 and 2002, numbers decreased again to the low rates of the mid-1990s.

During the 1990s, many important changes to the response to problem drug use occurred in Germany, including an expansion of substitution treatment, establishment of low-threshold services and an intensification of outreach health education. However, timing and extent of such measures differed considerably between regions. Major cities like Frankfurt and Hamburg implemented large-scale harm reduction programmes already from 1991 onwards and consumption rooms were one among many elements of these programmes. Frankfurt opened its four main consumption rooms within a period of 32 months from the end of 1994 until August 1996. Hamburg established nine rooms between 1994 and May 1999. The rooms in Hannover and Saarbrücken were established in December 1997 and April 1999, respectively. In all four cities, decreases in the numbers of drug-related deaths preceded the establishment of the rooms.

Monthly data on drug-related deaths were available for a period of 11 years for Hamburg and Saarbrücken, nine years for Frankfurt and seven years for Hannover. With regard to data quality and the applicability of the ARIMA method, Poschadel and colleagues (2003) mention that according to the official case definition of 'drug-related deaths' in Germany, data include besides deaths from drug overdoses and other toxicity also suicide, accidents and long-term consequences of drug use <sup>(19)</sup>. Furthermore, not all registered drug-related deaths are

<sup>(19)</sup> In Germany 'drug-related death' is defined as death following intentional or unintentional overdose, suicide resulting from despair about the circumstances of life or the effects of withdrawal symptoms, fatal accidents suffered by people under the influence of drugs or deaths resulting from long-term abuse. (see also Box 9 in the online-version of the EMCDDA Annual Report 2003 on the State of the Drugs Problem in the European Union and Norway at:

confirmed though toxicological analyses <sup>(20)</sup>, which leaves some uncertainty about the absolute numbers. An important precondition for the use of the ARIMA time-series analysis was that no major changes had occurred in definitions and data collection procedures over the time under study, which was the case.

Following a visual inspection of the data series, the model parameters were estimated and an equation that reproduced the available original data series as exactly as possible was generated. Seasonal effects were identified and integrated into the models. Specific parameters about the intervention ('opening of consumption room') were then added to the model and a fit to the data series made. The analysis of the data was based on the assumption that the establishment of a consumption room is a permanent intervention and, thus, its effect should be long-lasting and stable over time. The researchers specified that any effect would be delayed by six months but then persist. This assumption about a delay is supported by monitoring data from several consumption rooms that show steadily increasing utilisation rates over the first half year of operation, followed by stabilisation (see Spreyermann and Willen, 2002; data annex in Poschadel et al., 2003; MSIC Evaluation Committee, 2003).

The fit based on the model that included the additional information about the intervention provided a statistically significant ( $p < 0.05$ ) improvement with regard to reproducing the original data series compared with the model without such information. The statistically significant and stable effect on drug-related deaths was achieved in Hannover and Saarbrücken six months after opening of the respective consumption room, in Hamburg after the third room was opened, and in Frankfurt after the fourth room had become operational. The researchers conclude that for the four investigated cities, "...the work of consumption rooms is statistically significantly related to the reduction of drug-related deaths" (Poschadel et al., 2003, p. iv), within the assumptions and approximations of the model used.

#### *MSIC Sydney*

During the trial of a medically supervised injecting centre in Sydney, as part of the evaluation of its impact on public health, the incidence of fatal drug-related overdoses in the surrounding area was assessed (MSIC Evaluation Committee, 2003). The protocol for the evaluation discusses a number of important technical reasons why the analysis of overdose death data is likely to be difficult. These include variations in monthly rates due to continued growth of heroin use, seasonal trends, random variation and independent historical events such as changes in police/heroin dealer activity, heroin availability, changes in the operation of 'shooting rooms', a change in the number of users in the area or other reasons. The researchers also considered the potential number of deaths that might be prevented with the available capacity of supervised consumption of 16 places for eight hours per day to be low and effects on overdose deaths in the community as possibly too small to be observable. The use of an interrupted time-series analysis to detect a change in the rate of overdose deaths achieved by a supervised consumption facility was in principle considered methodologically adequate, provided seasonal effects and other correlated variance in the death rate could be removed. However, because in the MSIC vicinity the base rate of deaths per month was low, this type of analysis was not applicable (MSIC Evaluation Committee, 2001, p. 23)

Examining other indicators, the MSIC evaluation study found no evidence that the operation of the facility affected the number of heroin overdose deaths in the Kings Cross area, which was explained by the significant confounding effect of a heroin shortage, coinciding with the opening of the MSIC, on drug-related emergencies and deaths:

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<sup>(20)</sup> <http://annualreport.emcdda.eu.int/en/page090-en.html>). In Germany, around 10 % of drug-related deaths are attributed to the effects of 'long-term abuse', which includes the health consequences of drug use, such as AIDS.  
In 2002, 72% of all 1513 drug-related deaths were confirmed through forensic analyses (Bundeskriminalamt, 2003).

... In the months preceding the opening of the MSIC, the number of opioid-overdose ambulance attendances and deaths decreased dramatically in the Kings Cross area and across NSW. These decreases were attributed to the substantial reduction in the supply of heroin in Australia that occurred at the same time.

(MSIC Evaluation Committee, 2003, p. 44)

The scope of the potential preventative effect of the MSIC was considered to be limited, as it covered less than 5% of the target behaviour: only 200 of the estimated 6 000 heroin injections that take place in the Kings Cross area per day occurred under supervision at the MSIC.

Further analyses of the impact of the service on the number of lives saved by overdose management within the MSIC <sup>(21)</sup> were conducted, using multipliers based on clinical and epidemiological evidence of fatal overdose, in order to estimate the proportion of overdoses at the centre that might have been fatal if they had happened elsewhere.

Of the 329 overdoses at the MISC over the eighteen-month trial period, severe respiratory depression necessitating the administration of naloxone occurred in 81 cases. Based on the relative rate of death per ambulance attendance at suspected drug overdose events in New South Wales, which is 1: 12 (8.12%), the number of cases expected to result in death would be six. On the basis of these analyses, the researchers estimate that clinical intervention by MSIC staff prevented at least four deaths per year.

#### *Deaths prevented by the work of German consumption rooms*

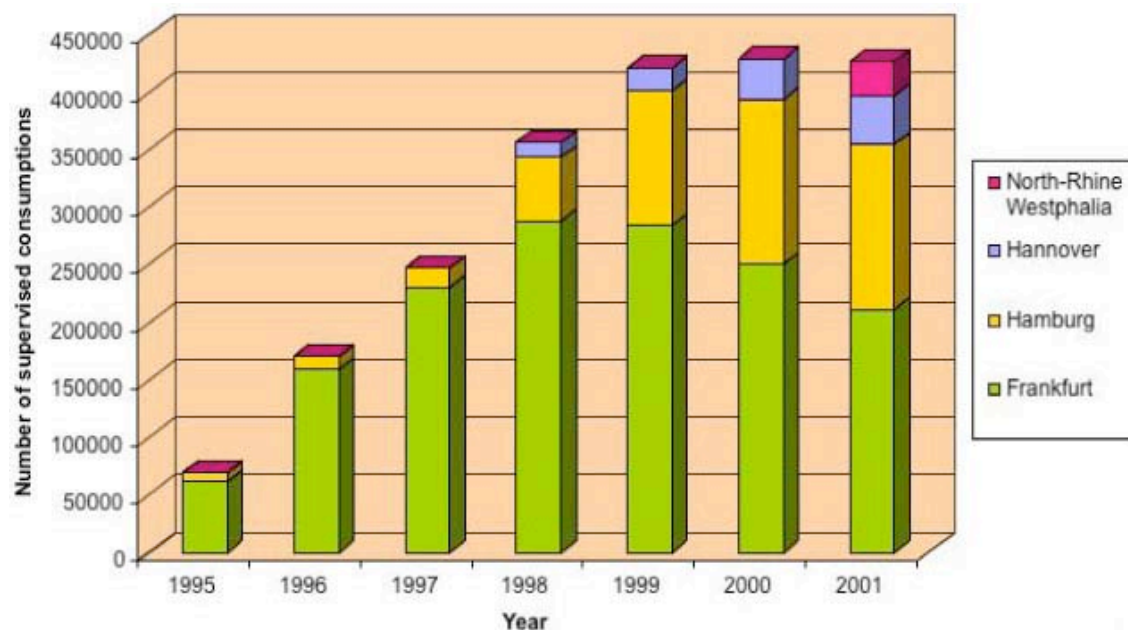
Applying estimated annual overdose mortality rates to the yearly total number of supervised drug consumptions in Germany, an estimate of the number of deaths prevented by the operation of consumption rooms can be calculated. In all consumption rooms in Germany, at least 500 000 drug consumptions are supervised each year <sup>(22)</sup>, see Figure 8 below). Assuming that one 'person-year of active use' are 1 000 consumptions (= two to three per day), these are 500 person years. Applying a mortality rate of 2%, which can be considered adequate for the populations reached by the rooms that are characterised by homelessness, frequent injection drug use and older age, at least 10 deaths per year would be prevented by the work of consumption rooms in Germany.

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<sup>(21)</sup> During the 18-month trial, 329 heroin-related overdoses occurred, all of which were managed successfully by MSIC staff.

<sup>(22)</sup> The total annual number of supervised consumptions in Germany was calculated on the basis of data reported from 18 rooms for the year 2001 (Poschadel et al., 2003, see also Figure 8), data for one further facility provided by Kimber et al. (2001) for the year 1999, plus conservative estimates of utilisation rates of several new facilities that had come into operation since then (the establishment of new consumption rooms in Dortmund, Bochum, Bonn, Bielefeld and Berlin added approximately 40 places to the 150 that existed in 2001). Despite important decreases in some services, documented in 2001 for Frankfurt (Drogenreferat der Stadt Frankfurt, 2002), it can thus still be assumed that at least half a million consumptions are currently supervised per year across all German services.

**Figure 8: Documented drug consumptions in supervised drug consumption facilities in Germany, 1995–2001**



Source: Poschadel et al., 2003, p. 156.

#### 4.2.3 Conclusions with regard to effects on morbidity and mortality

Health education at consumption rooms encourages sustainable changes in risk-taking behaviour by some clients and contributes to reducing drug-related health damage among a difficult to reach target group. No conclusions can be drawn about the direct impact on infectious disease incidence owing to a lack of studies and methodological problems associated with isolating the effect of consumption rooms. Where coverage is adequate, consumption rooms may make a contribution to reducing drug-related deaths at a city level.

Health education at consumption rooms can lead to increased risk awareness and reduced risk-taking behaviour among a target group of long-term drug users with risky drug use habits. Regular service users show an increased benefit from the repeated exposure to correct and consistent risk reduction messages. Direct, personalised training in injecting hygiene and technique increases the likelihood of sustained behavioural change. The development of targeted safer use education messages for the wider target group of drug users can be informed by consumption room experiences.

Despite the methodological limitations inherent in the studies (client self-report; cross-sectional samples; question of causality of behavioural change), it is likely that the direct and personalised safer use education in the setting of supervised consumption rooms contributes to a reduced risk of transmission of infectious diseases even outside the room. However, the extent to which subsequent risk behaviour is reduced merits further research attention. No conclusions can yet be drawn about the impact of consumption rooms on the incidence of infectious diseases because of a lack of long-term controlled studies.

Consumption rooms can contribute to a reduction in drug-related deaths at a wider, city level. The magnitude of their effect depends on several variables, including the extent to which they reach their target population and the number of deaths occurring outside the target population, e.g. in private and among socially more integrated users.

There is no evidence that the use of consumption rooms contributes to an increase in the risk of morbidity or mortality among drug users. On the contrary, the fact that no overdose-related death has yet occurred at these facilities despite the fact that millions of drug consumptions have been supervised and thousands of emergencies have been treated shows that they provide a high level of safety from overdose-death for those who use them.

### 4.3 Do consumptions stabilise and promote client health?

#### Long term health objective: To stabilise and promote the health of service users

Expected benefits of consumption rooms are that they:

- increase access to and use of basic medical care and counselling through on-site services;
- improve drug treatment uptake and promote longer term improvements in clients' health and social functioning through referral to other services.

The following might be considered to be possible risks:

- Clients use the consumption rooms only and are still 'not reached' by medical, counselling and treatment services.
- Consumption rooms may foster service dependence and hold clients back from starting treatment by making drug use more 'comfortable'.
- They might counteract the effects of treatment (e.g. allowing clients in oral methadone treatment to use the rooms for injection).

#### 4.3.1 Availability and use of services on-site

##### *Services available on-site*

An international survey as well as national surveys of consumption rooms in the Netherlands, Switzerland and Germany shows that the range of services available in consumption rooms is similar across countries (Kimber et al., 2001; Lindenmayer, 2003; Poschadel et al., 2003; Wolf et al. 2003). Besides safer use education, supervision of drug consumption and emergency management, the standard services include needle and syringe programmes, basic medical care, counselling and referral to medical, social welfare, drug treatment and employment and training services. Facilities are typically staffed by social workers and with medically trained personnel; several employ doctors and ex-users. Most consumption rooms are closely integrated with other drugs and health services or services for the homeless.

Between October 2000 and March 2001, Wolf et al. (2003) carried out a full survey among Dutch consumption rooms, to which 18 of the total of 21 facilities responded (response rate 86 %). Information about on-site services was available from 15 consumption facilities and showed that the provision of food and drinks was common, that two-thirds of services ran needle and syringe programmes, and that medical aid was available at half of services. The majority of these consumption rooms were integrated into existing drugs services and the main staff category was social education workers. The permanent presence of nurses was considered essential by some but not all services; doctors were attached to the facilities via municipal health services.

The full survey of all 19 consumption rooms in Germany conducted in 2002 (Poschadel et al., 2003) found that needle and syringe programmes were available at all services, as well as counselling and referral. Eleven of the 19 facilities employed doctors on a part- or full-time basis and at five of the eight services where this was not the case nurses provided basic medical care, including wound dressings. Café areas where drinks were available were common, and several facilities also provided food and basic hygiene services (showers, laundry).



### *On-site service delivery*

Consumption rooms that are located near illicit drug markets have often been added on to low-threshold centres with major outreach, medical, counselling and needle and syringe programmes (NSPs) that existed previously and target the same group of problem drug users. Outreach health education and needle exchange services, in particular, continue to play a major role in the overall activities of many services, even when an injecting room is set up (Diaz-Gutierrez, 2001; Groupe Sida Genève, 2003; Poschadel et al., 2003).

Besides safer use education, advice on vein care and the teaching of basic hygiene rules, services frequently delivered at consumption rooms are basic medical care, including treatment of small wounds, and psychosocial counselling (Table 7). During its first 26 months of operation, 5 086 drug users registered at DAVE in Madrid, 4 155 medical consultations took place, 3 841 basic medical treatments (e.g. wound dressings, skin disorder treatments) were administered, and 459 directly observed treatments<sup>(23)</sup> were performed (Ministerio del Interior, 2002). Overall, some form of medical service was provided at 10.5 % of all consumption visits.

Approximately 60% clients who registered with the MSIC during its 18-month trial period (2 186 of 3 810) received on-site services other than advice on safe injecting and vein care. A total of 5 964 services were delivered, including 1 271 medical treatments, 3 464 psychosocial consultations and 1 229 other basic services (an average of 2.7 services per client). Services were provided at more than 10 % of all client visits (MSIC Evaluation Committee, 2003).

Like the rooms in Madrid and Sydney, consumption rooms in the German federal state of North Rhine-Westphalia (NRW) place particular emphasis on providing drug users with access to medical care. Since 2001, areas for supervised consumption have been integrated into nine existing low-threshold drugs services in NRW and doctors are employed at all facilities. Data from the first six of these facilities, collected between April 2001 and July 2002, show that medical or psychosocial services were delivered on 6 860 occasions, i.e. 9 % of visits for supervised consumption led to the provision of further services (MFJFG NRW, 2002).

In most consumption facilities in Switzerland, Germany and the Netherlands, doctors are available at only specific hours or on certain days; however, the provision of medical and psychosocial services remains an important element of the function of consumption rooms in these countries. Additional services are provided on-site at about 5 % of consumption visits (Sozialamt der Stadt Zürich, 1995; Jacob et al., 1999; Benninghoff et al., 2003).

**Table 7: On-site service delivery**

Study reference	Number of individual clients or Number of supervised consumptions /period of time	Number and type of services delivered	Percentage of consumption visits at which medical and/or social services were delivered
Sozialamt der Stadt Zürich (1995)	135 576 supervised injections in three Zurich consumption rooms over a period of 24 months	6 244 wound care services	4.6 %
Jacob et al. (1999)	9 470 supervised injections during the first 10 months of operation of a consumption room in Hannover	202 medical consultations, 221 psychosocial counselling sessions, 33 general counselling sessions	4.8 %

<sup>(23)</sup> DOTs - Directly observed treatment, versus self-administered treatment (SAT) is a new paradigm of TB control to improve treatment adherence.

MFJFG NRW (2002)	75 527 supervised consumptions between April 2001 and July 2002 at six consumption rooms in North Rhine-Westphalia	6 860 medical and psychosocial services	9.1 %
Ministerio del Interior (2002)	5 086 clients/80 671 supervised injections during the first 26 months of operation of DAVE, near Madrid	8 455 medical services, including: 4 155 medical consultations, 3 841 basic medical care services/wound treatments, dressings, 459 directly observed treatments (DOTs)	10.5 %
MSIC Evaluation Committee (2003)	3 810 clients/56 861 injections during the 18-month trial phase of MSIC Sydney	1 271 medical services, wound dressings, abscess treatments, 3 464 psychosocial services, 1 229 other 'basic services'  (excluding 7 732 occasions of the provision of advice on safe injecting and vein care)	10.5 %
Benninghoff et al. (2003)	736 clients made 30 417 supervised injections during first 12 months of operation of 'Quai 9', Geneva	764 basic medical care services, est. 1 100 social services (active, individual counselling and stress- and violence-management sessions)  (excluding 556 referrals and services directly related to the supervision of drug consumption)	6.1 %

In evaluation studies of consumption rooms in Rotterdam, Venlo and Arnhem (Linssen et al., 2001), the effects of the use of the services on clients' health was examined through follow-up surveys among access card-holders (at registration for the rooms and 4–6 months later). In all three cities, clients attributed improvements in their health status to the use of the rooms.

Already the very first evaluation studies of consumption rooms, conducted in Basle and Lucerne in the mid 1990s, found that clients particularly welcomed the on-site provision of medical counselling and treatment services (Ronco and Spuhler, 1994; Ronco et al., 1994). Service monitoring data and client surveys suggest that consumption rooms improved access to medical and psychosocial assistance for extremely marginalised drug users and that the facilities had become an vital part of the local system of survival aid, one of the 'four pillars' of Swiss drug policy.

Sixty per cent of 168 consumption room clients interviewed in facilities across Germany in summer 2002 had received medical services at the rooms at least once; 37 % had received medical treatment (mainly the treatment of abscesses and small wounds) and 27 % of respondents had had infectious disease counselling sessions with medically trained staff. Fifty-nine per cent of clients perceived significant improvements in their current level of access to health care services compared with the situation before they used the consumption rooms. Furthermore, about two-thirds of respondents had participated in at least one general counselling session with consumption room staff, 42 % had done so repeatedly and 22 % were in regular counselling contact at the time of the interview (Poschadel et al., 2003).

About one-third of consumption room users in Hamburg and Rotterdam (28 % and 37 % respectively) report making regular use of the medical care services provided by consumption rooms; one-quarter of clients in Hamburg and 45 % in Rotterdam also avail themselves of the psychosocial counselling services available at consumption rooms (Zurhold et al., 2001; van der Poel et al., 2003). Only a minority of clients in Rotterdam (12 %; van der Poel et al., 2003) and Hamburg (11 %; Zurhold et al., 2001) use the consumption area exclusively and no other services.

Human resources to deliver further services besides supervision of drug use should continuously be adapted to the demand. It is important to review staff resources periodically, especially in the beginning, after facilities have been operational for some months and levels of use of the services provided have stabilised. Several studies have shown that clients' demand for additional services can be considerable and staffing needed to be adjusted after the initial period of service provision (Ronco et al., 1994, 1996a; Groupe Sida Geneve, 2003).

#### *Client satisfaction with staff competence and services*

Poschadel et al. (2003) found that consumption room users in Germany have a positive experience of contact with staff. On a five-point scale from very bad to very good, 47 % of clients rated the contact as 'quite good' (= 4) and a further 48 % as 'very good' (= 5). About one-quarter of respondents explicitly praised the high level of staff competence in social and legal matters and their non-judgemental attitudes. Client satisfaction ratings with services provided at the consumption rooms in Biel (Benninghoff and Dubois-Arber, 2002; Spreyermann and Willen, 2002), Berne (Reyes Fuentes, 2003) and Geneva (Benninghoff et al., 2003) were equally high.

Most clients of the centre in Sydney reported that the care they received was good; the relationship between staff and clients was described as honest and respectful (MSIC Evaluation Committee, 2003, pp. 30, 34).

#### **4.3.2 Referrals to further services**

A total of 1 385 referrals to further assistance were provided to 577 clients (15 % of all MSIC users) during the 18-month trial period of the centre in Sydney:

... with approximately one for every 41 client visits. Fifty five percent were verbal referrals and 45 % written referrals. The most frequent referrals were for drug treatment (43 %), in particular buprenorphine maintenance treatment (13 %), detoxification programs (10 %), and methadone maintenance treatment (9 %). The most common health care referral (...) was for medical consultations (23 %). The most frequent social welfare referral was for social welfare assistance (16 %).

Almost one-third of written referrals to drug treatment were provided for treatment-naive clients (MSIC Evaluation Committee, 2003).

The uptake of referrals was examined only for the 634 written referrals. They included postage-paid referral outcome cards, which the receiving services were asked to return to the MSIC. One in five referrals was confirmed to have resulted in the client making contact with the specified agency. Successful uptake was highest among frequent attendees of the MSIC, and most likely to be taken up were health service referrals (MSIC Evaluation Committee, 2003, section 5.3.6).

Ninety-one (54%) of 168 participants in a user survey at consumption rooms in Germany reported that they had at least once been referred by consumption room staff to further drugs and social services. An average of 1.5 referrals per person were reported, with 23 % of all referrals having been to a detoxification service, 20 % to social assistance services and 19 % to therapy. (Poschadel et al. 2003, p.123).

A high number of medical and social referrals are also reported from an injecting room in Geneva. Among 736 registered service users, 276 referrals to social services were registered over a six-month monitoring period. In addition, 56 referrals to specialised medical care were made by the consulting GP during one year (Benninghoff et al., 2003).

Data from the first 26 months of operation of DAVE Madrid show that 9 % of registered clients were referred to specialised services (Ministerio del Interior, 2002). And in Germany, Happel (2000) found that weekly 4% of clients were referred to emergency accommodation, drug counselling services or treatment. Of three evaluation studies of consumption rooms in the Netherlands which examined their effects with regard to getting users into regular addiction care, two reported positive results (Keetje Tippel and Spanjardstraat, Rotterdam) and one (Apeldoorn) found no effect on referral into care (Linssen et al., 2001).

As many services do not record the number of individual clients referred, referral rates can be calculated only as a proportion of consumption visits: among three consumption rooms in Zurich, the rate of referral to inpatient treatment was 1 per 365 supervised injections (Sozialamt der Stadt Zürich, 1995); according to Jacob et al. (1999), 1 in 152 consumption visits at Fixpunkt Hannover results in a referral; and the six consumption rooms in North Rhine-Westphalia report one referral per 68 supervised consumptions (MFJFG NRW, 2002). The annual total number of referrals to further social, health or addiction care services reported from individual consumption rooms in Germany can vary between 50 in small facilities to 1 000 in larger, centralised services (Poschadel et al., 2003).

#### **4.3.3 Conclusions with regard to effects on client health**

By increasing access to drugs and health services, consumption rooms promote the social inclusion of a group of extremely marginalised problem drug users.

Besides service delivery related to the supervision of drug consumption, a range of other services are usually delivered on-site. Low-threshold medical care and psychosocial counselling services are especially well used and contribute to the stabilisation and improvement of the somatic and psychological health of service users.

Consumption room staff make referrals to further services, including to drug addiction treatment services. For frequent users in particular, the rooms act as a link to the wider system of care, facilitating access to treatment.

Referral data should be further standardised, and should be interpreted with regard to the size of the client population, which is currently often unknown (for reasons of client confidentiality).

## 5 What are the effects of consumption rooms on public order and crime?

Acceptance of consumption rooms in local neighbourhoods has been a major concern in public debate in most countries. Plans to establish such rooms have been met by resistance from residents and businesses in many cities because of the fear that they will attract drug users and increase nuisance and crime. However, consumption rooms have also been expected to improve the situation for local residents by accommodating drug consumptions that would otherwise take place in public. Some cities have clear policies for the management of target groups of extremely problematic drug users in which consumption rooms play a central role.

Consumption rooms have two main objectives regarding public order and safety/crime:

- 1 to reduce public drug use and associated nuisance;
- 2 to avoid increases in crime in and around the rooms.

In the Netherlands, Switzerland and Germany, a clear role is attributed to consumption rooms with regard to nuisance reduction (see also section 2.2 on Driving forces). In the Netherlands, the reduction in public nuisance (*overlast*) is an important general objective of drug policy (Ministerie van Buitenlandse Zaken, 2002; NDM, 2002). And for local residents and local drug policy steering committees (comprising the local mayor, police representatives and public prosecutors), the role of consumption rooms in combating nuisance is of paramount importance. In the Netherlands, the initiative to establish supervised consumption facilities often comes from local residents affected by public drug use. This is clearly reflected in the admission policies of the rooms, which are directed at street users with a reputation of causing public nuisance. The rooms cooperate closely with the local police and neighbourhood committees (Wolf et al., 2003).

German drugs law requires that consumption rooms services cooperate formally with police authorities with the aim of preventing criminal offences in the vicinity of the services (BtMG-ÄndG, 2000: see § 10 a II No. 6). Statutory orders at the level of the federal state regulate the form and frequency of this cooperation and formalise any observation and documentation procedures required of service providers. Five of the six German states that have so far adopted a statutory order to allow consumption rooms have defined reduction of public nuisance as one objective of the work of the facilities. In the sixth, Hamburg, consumption room managers are required to report weekly to the police authorities on any effects of the facility on its neighbourhood. The ordinance in force in Lower Saxony even obliges consumption room staff to intervene if open drug scenes emerge.

From their historical development, it is clear that consumption rooms in Switzerland were established as an alternative to public drug use and to reduce nuisance.

Information about the part played by consumption rooms in any official anti-nuisance policy implemented by cooperation between police and drugs services is less clear in the case of the other countries. However, one of the reasons for the establishment of the room in Sydney was to reduce public injecting and improperly discarded syringes, and for the consumption room near Madrid one reason was to reduce the 'social impact of public drug use' (Ministerio del Interior, 2002).

## 5.1 Can problems related to public drug consumption be reduced?

### Public order objective: To reduce public drug use and associated nuisance

#### Expected benefits

- reduced drug use in public, especially drug injection;
- reduced level of nuisance in neighbourhoods with visible drug scenes

#### Possible risks

- Pull effect – consumption rooms might attract increasing numbers of drug users from other neighbourhoods or cities.

### 5.1.1 Drug use in public

#### *Changes in public drug use*

The fact that drug users readily accept and prefer the hygienic, safe and stress-free environment of consumption rooms to injecting in public has been reported in several studies (see Chapter 3 of this report). But drug users also welcome consumption rooms because they allow them to avoid public use, especially in settings that they themselves consider unacceptable, such as playgrounds (Poschadel et al., 2003). Thirty-one per cent of 168 clients interviewed in German consumption rooms considered the opportunity to avoid public drug use to be one of the most positive aspects of such services; 64 % considered consumption rooms to be their 'most important' place of drug use (in terms of relative frequency) compared with only 6 % reporting that they used drugs most frequently in public spaces.

In Switzerland, the risk behaviour of clients of local low-threshold services nationwide has been surveyed at regular intervals since 1986 in the context of the evaluation of the AIDS prevention strategy, mandated by the Federal Office of Public Health since 1986 (see also section 4.2.1). Data from client surveys conducted in low-threshold services in Biel and Geneva were compared before (2000) and after (2002) the establishment of injecting rooms in both cities (Benninghoff et al., 2003). In the earlier survey, in 2000, 21 % and 18 % of interviewees in Biel and Geneva, respectively, indicated that they mainly used in public (Benninghoff and Dubois-Arber, 2002; Benninghoff et al., 2003). In 2002, 49 % of respondents in Biel, where the consumption rooms had been in operation for one year, said that the consumption room was the place where had most often used drugs over the previous six months ( $n = 49$ ). The same percentage of interviewees said that they had used mainly at home, with only one client reporting having used mainly in public places. In Geneva, 61 % of a representative sample of clients of the injecting room interviewed in 2002 reported that they had most frequently injected at home during the previous six months, with 29 % reporting the consumption room as their most frequent location of drug use and 10 % continuing to inject most often in public. However, at the time of the study the service in Geneva had been open for less than five months, and further positive change might be expected over time.

In Rotterdam, more than 80 % of consumption rooms access card-holders reported that they used drugs less often in public after becoming registered service users (van der Poel et al., 2003). And in Hamburg 50 % of drug users (out of a total sample of 616, recruited at consumption rooms and in the open drug scene) said that supervised consumption rooms had been their 'most frequent location' for drug use during the past 24 hours, with 30 % attributing a reduction in their public drug use to the availability of the rooms (Zurhold et al., 2001).

### *Ongoing public use*

Poschadel et al. (2003) interviewed 168 consumption room clients recruited in 18 consumption rooms across Germany. Nearly two-thirds of respondents (64 %) considered consumption rooms to be their 'most important' location for drug use (defined as the place they injected most frequently), followed by their own house or the house of a friend (30 %). Only 6 % of the users indicated that they most frequently used drugs in public places (Poschadel et al. 2003, p. 121).

In the same study, 38 % of interviewees admitted having used drugs in public during the previous 24 hours. Half of this group gave as their reason the fact that the consumption room had been closed, with a further one-third claiming that they had used in public because the rooms were too full and they would have had to wait. Longer opening hours and the availability of the services during weekends were suggested as improvements by half of clients interviewed (Poschadel et al. 2003, pp. 118, 120).

In a questionnaire survey conducted in Hamburg in 1999/2000, 616 drug users were asked whether they had used drugs in public during the past 24 hours (valid  $n = 539$ ). More than one-third of respondents replied positively (37 %). On average, drug users had used in public on four occasions over the 24-hour period. Withdrawal symptoms were given as a main reason. The main locations were parks and squares, but 16 % of respondents had used in the vicinity of consumption rooms. Long waiting periods and limited opening hours of consumption rooms as well as distance (of decentralised rooms) from the places of drug purchase were given as reasons for not having used consumption rooms (Zurhold et al., 2001, 2003). The survey also found that the subgroup of 174 daily consumption room visitors were more likely than 'occasional' (those visiting consumption rooms once or twice per week) or 'rare' visitors to have used drugs in public. However, the researchers did not analyse whether 'frequent consumption room visitors' were in general using drugs more frequently than the other groups, which would have major implications for the interpretation of these results.

### *Discarded syringes and public safety*

Another measure that has been used to determine effects of consumption rooms on public safety is the number of syringes and needles found in public space as an indicator of the extent of public injecting.

In the area near the MSIC in Sydney, the number of discarded syringes decreased over the trial period of the consumption room, but it was not possible to determine if this could be attributed to the establishment of the centre or was related to the fact that availability of heroin was reduced over the period (MSIC Evaluation Committee, 2003, p. 124).

In Biel, a slight increase in the number of improperly discarded syringes was found after the introduction of a consumption room, even though return rates of the facility's needle and syringe programme were 93.8 %. A possible explanation put forward by the researchers was that more syringes were in circulation as cocaine use had increased substantially over the period under study, the use of cocaine being related to more frequent injecting (est. 3 to 8 times/day, compared to heroin users: 2-3 times/day, Burrows, 2000).

Local residents near a consumption room in Venlo were surveyed before and after the room became operational. They reported a reduction in the number of improperly discarded syringes following the opening of the room (Biesma and Bielemann, 1998c, Linssen et al., 2001).

### 5.1.2 Public nuisance

#### *Neighbourhood attitudes*

The reduction of *overlast* <sup>(24)</sup> is an important objective of Dutch consumption rooms. Frequently, a committee, composed of local residents, service staff, users and representatives of the police and the municipal health administration, meets regularly to address any problems that might arise from the operation of the 'user rooms'. Several studies in the Netherlands have examined the effect of the rooms on public nuisance.

Linssen and colleagues (2001) reviewed studies conducted in Apeldoorn (Biesma et al., 1999), Rotterdam (Biesma and Bielemann 1998a, 1998b), Venlo (Biesma and Bielemann, 1998c) and Arnhem (Warner, 1997) that examined the effects of the establishment of the facilities on public nuisance by comparing nuisance levels just before the consumption rooms became operational and 4–12 months later. The researchers collected information via interviews with local residents, police and key informants, through observation and from local nuisance registers. All five studies found that the consumption rooms had positive effects on public nuisance. For example, in one study, 750 telephone interviews were conducted with local residents before and one year after the opening of a user room (Biesma and Bielemann, 1998a; Linssen et al., 2001). At follow-up, the residents reported that levels of nuisance due to addicts in the street had reduced. Their attitudes towards drug users and the user room had substantially improved. Nuisance related to the existence of drug dealing addresses and to the general degeneration of the neighbourhood had however not been changed by the establishment of a user room.

The new user room in the city of Groningen was evaluated between June and December 2000. One question examined was whether nuisance (drug-related crime, public order offences and audiovisual nuisance) in the northern part of the city could be reduced by locating a user room in the south without any increase of nuisance near the new facility (Meijer et al., 2001). The evaluators conducted telephone surveys among 150 residents in the two neighbourhoods two months before and four months after the room was opened. In addition, they asked the city guards (*stadswachten*) for their observations regarding nuisance and collected data on the number and type of complaints registered at the '*meld- en regelpunten overlast*' (nuisance registers) and on criminal offences recorded in both areas. They found that the level of property crime had not changed, that the overall level of nuisance registered at the '*meldpunten*' in the north had decreased during the evaluation period and that nuisance near the new facility had not increased. The city guards reported having observed reductions in public drug use, public cursing and threatening. In contrast to the trends in registered nuisance, subjectively perceived nuisance among residents in the north of the city had fluctuated during the observation period. The authors of the study related this to increased police action focusing on nuisance reduction during the period under study.

The relocation by police of an open drug scene and its effects on utilisation rates of a consumption room is illustrated through an example in Box 8 below.

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<sup>(24)</sup> See footnote 6.



**Box 8: How police activities influence the use of consumption rooms**

When the 'Fixpunkt' consumption room in Hannover was established at the end of 1997, it was located about one kilometre (10 minutes' walk) from the drug market and drug scene in the city centre, which, according to police estimates, was visited by total of 150–200 persons daily and 20–40 persons at any one time. The weekly number of injections reached about 300 by the third month of operation, but then fell sharply to about 130 in month 5 (May 1998). Among the reasons for reductions in utilisation put forward by drug users was the distance from the place of drug purchase to the room and the police controls on the way to the service. Following negotiations between service providers and the police (as well as changes in service provision and rules), the number of weekly injections again reached 300 by October 1998. While uptake of the service remained relatively low during the first year, no open drug scene emerged outside the facility and the vast majority of clients had no negative experience with local residents (98 %) or with the police (94 %) (Jacob et al., 1999).

In subsequent years, the police increased pressure on the open scene by banning drug addicts from the town centre, with the result that the area in front of the facility became the new meeting point for drug users. The level of utilisation of the consumption room, measured by the average number of supervised injections weekly, increased steadily, from 390 in 1999 to 680 in 2000 and more than 800 in 2001. However, the relocation of the open scene led to considerable nuisance problems in the neighbourhood of the consumption room, which in turn resulted in police action, with more than 350 investigations launched in 2000 and 2001 against drug addicts, mainly for small-scale drug dealing (Poschadel et al., 2003).

Support for the establishment of the supervised injecting centre in the Kings Cross area in Sydney was examined by telephone interviews with about 500 local residents, 200 local businesses and 1 000 residents from throughout NSW before (2000) and during the trial period (2002). Around one-third of all groups disagreed with the establishment of supervised injecting centres in Kings Cross. Over the trial period however, the level of disagreement decreased significantly among local residents and among those from the other groups who knew the location of the MSIC. Acceptance of the facility in its current location increased from 68 % to 78 % among local residents ( $p = < 0.001$ ), from 58 % to 63 % among local businesses ( $p = 0.5$ ) and from 59 % to 62 % among NSW respondents ( $p = 0.001$ ) (MSIC Evaluation Committee, 2003, Chapter 8).

The consumption room Cactus in Biel was established in August 2001 as a measure to counterbalance the effects of closing down a 'scene' restaurant that had been a meeting place for between 20 and 40 drug users daily. One aim of the service was to provide an alternative space that would help prevent the emergence of an open drug scene and thus contribute to keeping Biel secure and orderly (see also section 3.2.4). An evaluation study was conducted over its first 12 months of operation (Spreyermann and Willen, 2002). The evaluators collected police information about neighbourhood complaints and conducted interviews among local residents, shop owners and business associations, as well as with representatives of health and social administration. They also interviewed the police about their perceptions of the role of the facility with regard to security and order. Neither the police nor the local health administration had received any complaints about nuisance in the vicinity of the services and there was no increase in the number of drug users coming from outside the city. According to the police and representatives of local businesses, health and social administration, the facility contributes to keeping the inner-city area clean and safe and to preventing the emergence of an open drug scene. The police maintain a high profile near the facility and disperse drug dealers through regular patrols (Spreyermann and Willen, 2002).

### *Open drug scenes and police policy*

The study by Benninghoff and colleagues in Geneva (Benninghoff et al., 2003) illustrates that consumption rooms, which are often established in 'difficult' neighbourhoods with long-standing social problems, are all too readily blamed for any increase in drug-related nuisance. A new police 'task force drogues' established in summer 2002 systematically targeted drug dealers and public drug use in the inner city. Open drug scenes were closed down and, as a result, drug dealing and use were dispersed over a larger area and drug users and public injecting became more visible. Residents attributed the intensification of problems to the consumption room rather than to police action.

In the context of the full survey of consumption rooms in Germany, the researchers interviewed service managers about their cooperation with the police and asked the local police to assess the rooms in terms of quality of cooperation with the management, integration of the service in the local neighbourhood and police interventions in the vicinity (Poschadel et al., 2003). Police reported few if any problems in the neighbourhood of 'decentralised' consumption rooms other than, in some cases, resistance from residents to their establishment. However, these rooms are also characterised by a lower level of use. Rooms located near illicit drug markets are frequented more often and thus potential public nuisance problems have to be tackled actively.

The results of the study suggest that the level of reported nuisance problems is related to the quality of cooperation arrangements between police and drugs services: there were fewer problems in cities where a political consensus about the need for the rooms and their public health and public order functions existed (e.g. Frankfurt, Saarbrücken) than in others where this was not the case (Hannover, Hamburg). This was reflected in the existence of direct cooperation between local police and service staff, backed up by local coordination bodies involving both parties that were competent to discuss and to take decisions about problems that arose<sup>(25)</sup>. In several cities, committees involving local residents and businesses have been set up. In some facilities designated staff deal with neighbourhood problems immediately. Regular police patrols outside the services as well as the cleaning of the streets around the facility are practical arrangements to keep nuisance levels low. Nuisance problems were reported when the capacity or location of the rooms did not meet local need, which also sometimes reflected the fact that there was no (or little) local support for their establishment. Because of the controversy surrounding consumption rooms in public debate, a change in the majority political party at local level can affect the operation of the rooms, as previous agreements between law enforcement and social and health services cease to exist and have to be renegotiated.

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<sup>(25)</sup> For a detailed discussion of different local cooperation models implemented in German cities see Schütze (1999).

**Box 9: What is the cause? What is the problem? Different perspectives**

Zurhold et al. (2001) examined the relationship between public nuisance and the operation of one drug service incorporating a consumption room in Hamburg by conducting structured in-depth interviews with two local residents, a shopkeeper, a social worker, a policy-maker and two local police officers. The policy-maker and local residents acknowledged that the room had led to reductions in public injecting. However, considerable public nuisance problems remained because of the large number of drug users and dealers in the area. The policy-maker attributed this to the 'pull effect' of the facility, whereas the other interviewees saw it as a consequence of police interventions against drug users in a neighbouring district, the existence of a local drug market or a failed policy of decentralisation that had left the facility with overwhelming demand and insufficient capacity. In response to the situation, the policy-maker was in favour of setting up additional decentralised consumption rooms to draw drug users away. The police officers agreed that it would be possible to relocate the drug scene, but, like the social worker, considered that the previous implementation of a decentralisation policy had caused the current problems. Nuisance problems around the facility continued unresolved. In summer 2003, the Senate of the city of Hamburg announced its intention to close the drug service by the end of the year.

Consumption rooms can be instrumental in managing existing open drug scenes (Prinzleve and Martens, 2003) and can to some extent be used to facilitate the relocation of drug users to different areas of a city. Poschadel et al. (2003) found that in several cases the area in front of the services became the new meeting place for drug addicts following police action in other areas where addicts were no longer tolerated (Hannover, Aachen, Frankfurt, Wuppertal, Saarbrücken). Often, relocation was the result of local policy for the management of drug scenes that had been agreed between health and law enforcement bodies and was actively supported by both sides (and in which consumption rooms played a crucial part). Sometimes, however, the rooms formed part of a strategy predominantly orientated towards public order (e.g. Hannover, Essen, Hamburg). In this case, driving drug users out of shopping and business areas or city centres without providing adequate alternative capacities at a new location could result in considerable problems with the new neighbours.

Interim evaluation of six consumption rooms in the German state of North Rhine-Westphalia concluded with regard to public safety and order that no considerable disturbances had occurred during a total of 61 months service in the six cities, that partnerships between police and service providers function well and that skilful public relations work by service providers had led to increased acceptance of the services in the local area (MFJFG NRW, 2002, p. 4). The 2001 annual report on the drug situation by the police forces of North Rhine-Westphalia includes a chapter dedicated to consumption rooms. The police note positively that legal criteria for access are respected and house rules are applied, in particular with regard to the prohibition of drug dealing inside the services. The police had received few or no complaints from local residents and, in addition, the report acknowledges the contribution made by consumption rooms in two cities (Essen and Wuppertal) in reducing public drug scenes (LKA NRW, 2002, section 11.3.2).

The extent to which a reduction in public drug use and open drug scenes is achieved depends on whether sufficient consumption room capacity is sufficient to meet demand. Studies conducted just after the establishment of such facilities in Zurich (Sozialamt der Stadt Zürich, 1995) and Frankfurt (Kemmesies, 1995) found that the expected reduction in public drug use was not achieved immediately and that capacity had to be adjusted to meet the demand (see also section 3.2 on coverage).

*Pull effect – do consumption rooms attract drug users from other cities?*

Most studies that have examined the place of residence of consumption room users have found that the large majority are local residents (80–90 % live in the city or its surrounding area; see

also section 3.1.5). However, where illicit drug markets are highly centralised and drug users come from a large geographical area to purchase drugs, users are likely also to make use of supervised consumption facilities nearby. In one of the first consumption room studies conducted in Frankfurt – a city which has just such a centralised illicit drug market – 37 % of service users were found to be non-locals (Happel, 1997). At the time of the study (1995), there was no consumption facility further to the south of Germany; the only other one in that part of the country (Saarbrücken) was not opened until 1999. Several cities in the southern German Landers of Baden-Württemberg and Bavaria would like to set up drug consumption rooms, but the necessary ordinances have not yet been enacted (Federal Ministry of Health and Social Security, 2003). To restrict the use of consumption rooms to local residents, the city of Frankfurt has introduced identification controls in all rooms.

Identification and other control measures were also introduced during the 1990s in Switzerland, where consumption rooms increasingly exclude Swiss non-locals, foreigners (e.g. from France) and in particular illegal immigrants (former Soviet Union States).

Whether the operation of the injecting centre in Sydney resulted in an influx of drug users into the area was examined by analysing client information collected at registration. The data showed that most MSIC clients already patronised the Kings Cross drug market before the establishment of the MSIC, although many travelled there from other areas of Sydney to purchase drugs. The researchers also examined data on criminal activity and loitering in the vicinity of the MSIC, and concluded that there was no substantial influx of drug users into the Kings Cross area as a consequence of the operation of the facility (MSIC Evaluation Committee, 2003, p. 204).

## 5.2 Do consumption rooms have adverse effects on crime in their area?

### **Public safety objective: to prevent increased crime in and around consumption rooms**

Consumption rooms have been considered as potential ‘magnet’ for drug users and dealers, resulting in more public nuisance and crime.

The rooms therefore aim to prevent:

- increases in acquisitive crime in the neighbourhood;
- increases in drug-dealing in the neighbourhood;
- drug dealing and other criminal activity in the rooms.

### 5.2.1 Acquisitive crime

Meijer et al. (2001), Spreyermann and Willen (2002) and Benninghoff et al. (2003) examined police data on acquisitive crime (including theft, robbery and burglary) committed in the vicinity of newly established consumption rooms in Groningen, Biel and Geneva, respectively, and found that the establishment of the rooms did not lead to an increase in crime in their area.

An assessment of the influence of a consumption room on crime was conducted in the framework of the MSIC evaluation. The two main questions investigated were: ‘Was there a significant increase in acquisitive crime (namely theft and robbery incidents) in the Kings Cross area associated with the MSIC?’ and ‘Was there an increase in drug transactions associated with the MSIC?’ (MSIC Evaluation Committee, 2003, p.129). Quantitative data sources used to explore these questions included police data on theft and robbery and the number of ‘drug-related’ loiterers near the facility. Furthermore, semistructured face-to-face follow-up interviews with a panel of 21 key informants from the community about negative and positive changes they had observed and attributed to the MSIC and focus group discussions with five to seven police

officers on changes in criminal activity were conducted at several points in time. The authors conclude:

The evidence (...) shows that there was no increase in acquisitive crime, particularly robbery and theft, in the Kings Cross area attributable to the MSIC. There was an overall decrease in crime attributable to the reduction in heroin supply. There was also no increase of any significance in drug-related loitering associated with the MSIC. (...) Data on MSIC client characteristics and self-reports from clients show that most '... were already participants in the Kings Cross drug market prior to the establishment of the MSIC and that many were already travelling to Kings Cross to purchase drugs. It is reasonable to conclude from the available evidence that there was not a substantial influx of illicit drug users or dealers into the Kings Cross area as a consequence of the MSIC.

(MSIC Evaluation Committee, 2003, p. 204)

The Department for Strategic Studies at the police headquarters in Geneva took part in the evaluation study of the local consumption room (Benninghoff et al., 2003). Police analysed data on the number of some types of crimes, for example various types of theft, burglary, aggression and threats, from different areas of the city before and after the consumption room was established. The results showed that there was no change in the level of crime following establishment of the consumption room.

Unfortunately, data on crime are sometimes difficult to obtain. For example, Poschadel et al. (2003) were unable to obtain data on drug-related crimes, especially acquisitive crimes, committed near German consumption rooms despite requesting such data from the police authorities.

## 5.2.2 Drug dealing in the vicinity of consumption rooms

Several studies report that small-scale drug trafficking takes place in the immediate vicinity of consumption rooms (e.g. Geense, 1997; Dubois-Arber et al., 1999; Kimber et al., 2001; Zurhold et al., 2001; Reyes Fuentes, 2003). It is quite possible that drug users sell drugs to other drug users whom they first meet at consumption facilities. However, as many rooms are deliberately located near places where illicit drugs are sold, it is difficult to claim that the existence of such rooms leads *per se* to drug dealing.

Gatherings of drug users and dealers outside the facilities are in the interest of neither the services nor their neighbours, and consumption room management have agreements with the police to prevent open scenes near consumption rooms. In the Netherlands, consumption room users may be required by their 'user contract' not to loiter near the facility.

## 5.2.2 Drug dealing inside consumption rooms

Drug dealing is forbidden at consumption rooms and house rules prohibit clients from sharing drugs inside the rooms <sup>(26)</sup> (Kimber et al., 2001; Poschadel et al., 2003). Several rooms carry out visual controls to ensure that drug users who enter the facilities carry only enough drugs for personal use; rules against drug sharing are enforced by staff supervising the consumption area. Infringements are punished with exclusion from the use of the room <sup>(27)</sup>. German legislation requires that 'drug trafficking and the supply of drugs in the consumption room are

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<sup>(26)</sup> With the exception of one consumption room in the Netherlands, where licensed house dealers operate.

<sup>(27)</sup> Data on the number of occasions on which users were excluded from the use of the consumption facility were available from six German services (Poschadel et al., 2003, pp. 236ff). One large service excluded drug users on 18 occasions per 1 000 supervised consumptions; the five small services used this punishment on fewer than six occasions per 1 000 consumptions. However, no information about what types of infringement elicited this punishment was provided.

prevented; in the vicinity of these rooms the police ensure the compliance with these preconditions' (BtMG ÄndG, 2000; Federal Ministry of Health and Social Security, 2003, p. 2).

### **5.3 Conclusions with regard to effects on public order and crime**

Consumption rooms can improve the local environment by reducing public nuisance, in particular the level of drug use in public places. Police recognise that consumption rooms play a role in decreasing and preventing open drug scenes. The extent to which this can be achieved depends on the coverage of the target behaviour and is determined by available capacity for drug consumptions that would otherwise take place in public and by police action that prevents open drug scenes but at the same time does not deter addicts from making use of the facilities.

Consumption rooms have greater impact where there is a political consensus on the rooms as part of a comprehensive local demand reduction strategy that acknowledges public and individual health objectives as well as the need to maintain an acceptable situation with regard to order and safety in the community.

The location of consumption rooms needs to be compatible with the needs of drug users but also with the needs of local residents. The facilities situated near illicit drug markets are not able to solve wider nuisance problems that result from these markets.

There is no evidence that the operation of consumption rooms results in a decrease or increase in the number of improperly discarded syringes and needles; it is even unclear whether syringe counts can be used as reliable indicator of the level of public injecting. Consumption equipment used at the facilities is collected and correctly disposed of on-site.

There is no evidence that the presence of consumption rooms leads to more acquisitive crime.

The services have no interest in drug dealing inside or outside their premises. No systematic data are available about infringement of the house rules that prohibit drug dealing, although it has been acknowledged by police that house rules against drug dealing are enforced and respected. Some small-scale drug dealing does take place in the vicinity of the services, which is not surprising given their locations.

## **6 Summary and conclusions**

### **6.1 What are consumption rooms?**

Consumption rooms are professionally supervised health care facilities where drug users can use drugs in safe, hygienic conditions. They are part of a wider network of services and usually operate from separate areas located in existing facilities for drug users or the homeless. The rooms are supervised by social workers, nurses, doctors or other staff trained in emergency aid and social assistance to drug users.

They are distinct from illegal 'shooting galleries' run for profit by drug dealers. As users have to bring their own, preobtained drugs, consumption rooms are also distinct from consumption facilities in the framework of drug prescription programmes, where the drugs are supplied to the users.

### **6.2 How did they come about?**

Morbidity and mortality associated with drug dependence, especially drug injecting, constitute major problems for public health. Drug users who congregate in public areas or open drug scenes are among the most vulnerable to disease and overdose. Severe health risks, such as transmission of infectious diseases and drug overdoses, are linked to street-based injecting. These users are often highly marginalised and lack access to social and health care services. Owing to their visibility they are also subject to public hostility, frequent police attention and intermittent, if usually short, periods of incarceration. All these factors serve to increase their vulnerability to injection-related complications, blood-borne infections and risk of overdose. Drug dealing and drug use in public can cause considerable nuisance in some neighbourhoods and create a feeling of lack of public order and safety.

Consumption rooms developed in cities where – despite the availability of a variety of treatment options, including methadone substitution, as well as a range of harm reduction services such as outreach and needle and syringe programmes – public drug use persisted and there remained serious concerns about rises in infectious diseases and drug-related deaths. They are thus highly specialised drugs services, embedded in comprehensive local strategies, that fulfil a limited but important function by establishing and maintaining contact with a high-risk group including those not reached by other drugs services and by providing a facility that other services cannot offer.

### **6.3 Who are they for and what are their objectives?**

Consumption rooms aim to reach and address the problems of specific, high-risk populations of drug users, especially drug injectors and those who use in public spaces. They can have public health and public order objectives.

The public health objectives of consumption rooms are to help drug users survive by reducing the immediate health risks related to drug use in high-risk settings; to provide a safe place that enables lower risk, more hygienic drug consumption; to reduce mortality and morbidity among their target population by providing risk reduction education and health promotion advice; and to stabilise and promote the health of their clients through increasing their access to and uptake of medical care and drug treatment services.

The public order objectives are to reduce nuisance and threats to public safety that arise from open drug scenes by providing a sheltered environment for drug consumption and thus reducing the level of public drug use.

Both public health and public order objectives are found in all countries, though the balance varies – some emphasise reducing public nuisance while others prioritise public health concerns.

Consumption rooms typically target drug injectors. However, in all Dutch services and in an increasing number of services in Germany and Switzerland, supervised consumption areas for drug inhalation are in place.

## 6.4 How many consumption rooms are there?

Drug consumption was unofficially tolerated in a few drug services in the late 1960s and early 1970s. However, the first officially approved and supervised consumption room opened in Basle, Switzerland, in 1986. Rooms were introduced in Germany and the Netherlands in the 1990s, and in Spain and subsequently Australia and Canada in the early 2000s.

In Europe, there are currently 62 consumption rooms, located in 36 cities in four countries. Trials are also being carried out in Canada and Australia. The number of facilities per country and the year when the rooms were introduced are summarised below.

- Switzerland      12 (seven cities)      1986
- Germany          25 (14 cities)          1994
- Netherlands      22 (12 cities)          1994
- Spain              3 (three cities)          2000

and

- Australia          1 (Sydney)              2001
- Canada            1 (Vancouver)          2003

Consumption rooms vary in size, each room providing between 4 and 16 places for clients to consume (in one case even 30). The larger rooms supervise 500–2 000 consumptions per week, while in smaller ones this number can be less than 100 per week.

## 6.5 How do consumption rooms work?

Drug consumption is supervised by staff, who also give advice on risks, educate clients about safer drug use techniques and provide emergency help in case of overdose or other adverse reactions. Education and general health promotion aim to increase knowledge and awareness of risks among clients and minimise risk-taking behaviour outside as well as within the service.

General admission criteria are that clients are regular or dependent users of heroin or cocaine and over 18 years old. Occasional or first-time users are excluded. Access controls to consumption rooms are strict, and in many services personalised user cards are issued after formal registration. In some cases, the number of cards is limited to prevent overcrowding. Use of a facility is sometimes restricted to local residents to limit the influx of drug users from other cities.

House rules prohibit drug dealing and specify basic hygiene requirements and safety procedures. Consumption rooms do not advertise, and staff do not help clients inject.

Front-desk staff check that potential service users meet the admission criteria and make them familiar with house rules. After receiving sterile equipment, clients can use the facility, usually



for about 30 minutes. Inside the supervised consumption area, a staff member makes clients aware of health risks and dangerous modes of consumption, observes during consumption and provides safer use advice, e.g. on injecting techniques. Other staff are available to provide immediate help in case of an emergency. As most consumption rooms are integrated into wider drugs services, many clients also use other services available on site.

In the Netherlands and Spain, the operation of supervised consumption rooms is based on municipal regulations, in Germany on an amendment to the national drugs law that enables federal states to regulate implementation, and in Switzerland on the decision of the Public Prosecutor supported by legal assessments that they do not violate Swiss or international law. In Australia and Canada the facilities have the status of scientific trials.

## **6.6 What are their expected benefits and risks?**

The expected benefits are decreases in high-risk drug use, morbidity and mortality among the target population, increased uptake of health and social care including drug treatment, and reductions in public drug use and neighbourhood nuisance.

Possible risks are that they encourage increased drug use, that new users might be initiated, that they make drug use more acceptable and comfortable, thus conflicting with treatment goals, and that they increase public order problems by attracting drug users and drug dealers from other areas.

Because consumption rooms target those who are not ready for treatment, a major function is to offer other survival-oriented services, including basic medical care, food, drinks, clothes and shelter. The rationale underlying this function is that drug users should, as long as they cannot or do not want to stop drug use, be enabled to survive in the hope that they may at some later stage be able to give up drug use.

## **6.7 What evidence is currently available?**

The first studies that were conducted during the 1990s covered facilities in Berne, Zurich, Basle, Lucerne, Frankfurt and Hannover. More recent studies, published from 2001 include:

- an international survey of 39 supervised drug consumption rooms in Europe;
- a European Commission-funded study presenting data from rooms in Hamburg and Rotterdam;
- a review of evaluation studies and a full survey of Dutch facilities mandated by the Trimbos Institute in the Netherlands;
- a national survey of consumption rooms for the German Ministry of Health;
- evaluation studies of rooms in Zurich, Olten, Biel and Geneva for the Swiss Federal Office for Public Health and other public funders;
- a comparison of client survey results from 1990, 1995 and 2001 from the oldest consumption room in Berne; and the first report on a room outside Europe;
- the process, impact and economic evaluation of the first 18 months of operation of the medically supervised injecting centre in Sydney, Australia;

Evaluating the impact of specific interventions that form part of a wider network of services and responses (health, social, legal) to a complex and often changing phenomenon poses many methodological challenges. All the studies have their limitations, and it is not possible to draw reliable conclusions from any single study. The approach in this report is to set the range of results from a variety of evaluation methods against the various objectives and describe the extent to which evidence exists regarding whether or not the expected benefits or risks were realised.

The remainder of this chapter summarises the evidence reported in Chapters 3, 4 and 5.

## 6.8 Do consumption rooms reach their intended target groups?

### First objective: to reach as much of the target population as possible

Target populations are typically defined as high-risk problem drug users, especially regular or long-term users of heroin and cocaine, drug injectors, drug-using sex workers, street users and other marginalised, often not in treatment, groups.

To achieve their public health and order objectives, services must be used. They should thus:

- attract the target population and be run so that supervised consumption is acceptable to drug users and clients continue to attend regularly;
- provide sufficient capacity at local level, in the right places and at the right times, to achieve coverage of the target population.

Potential risks include:

- People other than the intended target group might use the service and new people could be recruited into drug use.
- Service policy may make it difficult for clients such as more marginalised or chaotic users to attend on a regular basis, reducing the impact of the room.

### 6.8.1 Indicators

The following indicators are used to determine the extent to which the first objective is fulfilled:

- profile of service users;
- levels and patterns of use of consumption rooms;
- location and opening hours;
- coverage of target populations at city level.

### 6.8.2 Characteristics of service users

#### *Age, sex and drug use profile*

Supervised drug consumption services reach a largely ageing population of drug users characterised by long-term addiction and frequent drug use, mainly heroin and cocaine injecting, often including consumption in public places. Women account for about one-fifth of clients.

There is no evidence that naive users are initiated into injecting as a result of the presence of consumption rooms.

#### *Social characteristics*

Homelessness or living in unstable accommodation, high rates of unemployment and dependence on social welfare payments as well as previous imprisonment are common client characteristics. Most clients are locals – service provision is increasingly restricted to local residents.

#### *Previous treatment experience and contact with other services*

A significant minority of clients are extremely marginalised and not reached by any other services, including substitution treatment. For some, consumption rooms are an entry point to the drugs help system. Others have had treatment in the past but are not currently in treatment.

Different approaches are taken with regard to admission of clients who are on substitution treatment.

### **6.8.3 Utilisation and coverage**

#### *Drugs used in consumption rooms*

Heroin and cocaine are the main drugs used in the rooms, and the main mode of administration is injection, except in the Netherlands.

#### *Level of utilisation and regular attendance*

The level of utilisation ranges from 50 to 2 000 consumptions per room per week. High rates of regular use of rooms (five times per week or more) are reported by clients in Switzerland, Germany and, in particular, the Netherlands. In contrast, rooms in Spain and Sydney report much higher client turnover, in part because of high turnover in the local scene and in part because of service policy.

#### *Location and opening hours*

How extensively and how regularly the rooms are used depends on their location and capacity, on the nature of the drug scene and on their service policy, in particular opening hours and access criteria. High levels of use are found in larger facilities based near major illicit drug markets, especially if they have long opening hours. Decentralised facilities report much lower levels of use.

#### *Coverage at city level*

To achieve adequate coverage, in bigger cities at least, capacity is distributed across several facilities.

### **6.8.4 Conclusions on reaching the target population**

Consumption rooms reach their defined target population, including street users and older, long-term users who have never been in treatment. There is no evidence that they recruit drug users into injecting.

To achieve adequate coverage and high rates of regular use 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, especially in the evening. Rooms targeting drug-using sex workers also need to be appropriately situated and remain open in the evening and night.

Given the nature of the target population, it is vital that the 'house style' encourages rather than deters potential clients. This implies that staff need to be sympathetic and non-judgemental towards problematic, marginalised and sometimes difficult clients, yet at same time be clear and consistent about admission criteria and house rules.

## 6.9 Impact of consumption rooms on health

Improving public health is one of the major goals of consumption rooms. Three objectives can be identified:

- 1 immediate: to provide a safe environment for less risky, more hygienic drug consumption;
- 2 medium term: to reduce morbidity and mortality;
- 3 long term: to stabilise and promote health.

### 6.9.1 Do consumption rooms ensure safe and hygienic drug use?

**Immediate health objective: to provide a safe environment that enables lower-risk, more hygienic drug consumption**

Expected benefits are reductions in the immediate harms that can arise from drug consumption, especially those related to hurried drug injecting in public places. To achieve this, consumption rooms seek to ensure that:

- drugs are consumed under hygienic conditions and safer use is facilitated;
- rapid care is available in the event of emergencies.

Effects that might be considered risks include:

- Better conditions for drug use could increase levels of drug use or encourage riskier patterns of use.

#### *Indicators*

The following indicators are used to determine the extent to which the immediate health objective is fulfilled:

- house rules on hygiene and safety;
- supervision and 'tailor-made' risk reduction advice;
- emergencies: types and outcomes;
- levels and patterns of drug use.

#### *Hygiene, safety and supervision*

*House rules and safety conditions.* In all consumption rooms, house rules and service standards exist and are implemented to ensure that drug use takes place under safe and hygienic conditions. Supervision of consumption is universal and provides staff with the opportunity to give tailor-made risk reduction advice.

*Hygiene and safety as reasons for attendance.* Hygienic conditions, availability of emergency aid and the possibility to consume drugs 'in peace' are important reasons why clients use the rooms.

#### *Emergencies*

*Types of emergency.* The large majority of emergencies at consumption rooms are related to heroin overdose, in particular respiratory depression after heroin injection. Cocaine emergencies account for about 15 % of episodes and mostly involve seizures and agitated behaviour.

*Emergency rates.* There is considerable variation in numbers of emergencies recorded. Reported rates at drug consumption rooms vary between one and seven emergencies per 1 000 supervised injections but are considerably lower for consumptions involving inhalation.

Apart from route of drug administration, explanations for differences in reported emergency rates could include heterogeneity of classification and reporting systems, variations in local drug use and risk-taking patterns, especially regarding drug mixtures involving benzodiazepines, and supply-related variables such as changes in drug availability and quality.

*Outcomes of emergencies.* Most emergencies at consumption rooms are dealt with on site, either by the staff or by attending ambulance teams. Due to immediate intervention, outcomes of emergencies at consumption rooms are less severe than those occurring outside in the local scene and hospitalisation is a rare outcome of supervised consumption. The availability of fully equipped on-site emergency rooms plays an important role in Spain and Australia. Such resources may not be necessary 'on site' if a hospital can be reached within few minutes, as in the Swiss and German cities. One death has occurred at a consumption room, due to anaphylactic shock. No fatal overdose has been reported in a consumption room.

#### *Level and pattern of drug use*

Most clients report that their level and pattern of drug use remained largely unchanged after they started attending a consumption room. A minority (typically 20–25 %) do report changes, with roughly equal proportions reporting increases and reductions in drug use. However, in only a few cases is this attributed to the impact of the consumption room.

Levels of drug taking can fluctuate for many reasons, including other events in clients' lives or changes in drug availability.

Overall, there is no evidence of a causal link between consumption rooms and changes in the level of drug use. The broad picture shows continuity rather than dramatic change.

#### *Conclusions immediate health objective*

Consumption rooms achieve the immediate objective of providing a safe place for lower risk, more hygienic drug consumption without increasing the levels of drug use or risky patterns of consumption.

### **6.9.2 Do consumption rooms reduce morbidity and mortality?**

#### **Medium-term health objective: to reduce morbidity and mortality**

Expected benefits to be achieved through health promotion and safe use education at consumption rooms are:

- sustainable improvements in knowledge and risk awareness among clients;
- reduced high-risk behaviour beyond the consumption room setting itself;
- reduced exposure to and transmission of drug-related infectious diseases;
- reduction in overdoses.

Safer use and management of drug emergencies at consumption rooms should contribute to a reduction in overdose-related deaths in the community.

The following might be considered a possible risk:

- Consumption rooms increase morbidity and mortality by 'condoning' injecting.

### *Indicators*

The following indicators are used to determine the extent to which the medium term health objective is fulfilled:

- knowledge of risks (overdose, infections);
- changes in risk-taking behaviour;
- incidence of drug-related infectious diseases;
- drug overdoses and deaths.

### *Knowledge, risk awareness, behaviour and infectious diseases*

*Self-reports and staff observations.* Clients of consumption rooms report improved knowledge of safer use and injection techniques as well as reductions in risk behaviour. Positive behavioural changes are confirmed by staff, although this process is sometimes slow. Despite methodological limitations, it is likely that safer use education given at consumption rooms has contributed to this. Effects increase with length and frequency of service use and behaviour changes are sustained outside the facilities.

*Incidence of drug-related infectious diseases.* Few data are available regarding the impact of the rooms on the incidence of infectious diseases among clients. Methodologically, it is difficult to establish a causal effect of the rooms *per se* that can be distinguished from the effects of the gamut of health promotion and harm reduction activities aimed at preventing drug-related infectious diseases.

### *Overdoses and drug-related deaths at community level*

There is some evidence from a statistical time-series analysis of drug-related deaths in four German cities that consumption rooms can contribute to a reduction in drug-related deaths at community level. The robustness of these analyses remains to be verified by further research data based on longitudinal analyses in different contexts that reproduce these results across time or geographic location.

The size of the impact may depend on several variables, including coverage of the target population as well as the death rate outside the target population (e.g. in private and among socially more integrated users). There is no evidence at all that consumption rooms contribute to increased morbidity or mortality risks among drug users. Millions of drug consumptions have been supervised and thousands of emergencies been treated – with no deaths from overdose.

### *Conclusions medium-term health objective*

Health education at consumption rooms encourages sustainable changes in risk-taking behaviour by some clients and contributes to reducing drug-related health damage among a difficult to reach target group. Risky drug use habits of long-term problem drug users can be changed through systematic safer use education in consumption room settings.

No conclusions can be drawn about the direct impact on infectious disease incidence owing to a lack of studies and methodological problems associated with isolating the effect of consumption rooms. Where coverage is adequate, consumption rooms may make a contribution to reducing drug-related deaths at a city level.

### 6.9.3 Do consumption rooms stabilise and promote health?

#### Long-term health objective: to stabilise and promote health

Expected benefits of consumption rooms are that they:

- increase access to and use of basic medical care and counselling through on-site services;
- improve drug treatment uptake and promote longer term improvements in clients' health and social functioning through referral to other services.

The following might be considered to be possible risks:

- Clients use the consumption rooms only and are still 'not reached' by medical, counselling and treatment services.
- Consumption rooms may foster service dependence and hold clients back from starting treatment by making drug use more 'comfortable'.
- They might counteract the effects of treatment (e.g. allowing clients in oral methadone treatment to use the rooms for injection).

#### *Indicators*

The following indicators are used to determine the extent to which the long term health objective is fulfilled:

- availability of other services on-site;
- use of on-site services: e.g. medical care;
- client self-reports regarding health and satisfaction with services;
- referrals to treatment and other services.

#### *Use of other on-site services*

*Availability of on-site services.* Consumption rooms are strongly integrated in a network of wider services for drug users or the homeless. The range of services provided at the facilities includes needle and syringe programmes, medical care, counselling and referral.

*Use of on-site services.* Most clients who use consumption rooms make use of a range of other on-site services, including medical care and psychosocial counselling. Rates of on-site delivery in 5–10 % of consumption visits are reported, depending on the service delivery models. Only a minority of clients use the consumption area exclusively and no other services.

*Client satisfaction.* Service users report high levels of satisfaction with staff competence and service provision at consumption rooms. Among the services that are available on site at consumption rooms, basic medical care plays an important role in terms of use and client satisfaction.

#### *Referral to drug treatment and other services*

Considerable numbers of clients of consumption rooms are referred to further medical and social assistance, including to addiction treatment services. It is difficult to quantify this precisely, and referral data are not comparable between services, as the need to refer clients to other agencies depends on what services are available on site. Consumption rooms with fewer on-site services rely more on referrals than those based in more comprehensive, integrated services offering a range of options. On the other hand, referrals within the same agency often remain completely unaccounted for.

Referral data could be further standardised and interpreted with regard to the size of the client population, which is currently often unknown (for anonymity reasons).

### *Conclusions long-term health objective*

Consumption rooms clearly increase access to drug services and health and social care. In so doing, they promote the social inclusion of a group of extremely marginalised problem drug users.

Besides supervision of drug consumption, a range of other services are usually delivered on site. Low-threshold medical care and psychosocial counselling services are especially well used and contribute to stabilisation of and improvement in the somatic and psychological health of service users.

Consumption rooms make referrals to further services, including drug treatment. For frequent attenders in particular, the rooms act as a link to the wider system of care. Only a small proportion of clients use the facilities for drug consumption purposes only. The majority at some point make use of other medical, counselling and treatment services.

It is possible that consumption rooms encourage some degree of service dependence in some clients. This is a fairly common observation in many services dealing with marginalised and problematic client groups. There is, however, little evidence to suggest that consumption rooms hold clients back from starting treatment by making drug use more 'comfortable'.

The question of whether consumption rooms conflict with treatment goals, in particular whether they should allow clients in oral methadone treatment to use the rooms for injection, is dealt with in different ways. In some countries, for example Germany, methadone clients are excluded from most consumption rooms. Other countries, for example Switzerland, take the pragmatic view that if methadone clients are going to inject anyway it is better that they do so in safe and hygienic circumstances.

## **6.9.4 Conclusions regarding public health objectives**

### *Benefits*

Consumption rooms provide a safe environment for less risky and more hygienic drug use (one death due to anaphylactic shock, no overdoses out of some millions of supervised drug consumptions).

Many clients receive much needed health and survival services in addition to benefiting from less hurried and more hygienic consumption. For some highly marginalised drug users they can be the first step into the health and social care system, in some cases including drug treatment.

There is a reduction in clients' risk-taking behaviour, though it is not known how far consumption rooms *per se* contribute to reductions in the transmission of drug-related infectious diseases. There is evidence that 'safer use' messages have an impact on clients' risk behaviours outside the rooms and may influence a wider population of users.

Most emergencies can be managed at service level, without hospitalisation.

Where coverage is sufficient and access and opening hours are appropriate, consumption rooms may contribute to a reduction in drug deaths at city level.

### *Risks*

There is no evidence that consumption rooms increase levels of drug use or encourage riskier patterns of use, nor that they increase morbidity and mortality.

Few clients use the facilities only for drug consumption. Most at some point use other services, especially medical and in some cases drug treatment.



There is little evidence that consumption rooms undermine treatment by making drug use more 'comfortable'. Whether clients in oral methadone treatment are allowed to use the rooms for injection, is dealt with in different ways.

## 6.10 Impact on consumption rooms on public order and crime

Acceptance of consumption rooms in local neighbourhoods has been a major issue in public debate in many cities. Plans to establish rooms are met by resistance from residents and businesses. However, consumption rooms are also expected to improve the local situation, accommodating drug consumptions that would otherwise take place in public. Some cities have clear policies for managing target groups of extremely problematic drug users in which consumption rooms play a central role.

Consumption rooms have two main objectives regarding public order and crime:

- 1 to reduce public drug use and associated nuisance;
- 2 to avoid increases in crime in and around the rooms.

### 6.10.1 Can problems related to public drug consumption be reduced?

#### **Public order objective: to reduce public drug use and associated nuisance**

##### Expected benefits

- reduced drug use in public, especially drug injection;
- reduced level of nuisance in neighbourhoods with visible drug scenes

##### Possible risks

- Pull effect – consumption rooms might attract increasing numbers of drug users from other neighbourhoods or cities.

#### *Indicators*

The following indicators are used to determine the extent to which the public order objective is fulfilled:

- client self-reports on locations for drug consumption;
- neighbourhood surveys on public drug use and nuisance;
- police reports and observations;
- discarded syringes;
- data on clients' area of residence.

#### *Drug use in public*

*Changes in public use.* Surveys in several countries have found that significant proportions of clients report decreases in drug use in public and attribute this to the existence of consumption rooms. Clients appreciate the peaceful, safe and hygienic conditions provided by consumption rooms and give them preference to injecting in public. Many consumptions that would have otherwise taken place in public now take place off the street and under supervision. It must, however, be remembered that other factors can also influence changes in behaviour over time.

*Ongoing public use.* Some consumption room clients continue to use drugs in public. This behaviour appears to a large extent related to insufficient coverage and capacity. With longer opening hours and higher capacity, a greater proportion of the target behaviour can be covered.

*Discarded syringes.* Little evidence is available regarding the impact of consumption rooms on the number of improperly discarded syringes and needles; it is even unclear whether syringe counts can be used as a reliable indicator of the level of public injecting. It is possible that changes may reflect wider changes in availability of heroin or cocaine rather than the effect of consumption rooms. All equipment used at the facilities is properly discarded and poses no risk to community safety.

*Public nuisance in neighbourhoods with visible drug scenes*

*Neighbourhood attitudes and perceptions.* Surveys of local residents and businesses, as well as registers of complaints made to the police, generally show positive changes following the establishment of consumption rooms, including perceptions of decreased nuisance and increases in acceptance of the rooms. Police, too, often acknowledge that consumption rooms contribute to minimising or preventing open drug scenes.

*Open drug scenes and police policy.* There are instances where consumption rooms have been blamed for increasing public nuisance, including open drug scenes and dealing. These arose where police actions in other areas had the effect of relocating drug markets and open scenes.

*Pull effect.* Available evidence is not sufficient to draw conclusions on whether consumption rooms exert a 'pull-effect' by attracting drug users from other areas, thus adding to the situation already created by established drug markets. Attempts to decentralise drug scenes by dispersing consumption rooms have not led to increased nuisance around the rooms. However, they have not attracted large numbers of clients either.

Thus, consumption rooms can be a useful tool for managing problematic street drug users and for reducing public nuisance and community concern about public drug use. However, there are limits to the degree to which drug scenes can be relocated from illicit drug markets via consumption rooms in decentralised locations. An essential condition is a policy agreement and close cooperation between health, law enforcement actors and local communities.

### 6.10.2 Do consumption rooms have adverse effects on crime in their area?

**Public safety objective: to prevent increased crime in and around consumption rooms**

Consumption rooms have been considered as potential 'magnet' for drug users and dealers, resulting in more public nuisance and crime.

The rooms therefore aim to prevent:

- increases in acquisitive crime in the neighbourhood;
- increases in drug-dealing in the neighbourhood;
- drug dealing and other criminal activity in the rooms.

*Indicators*

The following indicators are used to determine the extent to which the public safety objective is fulfilled:

- local crime surveys;
- police crime statistics and observations;
- reports and observations from consumption room staff;
- client surveys/interviews.

*Acquisitive crime*

According to the few studies that have examined the effects of consumption rooms on acquisitive crime, there is no evidence from police data of a negative effect on local levels of theft, robbery and burglary.

*Drug dealing in neighbourhood*

The direct effect of the rooms on the small-scale drug dealing in their vicinity is difficult to determine as one of the criteria for deciding where to locate rooms is the existence of public drug use and drug markets.

Services have no interest in drug scenes and drug markets expanding outside their front door and rely on sensible police action to prevent these without deterring drug addicts from the use of the supervised consumption facility. House rules in some rooms require that clients do not loiter outside the facility.

*Drug dealing and other crime in consumption rooms*

Consumption room rules prohibit drug dealing, and infringements are punished by exclusion from the use of the rooms. No systematic data are available regarding implementation of these rules, although it has been acknowledged by police that house rules against drug dealing are enforced and respected. As with drug dealing immediately outside the door, it is not in the interests of consumption rooms to allow dealing inside the facility.

**6.10.3 Conclusions regarding public order and crime objectives**

Consumption rooms can reduce significantly the level of drug use in public. The extent to which this is achieved depends on their accessibility, opening hours and capacity to accommodate drug consumptions that would otherwise occur in public.

The location of consumption rooms needs to be compatible with the needs of drug users but also to take account of the needs and expectations of local residents. A reduction in the number of public consumptions can contribute to improvements in the neighbourhood by helping to reduce public nuisance associated with open drug scenes. However, facilities near illicit drug markets are not able to solve wider nuisance problems that result from these markets.

Police actions against drug markets and drug scenes in other neighbourhoods may sometimes increase public order problems near consumption rooms. This implies that, if rooms are to contribute to reducing public nuisance rather than be blamed for aggravating it, there needs to be consultation not only with local residents but also with police, so that action to discourage open drug scenes does not at the same time deter drug users from making use of the facilities.

Consumption rooms have greater impact where there is a political consensus that they are part of a comprehensive local strategy to respond to drug use-related problems that acknowledges public and individual health objectives as well as the need to maintain an acceptable situation with regard to order and safety in the community.

There is no evidence that the operation of consumption rooms leads to more acquisitive crime. There is small-scale drug dealing in the vicinity of many services, which is not surprising given their location.

## **6.11 Overall conclusions on benefits and risks of consumption rooms**

The research evidence on the impact of consumption rooms, although still incomplete, suggests that consumption rooms do achieve some of the specific purposes for which they were set up.

They reach a population of long-term problem drug users with various health and social problems. They provide a hygienic environment for drug use and, for regular attenders at least, decrease exposure to risks of infectious diseases. They contribute to a reduction in levels of risk-taking among their clients and increase access for specific 'hard-to reach' target populations of drug users to health, welfare and drug treatment services. They provide immediate emergency help in case of overdose, and can make a contribution to the reduction of overdose deaths at community level.

Even among this problematic client group, consumption rooms have facilitated improvements in health, have provided counselling and other therapeutic options and have referred many to medical services and in some cases drug treatment.

As long as there is sufficient capacity and coverage in terms of location and opening hours, as well as consultation with residents and police, consumption rooms can reduce the level of drug use in public places and help to reduce public nuisance.

### **6.11.1 Benefits**

The expected benefits of consumption rooms are:

- decreases among the target population in high-risk drug use, morbidity and mortality (in particular supervised drug injecting facilities);
- increased uptake of health and social care including drug treatment;
- reductions in public drug use and neighbourhood nuisance.

The evidence suggests that all these benefits can be realised. However, the size of the effect depends on providing adequate capacity, appropriate locations and opening hours, as well as relevant policies regarding access and management of clients. Achieving these benefits also requires that consumption rooms are embedded in a wider network of services and that there is political consensus regarding their role.

Inhalative modes of drug consumption pose a much lower risk of overdose. While Dutch studies have shown that drug consumption facilities that are mainly for non-injectors deliver benefits with regard to reducing nuisance, their impact on morbidity is more difficult to assess.

### **6.11.2 Risks**

There is no evidence that consumption rooms encourage increased drug use or initiate new users. There is little evidence that by providing better conditions for drug consumption they perpetuate drug use in clients who would otherwise discontinue consuming drugs such as heroin or cocaine, nor that they undermine treatment goals.

When managed in consultation with local authorities and police, they do not increase public order problems by increasing local drug scenes or attracting drug users and dealers from other areas. If consultation and cooperation between key actors does not take place, then there can be a risk of a 'pull effect' and consumption rooms run the risk of being blamed for aggravating local problems of public order including drug dealing.

### 6.11.3 Limitations

While the evidence suggests that the benefits of consumption rooms can outweigh the risks, 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 consumption rooms can or cannot achieve. In particular, it is unrealistic to expect that they can:

- prevent all public drug use;
- persuade all clients to reduce risky drug use or enter treatment;
- in themselves be the major factor in reducing morbidity and mortality;
- solve wider problems of drug markets and drug dealing.

### 6.11.4 Conclusion

Three key points must be emphasised. The evidence suggests that consumption rooms only make sense, and can only be effective, if they are:

- established within the wider framework of a public policy and network of services that aim to reduce individual and social harms arising from problem drug use;
- based on consensus and active cooperation between key local actors, especially health workers, police, local authorities and local communities;
- seen for what they are – specific services aiming to reduce problems of health and social harm involving specific high-risk populations of problematic drug users and addressing needs that other responses have failed to meet.

## Annex I

**Table A: Characteristics of consumption room users (data from client surveys)**

Reference	<i>n</i>	Type of study	Average age Age range Gender	Drug use history & current use patterns	Treatment experience Current contact other services	Other characteristics
Reyes Fuentes (2003)	147	Full client survey at (Fixerstübli) CR <b>Berne</b> during four weeks in 2001.  Self-administered, anonymous questionnaire	33 years  15% younger than 25 years  68% male	Life-time prevalence: 99% heroin, 97% cocaine, 92% methadone.  Last week prevalence: 93% heroin, 74% cocaine, 56% methadone	31% contact low-threshold service > 3 times/week	33.3% no own accommodation/apartment  74.7% ever imprisoned  Main source of income: 32.8% social security, 18.8% regular employment, 14.8% receive invalidity pension
Minder Nejedly & Buerki (1999);  Reyes Fuentes (2003)	155	Full client survey at CR <b>Berne</b> during one week in 1995, response rate > 90%.  Self-administered, anonymous questionnaire	30 years  17% younger than 25 years  71% male	Average age first heroin use 19 years;  Life-time prevalence: 99% heroin, 97% cocaine, 84% methadone.  Last week prevalence (current use): 91% heroin, 77% cocaine, 47% methadone	32% contact low-threshold service > 3 times/week	12.2% no own accommodation/apartment  73% ever imprisoned  Sources of income: 27% permanent employment, 13% temporary employment, 49% social services (incl. 3.9% invalidity pension)

Minder Nejedly & Buerki (1999); Reyes Fuentes (2003)	112	Full client survey at CR <b>Berne</b> during one week in 1990, response rate > 90%.  Self-administered, anonymous questionnaire	26 years  55% younger than 25 years  69% male	Average age first heroin use: 19 years;  Life-time prevalence: 99% heroin, 95% cocaine, 67% methadone.  Last week prevalence (current use): 90% heroin, 70% cocaine, 36% methadone	32% contact low-threshold service > 3 times/week	8.2% no own accommodation/apartment  68% ever imprisoned  Sources of income: 41% permanent employment, 23% temporary employment, 12% social services (incl. 1.8% invalidity pension)
Benninghoff et al., 2003	82	Representative client survey at CR <b>Geneva</b> during one week, after 6 months of operation (May/June 2002)	34 years  Age range: 21-49 years  75% male	Average age first heroin use: 19.3 years; average age first injection: 21 years  Frequent injectors: average 15 injections/last week	72% currently in substitution treatment (client profiles untypical for methadone clients Geneva)	50% ever imprisoned, 20% imprisoned during last two years  19% ever sex work, 9% during past six months  <u>Month prior to survey:</u> 8% without fixed accommodation, 94% current residence city Geneva or canton Vaud  42% social security income, 40% insurance payments, 14% full-time employment  17% HIV+ (98% tested), 61% HepC+ (89% tested)
Poschadel et al. 2003	168	Non-random sample of up to 10 users recruited at 18 CRs during full survey of 19 consumption rooms in operation in 2001 in <b>Germany</b>	35 years  Age range: 21-60 years  79% male	94% used heroin last 24 hours, 49% cocaine  average 12.5 years since first heroin use (SD 7.0)  4% use heroin since < 1 year	For 34% the CR has been the first contact with the drugs help system ; 50% ever started abstinence-oriented treatment, and 15% never started any treatment. 43% ever in substitution treatment; 11% currently in substitution treatment.	5% homeless  76% local residents  84% use CR several times/week (incl. 51% daily)  64% mainly use drugs at CRs; 27% mainly at home

Benninghoff & Dubois-Arber 2002	49	Injecting room users in <b>Biel</b> (Switzerland); one-week client survey May 2002; N=86; structured questionnaire	35 years Age range: 23-54 years 80% male	Average age first injecting heroin use: 20.8 years  Frequent injectors: average 10 injections/last week	80% currently in substitution treatment	65% ever imprisoned; 38% imprisoned last 2 years;  11% without fixed accommodation; 22% full-time employment, 43% social security income last month  89% use CR several times per week, incl. 47% daily users
van der Poel, Barendregt & van de Mheen 2003; and Zurhold et al., 2001	67	Subsample of drug users that are 'user card' holders at 4 different consumption rooms in <b>Rotterdam</b> , surveyed in regular drug scene-monitoring study, 2000	36 years Age range: 22-51 yrs 67% male	Average age first regular use of heroin: 20.9 years  99% last 30-day prevalence heroin use with 19% mainly injectors;  100% last 30-day prevalence cocaine use with 13% mainly injectors	No information	55% permanent address  Source: Zurhold et al., 2001:  61% social security income; 26% income from regular employment; 94% use CR more than once per week, incl.. 75% daily service users
Zurhold et al., 2001	616	Non-random sample of drug users. 95% recruited at consumption rooms and 5% in open drug scene <b>Hamburg</b> . Semi-standardised questionnaire interview	33 years Age range: 17-54 years 79% male	Average age first regular use of hard drugs: 20.9 years  Drug use past 24 hours: 84% heroin, 73% cocaine, 32% methadone	No information	25% instable housing  63% unemployed  26% income from regular employment
Happel, 2000	189	Representative client survey of one injection room in <b>Frankfurt</b> , conducted during one month in 1997, structured	31 years 74% male	Average age at start of dependent use of drugs: 22 yrs  80% frequent heroin users (>several times/week)	No information	25% no own accommodation/apartment (of which 6% homeless); 63% local residents  63% use injection room more than once/week, including 34% daily users of the facility



		questionnaire		(>several times/week)		
Jacob et al. 1999	105	Representative survey of clients of a drugs service with consumption room in <b>Hannover</b> , conducted during 4th to 7 <sup>th</sup> months of operation	32 years Age range: 18-47 yrs, with 58% of clients 31 or older 84% male	74% use heroin since > 6 years (incl. 40% since 11 years or more); 9.4% recent heroin users < 2 years; 61% daily heroin injectors	40% in substitution treatment  Average number of services used in addition/parallel: 1,9  74% currently clients of drugs service in vicinity.	68,6% unemployed, 8,6% full-time employment  79% residents of the city or live in surrounding area  9% homeless  23% institutional accommodation (e.g. shelter, temporary housing)
Kemmesies , 1995	150	Sample of drug users recruited at injecting rooms (N=50) and in open drug scene <b>Frankfurt</b> (N=100)	31 years Age range: 20-44 years 75% male	Average age first heroin use: 18.4 years  99% lifetime prevalence heroin and cocaine use  96% current injectors	88% in contact with other services, average 5 contacts/week to: harm reduction/survival-oriented services incl. needle and syringe programmes (75%) and shelters (29%). 34% had contacts with counselling services	46% no own accommodation/apartment (among them 13% homeless, 27% in emergency accommodation and 6% who lived with friends)  61% received social welfare payments  27% had income from regular employment

**Table B: Characteristics of consumption room users upon registration (data from service monitoring systems)**

Reference	n	Monitoring period	Average age	Drug use history & current drug use, upon registration at CR	Treatment experience upon registration at CR	Other characteristics
MSIC Evaluation Committee, 2003	3 810	All drug users who registered at MSIC ( <b>Sydney</b> ) during 18-months trial phase (May 2001 – October 2002)	31 years  Age range: 18-67 years  73% male	Average age first injecting use: 19 years  42% daily injectors (month prior to registration); 44 % ever overdosed	66% ever in drug addiction treatment; 26% entered treatment during past 12 months; 41% currently clients of drugs service in vicinity	57% social security as main income; 21% full time employment; 11% unstable accommodation; 26% imprisoned in year prior registration <u>Month prior to registration</u> : 39% injected in public places; sex work: Male = 3%, Female = 29%
Agencia Antidroga, 2000	1 499	Drug users registered at CR DAVE ( <b>Madrid</b> ) during the first six months of operation (May – October 2000)	68% of clients are 31 years or older  85% male	80% first injecting drug use between 17 and 20 years of age	50% ever in addiction treatment	38% ever imprisoned;  42% homeless;  65% unemployed
Benninghoff & Dubois-Arber, 2002	441	Drug users registered at CR <b>Biel</b> during first nine months of operation (August 2001 – April 2002)	32 years  Age range: 18-55 years  75% male	Average age first drug use: 21.5 years  On average 1.3 drug consumptions during previous 24 hours	No information	93% residents of city of Biel or surrounding area
Benninghoff et al., 2003	736	Drug users registered at CR <b>Geneva</b> during first year of operation (Dec 2001- Dec 2002)	33 years  Age range: 18-62 years incl 12 clients younger than 20; 73% male	On average 1.8 injections during previous 24 hours  20% made last injection in public place	59% currently in substitution treatment (of which 17% report regular heroin consumption , compared to 44% of clients not in treatment)	12% HIV+ (95% tested); 53% HepC+ (90% tested) <u>Month prior to registration</u> : 16% without fixed abode; 81% residents Geneva and canton Vaud; 33% income from regular employment; 60% social welfare payments

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