

AN OVERVIEW OF DRUG CONSUMPTION ROOMS*

Uyuřturucu Kullanım Merkezleri Üzerine Bir İnceleme

Dr. Mehmet Zülfü ÖNER**

ABSTRACT

In response to growing concerns about the public health and public order problems related to drug use, countries use a comprehensive approach to the drug problem, which includes prevention, harm reduction, treatment, and enforcement. Harm reduction encompasses interventions, programmes and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies. Drug consumption rooms are an example of a harm reduction programme and are a component of some drug strategies in some countries.

Drug consumption rooms (DCRs) are legally sanctioned public health facilities that offer a hygienic environment where people can use drugs under the supervision of trained staff. The overall rationale for 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. Drug consumption rooms aim to reduce the risk of transmission of blood-borne infections, in particular HIV (Human Immunodeficiency Virus) and hepatitis; to reduce the likelihood of illness and death resulting from overdose; and to help people who use drugs avoid other harms associated with drug consumption under unhygienic or unsafe conditions.

This article looks at the experiences with drug consumption rooms describes the general features and analyzes them from a historical point of view. This article also explores the position of these rooms in international law.

Key Words: drug consumption rooms, drug policy, harm reduction, drug use, drug addiction, injecting drug use.

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** Dr., Judge, Public Prosecutor, mehmetzulfuoner@hsyk.gov.tr

ÖZET

Ülkeler uyuşturucu kullanımı ile ilgili ortaya çıkan kamu sağlığı ve düzenine ilişkin kaygıları karşılamak için yaptırım, tedavi, zarar azaltma ve önlemeyi içine alacak oldukça geniş yaklaşımı benimsemektedir. Zarar azaltma, uyuşturucu kullanımının bir-eye, topluluklara ve topluma vermiş olduğu sağlık, sosyal ve ekonomik alandaki zararları azaltmayı amaçlayan çeşitli politika, program ve uygulamaları kapsamaktadır. Çalışmanın konusu olan uyuşturucu kullanım merkezleri, bazı ülkelerde bir zarar azaltma programı ve uyuşturucu ile mücadeleye karşı bir araç olarak uygulanan bir örnek olarak karşımıza çıkmaktadır.

Uyuşturucu kullanım merkezleri, eğitimli personel gözetiminde uyuşturucu kullanıcılarına sağlıklı bir kullanım ortamı sunan yasal olarak onaylanmış kamu sağlığı servisleri olarak tanımlanmaktadır. Bu merkezlerin kurulmasının asıl nedeni, özellikle kamuya açık alanlarda şırınga ile uyuşturucu kullanan yüksek riskli kullanıcılara ulaşarak bu alandaki sorunları çözmektir. Uyuşturucu kullanım merkezleri, özellikle HIV ve hepatit gibi kan ile bulaşan hastalık riskini ve aşırı dozdan kaynaklanan ölüm ve hastalık risklerini azaltmayı, uyuşturucu kullanıcılarını sağlıklı ve güvenilir olmayan ortamlarda uyuşturucu kullanımından kaynaklanan diğer risklerden koruyarak onlara yardım etmeyi amaçlamaktadır.

Bu çalışmada, uyuşturucu kullanım merkezleri incelenmektedir. Bu merkezlerin genel özellikleri açıklanmakta ve tarihsel gelişimleri analiz edilmekte, ayrıca bu merkezlerin uluslararası hukuktaki yerine değinilmektedir.

Anahtar Sözcükler: uyuşturucu kullanım merkezleri, uyuşturucu politikası, zarar azaltma, uyuşturucu kullanımı, uyuşturucu madde bağımlılığı, uyuşturucu madde enjeksiyonu.



1. INTRODUCTION

Drug dependence affects a sizeable number of people and constitutes major problems for public health¹. To address drug-related problems, communities across the world have responded with policies and programmes designed to reduce demand for illicit drugs, reduce the supply of illicit drugs, and re-

¹ See World Drug Report 2013, United Nations Office on Drugs and Crime.

duce drug-related harm². Many countries are facing a public health crisis of epidemic proportions with respect to injection drug use (IDU), and as a result of unsafe injecting practices, injection drug users face serious health risks, including fatal and near-fatal overdoses and the contraction of blood-borne diseases, including HIV (Human Immunodeficiency Virus) and hepatitis C³. UNAIDS⁴ suggests that the use of contaminated injection equipment accounts for the majority of HIV infections. Globally, less than five percent of people who inject drugs are estimated to have access to HIV prevention services, and even in regions where they account for the majority of HIV infections, people who use drugs are routinely excluded from HIV/AIDS care and treatment⁵. Despite some efforts, millions of people around the world who use drugs do not have access to such services because of legal and social barriers. The continuing threat posed by HIV, drug overdose, and other injection-related health problems around the world indicates the need for further development of innovative interventions for drug injectors, for reducing disease and mortality rates, and for enrolling injectors into drug treatment and other health care programs⁶.

Harm reduction policies became prominent in the mid-1980s as a response to newly discovered HIV epidemics amongst people who inject drugs in some cities. 'Harm reduction' is a term that is used to refer to a set of general principles used to underpin policies concerning the way that societies respond to drug problems⁷. The harm reduction approach increased in global coverage

² See Babor T.F., Caulkins J.P., Edwards G., Fischer B., Foxcroft D.R., Humphreys K., Obot I.S., Rehm J., Reuter P., Room R., Rossow I. & Strang J., *Drug Policy and the Public Good*, Oxford, United Kingdom, Oxford University Press, 2010.

³ See Malkin Ian, Elliott Richard & McRae Rowan, "Supervised Injection Facilities and International Law", *Journal of Drug Issues*, Vol.33, Issue 3, Summer 2003, pp.539-578.

⁴ The Joint United Nations Programme on HIV and AIDS established in 1994 by a resolution of the UN Economic and Social Council, and is the main advocate for accelerated, comprehensive and coordinated global action on the HIV/AIDS epidemic. See <http://www.unaids.org/en/>, 16.07.2014

⁵ 2006 Report on the Global AIDS Epidemic, UNAIDS, May 2006, p. 114.

⁶ See Broadhead R.S., Grund J.C., Kerr T.H. and Altice F.L., "Safer Injection Facilities in North America: Their Place in Public Policy and Health Initiatives", *Journal of Drug Issues*, Vol.32, No.1, 2002, pp.330-356.

⁷ See Hunt Neil, *A Review of the Evidence-Base for Harm Reduction Approaches to Drug Use*, *Forward Thinking on Drugs*, 2003, p.2, available at: www.forward-thinking-on-drugs.org/

and acceptance throughout the 1990s and became an integral part of drug policy guidance from the European Union at the turn of the century. The main stimulus to the development of harm reduction policies and programmes was the identification of the role of injecting drug use⁸ and the sharing of needles and syringes in the transmission of HIV and AIDS (Acquired Immune Deficiency Syndrome).

Harm reduction generally refers to policies and practices aimed to reduce adverse health, social and economic consequences of the use of drugs, the drug users, their families and the community⁹. This policy aims to prevent the consequence of drug use, that is, to reduce the burden of disease and improve the health of the population.

Harm reduction projects are applied in Europe, Canada and Australia, and in recent years they have been established on a wide scale in many countries in Asia, and numerous cities in the United States. Harm reduction is an official policy of the United Nations, and Europe has played a key role in this development and continues to do so¹⁰. Harm reduction programs have also been gaining ground in some Latin America countries, notably Brazil, Argentina and Uruguay. In Europe, harm reduction interventions include: needle and syringe

review2-print.html, 16.07.2014; In the early 1980s, harm reduction referred to policies and programs directed primarily at reducing the adverse health consequences of illicit drugs. More recently, the term has been used to mean all measures that might reduce drug-related harm, including interventions intended to reduce the supply and demand for drugs. See Patel Kiran, "Exchange Programs Research Note: Drug Consumption Rooms and Needle and Syringe", *Journal of Drug Issues*, Vol. 37, 2007, p. 737.

⁸ Injection drug use is a process whereby one or more psychoactive substances are injected directly into the body using a hypodermic needle and syringe. Although many drug users don't like this way of taking drugs because of discomfort or fear of needles, it is often the preferred method of consumption because the drug enters the blood stream more quickly and directly than with other methods (e.g., smoking, swallowing, or snorting). It is considered by injection drug users to be more efficient, less wasteful and therefore less costly than other means of consumption. See Weekes John, Percy Leah & Cumberland Karen, *Supervised Injection Facilities (SIFs)*, Canadian Centre on Substance Abuse, 2004, available at: <http://www.ccsa.ca/Resource%20Library/ccsa-010657-2004.pdf>, 16.07.2014

⁹ See Wodak Alex, *Demand Reduction and Harm Reduction*, Global Commission on Drug Policies, Geneva, Working Paper, 24-25 January 2011, p.8.

¹⁰ See Marlatt, G. Alan, Larimer Mary E., Witkiewitz Katie, *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*, The Guilford Press, 2012.

programmes¹¹ and opioid substitution treatment¹²; drug consumption rooms (DCRs), and peer naloxone distribution¹³. In this sense, drug consumption rooms are an example of a harm reduction program and are a component of some drug strategies¹⁴.

2. DRUG CONSUMPTION ROOM

Drug consumption rooms are defined as ‘professionally supervised health care facilities where drug users can use drugs in safe, hygienic conditions’¹⁵. We have also defined a drug consumption room as ‘a facility under the administration of an official organization, where drug users are given the op-

¹¹ NSPs (operate across all EU Member States) provide sterile needle/syringes and other injecting equipment to injecting drug users. The role of needle sharing in the transmission of blood-borne viral infections such as hepatitis B among injecting drug users had been known since at least the 1970s. The primary goal of NSPs is therefore to prevent the transmission of HIV/AIDS and other blood-borne viral infections that are spread between injecting drug users through the sharing of injecting equipment. See Kimber Jo, Palmateer Norah, Hutchinson Sharon, Hickman Matthew, Goldberg David and Rhodes Tim, “Harm Reduction among Injecting Drug Users-Evidence of Effectiveness”, *Harm Reduction: Evidence, Impacts and Challenges*, European Monitoring Centre for Drugs and Drug Addiction, 2010, p.118.; Howard J. and Borges P., “Needle Sharing in The Haight: Some Social and Psychological Functions”, *Journal of Psychedelic Drugs*, Vol. 11, 1970, pp. 220-230.

¹² OST is prescribed to dependent users to diminish the use and effects of illicit opiates. Community-based OST is available across all EU Member States and prison-based OST is officially available in the majority of Member States, although overall accessibility is limited. See Kimber et al., 2010, p.118.

¹³ Peer naloxone distribution (PND) or ‘take-home naloxone’ programmes provide the antagonist drug, with training to injecting drug users and/or carers to improve their capacity for effective intervention at opioid-related overdose. Naloxone is currently available on a take-home basis in Italy, Germany, Spain, Lithuania and Norway. See Kimber et al., 2010, p.118.

¹⁴ See Malkin, Elliott & McRae, 2003, p.540.; Szuba J.Tadeusz, “International Comparison of Drug Consumption: Impact of Prices”, *Social Science Medicine*, Vol. 22, No. 10, 1986, pp. 1019-1025.; Csete Joanne, Kaplan Karyn, Hayashi Kanna, Fairbairn Nadia, Suwannawong Paisan, Zhang Ruth, Wood Evan, Kerr Thomas, “Compulsory Drug Detention Center Experiences Among a Community-Based Sample of Injection Drug Users in Bangkok, Thailand” *BMC International Health and Human Rights*, Vol. 11, Issue 12, 2011, pp.1-6.; Liang Bin, Lu Hong, Taylor Melanie, “Female Drug Abusers, Narcotics Offenders and Legal Punishment in China”, *Journal of Criminal Justice*, Vol.37, 2009, p.135.

¹⁵ See Dolan Kate, Kimber Jo, Fry Craig, Fitzgerald John, Mcdonald David, Trautman Franz, “Drug Consumption Facilities in Europe and The Establishment of Supervised Injecting Centres in Australia” *Drug and Alcohol Review*, Vol. 19, 2000, p.337.

portunity to take drugs'¹⁶ or 'as legal facilities that enable the consumption of pre-obtained drugs in an anxiety- and stress-free atmosphere under hygienic conditions'¹⁷. These rooms are also called "health rooms" or "fixer rooms", "safe injection sites," "supervised injection centres/sites/facilities" and "safe consumption centres"¹⁸. They comprise a highly specialized drugs service within a wider network of services for drug users and usually operate from separate areas located in existing facilities for drug users¹⁹.

Although the collective term 'drug consumption rooms' is used, this embraces a range of types of service, delivered in differing ways, targeting different populations, within different contexts. While these rooms differ in their models of service delivery, there are some basic common elements. These include: being officially sanctioned; regulated entry; supervised injecting; provision of sterile injection equipment; immediate resuscitation after overdose; primary health care and referral to drug treatment²⁰.

DCRs can generally be seen as an integral component of a wider network of services intended to meet the needs of the intravenous drug-using population. DCRs offer a potential gateway²¹ to further treatment and social assis-

¹⁶ See de Jong W. & Weber U., "The Professional Acceptance of Drug Use: A Closer Look at Drug Consumption Rooms in the Netherlands, Germany and Switzerland", *International Journal of Drug Policy*, Vol. 10, Issue 2, 1999, p.99.; Kimber et al. states "Drug consumption facilities or rooms (DCRs) are legally sanctioned low threshold facilities which allow the hygienic consumption of pre-obtained drugs under professional supervision in a non-judgemental environment." See Kimber, J., Dolan K., Beek, V., Hedrich, D., and Zurhold H. "Drug Consumption Facilities: an update since 2000", *Drug and Alcohol Review* Vol.22, 2003, p.227.

¹⁷ See Fry C. L., Cvetkovski Stefan & Cameron Jacqui, "The Place of Supervised Injecting Facilities within Harm Reduction: Evidence, Ethics and Policy", *Addiction*, Vol.101, 2006, p.465.

¹⁸ Terms such as "shooting galleries" and "fixing rooms" have been used, and these often have negative connotations among nondrug using members of the general public. Other terms such as "safer injecting rooms" and "medically supervised injecting centers" suggest a more therapeutic approach. See Strang, J., and Fortson, R., "Supervised Fixing Rooms, Supervised Injectable Maintenance Clinics-Understanding the Difference" *British Medical Journal*, Vol. 328, No.7431, pp.102- 103.

¹⁹ See Davies Garth, "A Critical Evaluation of the Effects of Safe Injection Facilities" *The Journal of Global Drug Policy and Practice*, Vol. 1, Issue 3, Fall 2007, p.10.

²⁰ See Webster Christopher D., "Compulsory Treatment of Narcotic Addiction", *International Journal of Law and Psychiatry*, Vol. 8. 1986, pp. 133-156.

²¹ See Kimber Jo, Mattick Richard, Kaldor Jhon, Beek Ingrid Van, Gilmour Stuart, Rance Jake

tance, which include, but are not limited, to the following: provision of sterile injecting equipment and alcohol swabs to sterilize injection sites; emergency medical care, which can be found in most facilities (e.g., oxygen, naloxone for overdoses, etc.); basic health services; needle exchange; counseling services; referrals to other agencies and services such as needle exchange programs, drug treatment, methadone maintenance programs, social welfare programs etc.; information and education on drugs, safer injection techniques and primary health care services; social support network for injecting drug user who are in regular contact with DCR staff members²².

DCR staff members often include multiple disciplines, including medical doctors, nurses, counselors, social workers, psychologists and medical officers, and some services employ ex-intravenous drug users as well. Staff activity is typically scheduled on a rotating basis and at least one staff member supervises clients in the consumption room at all times²³. Services offered at DCRs may include provision of sterile injection supplies and safe disposal, education about safer drug use and communicable disease prevention, support, counseling, referrals to health and social services, and first aid and resuscitation for onsite overdose. Generally, to take advantage of DCRs, participants must meet certain criteria, including being active drug users, being over 18 years of age, accepting the room regulations²⁴.

A., "Process and Predictors of Drug Treatment Referral and Referral Uptake at the Sydney Medically Supervised Injecting Centre", *Drug and Alcohol Review*, Vol. 27, November 2008, p. 602–612.

²² See Broadhead et al., pp.330-356.

²³ See Dolan et al., 2000, p.338.

²⁴ See Broadhead et al., p.346. "...Some of the rules below, as well as distribute printed copies of house rules to clients: - Clients are prohibited from dealing drugs on-site, or from injecting anywhere except in specifically designated rooms.- Some SIFs allow clients to divide-up the drugs they bring into a SIR together, and assist one another in injecting.- Some SIFs require clients to be registered and show an I.D. before admission to the injection room, and/or to demonstrate that they are injectors, city residents, and of minimum age (typically 18 years). - SIRs limit the amount of time clients can use the injection room (30-45 minutes), but clients are allowed to return to the room several times throughout the day or evening.- Clients are prohibited from threatening or intimidating staff members and other clients, and from using loud or offensive language. - Clients are required to clean up after their use of an injection space and to dispose of all used materials in garbage containers before leaving. - Clients are encouraged to assist in keeping the SIF clean and to collect drugrelated debris in the SIF's vicinity...".

Some²⁵ argued that there are three main types of DCRs: ‘integrated’, ‘specialized’ and ‘informal’. Firstly, integrated rooms (or 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 addicts²⁶. 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. Secondly, specialized rooms (or facilities) serve exclusively consumption room users. They are much less common than integrated services, and 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. Finally, informal consumption rooms (or semi-official injecting centers), run by current or former drug users but tolerated by the police, and mostly restricted to drug smoking or inhalation. These centers have been documented in countries including the Netherlands and Switzerland dating back as far as the 1960s, and characterized as areas for tolerated drug use and are distinct from contemporary DCRs with their emphasis on supervised consumption, injecting hygiene and distributing sterile injecting equipment²⁷.

3. OBJECTIVES OF DRUG CONSUMPTION ROOMS

In general, drug consumption rooms have health and public order and

²⁵ See Hunt Neil, *The Evaluation Literature on Drug Consumption Rooms*, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006, p.4.

²⁶ Some rooms offering a safe using place for homeless drug users as well as housing, and also function as a gateway to further assistance in offering all kinds of low-threshold services such as: meals; laundry; showers; medical care; information about assistance; counselling and therapy; and information on safe use. See van der Poel Agnes, Barendregt Cas, van de Mheen Dike, “Homelessness and other Living Condition Characteristics of Drug Users 2003 – 2007, in Rotterdam, the Netherlands”, *European Journal of Homelessness*, Vol. 2, December 2008, pp.235-257.; See Wolf, J., Linssen, L., de Graaf, I., van Dam, T. “Drug Consumption Facilities in the Netherlands”, *Journal of Drug Issues*, Vol.33, 2003, pp.649–661.

²⁷ See Hunt Neil, *An Overview of Models of Delivery of Drug Consumption Rooms*, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006, p.3.

safety objectives²⁸. They are designed to address the health and social problems²⁹, 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 services³⁰. Their primary aims are to reduce the mortality and morbidity associated with drug overdose, public drug use, intoxication and inappropriately discarded injecting equipment, blood-borne virus risk behavior and to act as an access point to drug treatment, health-care and social welfare assistance³¹.

DCRs have most commonly been implemented in cities with high rates of overdose and HIV and Hepatitis B and C transmission among people who use drugs, and high rates of public drug use. DCRs aim to reduce high-risk and public drug use and to improve public amenity near urban drug markets, by providing a hygienic and regulated environment for drug use off the streets³². DCRs can benefit the community by reducing problems associated with drug use and, in the longer term, by helping to engage problem drug users in treatment programmes that are demonstrably effective in cutting drug-related crime and other social problems. DCRs also aim to create an acceptable situation for the public with regard to order and safety concerns that arise from open drug scenes while providing a sheltered and dignified environment for drug consumption. With objectives in public health and public order, DCRs operate within a triangle of individual and public health interests and the public order interests of local communities. Some³³ argue that, more than many

²⁸ See Zurhold, Degkwitz, Verthein & Haasen, 2003, p.667.

²⁹ See Dolan et al., 2000, p.338.; Cook Catherine, Bridge Jamie and Stimson Gerry V., "The Diffusion of Harm Reduction in Europe and Beyond", Harm Reduction: Evidence, Impacts and Challenges, European Monitoring Centre for Drugs and Drug Addiction, 2010, p.39.

³⁰ See Wright, N. M. J., "Supervised Injecting Centres, "British Medical Journal", Vol. 328, No.7431, 2004, pp.100-102.

³¹ See Bayoumi A.M. and Strike C. (co-principal investigators), Jairam J., Watson T., Enns E., Kolla G., Lee A., Shepherd S., Hopkins S., Millson M., Leonard L., Zaric G., Luce J., Degani N., Fischer B., Glazier R., O'Campo P., Smith C., Penn R., Brandeau M., Toronto, Report of the Toronto and Ottawa Supervised Consumption Assessment Study, Ontario: St. Michael's Hospital and the Dalla Lana School of Public Health, University of Toronto, 2012, p.17.

³² See Rhodes, T., Kimber, J., Small, W., et al., "Public Injecting and the Need for "Safer Environment Interventions" in the Reduction of Drug-Related Harm', Addiction Vol. 101, 2006, pp.1384-1393.

³³ See Hedrich Dagmar, Kerr Thomas and Dubois-Arber Françoise, Drug Consumption

other public services, they rely on acceptance by a wide range of key actors: drug users, communities, other health and social agencies, judicial branches, police and politicians.

On the other hand, critics of DCRs argue that there are a number of risks associated with their establishment. Some³⁴ believe that the establishment of centers will give the appearance of condoning drug use or encourage the continuation of drug use where an individual may have otherwise sought treatment. They are also concerned that drug users and dealers may congregate around the centre and that this may impact negatively on nearby businesses and public amenities³⁵.

a. Provide an Environment for Safer Drug Use

Injection drug use continues to present a major public health challenge in urban settings around the world³⁶. The number of IDU worldwide was estimated as approximately 13.2 million. Over ten million (78%) live in developing and transitional countries (Eastern Europe and Central Asia, 3.1 million; South and South-east Asia, 3.3 million; East-Asia and Pacific, 2.3 million)³⁷. Unsafe injection practices are prevalent among injection drug users and have resulted in numerous forms of drug-related harm including HIV/HCV transmission

Facilities in Europe and Beyond, Harm Reduction: Evidence, Impacts and Challenges, European Monitoring Centre for Drugs and Drug Addiction, 2010, p.307.

³⁴ See The Report of the Independent Working Group on Drug Consumption Rooms, Joseph Rowntree Foundation, 2006, pp.66-88.; Kimber J, Dolan K, Wodak A., International Survey of Supervised Injecting Centres 1999-2000, National Drug and Alcohol Research Centre, Sydney, 2001, p.23.; Gunaratnam Praveena, Drug policy in Australia: The Supervised Injecting Facilities Debate, Asia Pacific School of Economics and Government, The Australian National University, 2005, p.1.

³⁵ See The Report of the Independent Working Group on Drug Consumption Rooms, 2006, p.86.

³⁶ Illicit injection drug use continues to fuel infectious disease and fatal overdose epidemics in many settings, and has prompted substantial community concerns due to public drug use and publicly discarded syringes. See De Beck Kora, Kerr Thomas, Bird Lorna, Zhang Ruth, Marsh David, Tyndall Mark, Montaner Julio, Wood Evan, "Injection Drug Use Cessation and Use of North America's First Medically Supervised Safer Injecting Facility", Drug and Alcohol Dependence, Vol. 113, 2011, p.172.; See Drucker E., "Drug Prohibition and Public Health: 25 Years of Evidence", Public Health Reports, Vol.114, No.1, 1999, pp.14-29.

³⁷ See Aceijas C., Stimson G.V., Hickman M., Rhodes T., "Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users", AIDS, Vol. 18, No.17, p.2295.

and other bacterial and viral infections³⁸. Safer injecting education has been widely employed in order to address the harms associated with injection drug use, and numerous harm reduction programs provide information on safer injecting, and street outreach programs work to seek out injection drug users. In this context, DCRs constitute a tool of intervention, in that they provide a sanctioned drug-using environment that is constantly supervised by health-care professionals.

Hygienic consumption conditions reduce the risk of drug-related diseases such as HIV, hepatitis and abscesses, and the facility provides injection utensils and materials for a hygienic and lower-risk consumption in an anxiety- and stress-free atmosphere³⁹. DCRs reach and are accepted by their target populations, including marginalized street users and those at higher risk of infectious diseases or overdose. They provide conditions, especially for regular clients, which improve hygiene and reduce exposure to health risks such as infectious diseases or overdoses. On the basis of available evidence, consumption rooms achieve their immediate objective of providing an environment away from the streets, where high-risk or public drug users can consume their drugs more safely and hygienically, and they do not encourage drug use or injecting⁴⁰. The constant supervision of consumption events allows for immediate first aid in case of an overdose and other emergencies (loss of consciousness, respiratory suppression, respiratory arrest, cardiovascular arrest, shakes, epileptic attacks, anxiety attacks, hallucinations, etc.)⁴¹.

Some⁴² argue that there are some difficult issues associated with deciding

³⁸ See Fast D., Small W., Wood E. and Kerr T., "The Perspectives of Injection Drug Users Regarding Safer Injecting Education Delivered through a Supervised Injecting Facility", *Harm Reduction Journal* 2008, Vol. 5, Issue 32, p.5.

³⁹ See Drug Consumption Rooms in Germany, A Situational Assessment by the AK Konsumraum, Ed.Dirk Schaffer, Heino Stover, September 2011, p.13.

⁴⁰ Hedrich et al., 2010, p.321.

⁴¹ See Solai, S., Dubois-Arber, F., Benninghoff, F., & Benaroyo, L., "Ethical Reflections Emerging during the Activity of a Low Threshold Facility with Supervised Drug Consumption Room in Geneva, Switzerland", *International Journal of Drug Policy*, Vol.17, No.1, 2006, pp.17-22.

⁴² See Fry C., Fox S, Rumbold G., "Establishing Safe Injecting Rooms in Australia: Attitudes of Injecting Drug Users", *Australian and New Zealand Journal of Public Health*, Vol. 23, No. 5, October 1999, pp.501-504.

the location of a DCR in some countries. A great deal of community consultation needs to take place to find a location that is appropriate and accepted by the local businesses, residents and other parts of the community. A primary point of consideration in locating such a facility is that injecting drug users must be willing and able to use it. The facility must therefore be located within a certain distance of drug suppliers and also be located in an area with high rates of drug use.

b. Improve Health Status of Target Group

DCRs help to improve the health status of the target population and contribute to reductions in high-risk injecting behavior⁴³. DCR rules may differ between and within countries, however DCR entry criteria generally include being aged at least 18 years. Many Swiss and Dutch DCRs do not admit injecting drug users who are not resident in the local area and pregnant women are excluded in Australia⁴⁴. Frequently prohibited behaviors on DCR premises include: drug dealing or drug sharing, aggressive behavior, etc⁴⁵. Rooms typically supervise people who inject drugs, but some European rooms have also allowed people to smoke or inhale drugs, such as in the Netherlands where most facilities offer separate rooms for injecting and smoking⁴⁶.

⁴³ See Rhodes Tim, Watts Louise, Davies Sarah, Martin Anthea, Smith Josie, Clark David, Craine Noel, Lyons Marion, "Risk, Shame and The Public injector: A Qualitative Study of Drug Injecting in South Wales", *Social Science & Medicine* Vol.65, Issue 3, 2007, p.582.

⁴⁴ See Solai, et al., 2006, p.17.

⁴⁵ The ethical, legal or political context guiding the formulation of DCRs' operational rules tends not to be explicitly defined. There has been some discussion on drug mixing, doses, and legal liability (i.e. in the case of death in a DCR), international law obligations, in particular human rights issues, and confidentiality issues in illicit drug use. See Solai, et al., 2006, p.17.

⁴⁶ A few DCRs in Europe are exclusively smoking facilities (and those that are may see more "chasing the dragon," smoking heroin, than smoking crack cocaine), while some are combined facilities for injection and smoking drugs. In the Netherlands, heroin-assisted treatment programs offer clients injectable or inhalable heroin and people who opt to smoke do so in ventilated rooms where staff observe them through windows, but are not physically in the same space. See Watson Tara Marie, Strike Carol, Kolla Gillian, Penn Rebecca, Jiram Jennifer, Hopkins Shaun, Luce Janine, Degani Naushaba, Millson Peggy, Bayoumi Ahmed M., "Design Considerations for Supervised Consumption Facilities (SCFs): Preferences for Facilities Where People Can Inject and Smoke Drugs", *International Journal of Drug Policy* Vol. 24, 2013, pp.156-163.

DCRs usually have primary health care professionals, trained in emergency procedures, to respond to overdose and other health emergencies, as well as social workers. Education and general health promotion services are offered to increase knowledge and awareness of risks among clients and minimize risk-taking behavior within and outside the facility. Many European DCRs provide a comprehensive range of services aimed at maximizing the health of injecting drug users. For example in Switzerland, in addition to the supervision of injecting practices, the centers provide counseling, referral, free soup, tea and coffee and cheap fruit and vegetables. Similar arrangements exist in a number of cities in the Netherlands and in Germany⁴⁷. In Rotterdam, the Netherlands, the facility provides a supervised injecting centre as well as a cafeteria, an activity centre with classes in handicrafts, painting and drawing and religious studies⁴⁸.

According to some⁴⁹, there is evidence that when coverage and capacity are adequate, DCRs help to reduce overdose deaths. DCRs do increase access for specific 'hard-to reach' target populations of drug users to health, welfare and drug treatment services⁵⁰.

Drug consumption rooms offer a variety of opportunities to convey health-oriented messages to drug users. These include the provision of safer use advice and simple hints for hygienic injection (washing hands, use of plaster, alcohol swabs etc.), identifying risk situations, teaching personal hy-

⁴⁷ Dolan et al., 2000, p.337.

⁴⁸ See Dolan K., 'Injecting Rooms in Switzerland', NSW Public Health Bulletin, Vol. 10, No. 6, June 1999, pp.59-60.

⁴⁹ See Salmon A.M., Van Beek, I., Amin J., Grulich A., & Maher L., "High HIV Testing and Low HIV Prevalence among Injecting Drug users Attending the Sydney Medically Supervised Injecting Centre" Australian and New Zealand Journal of Public Health, Vol.33, No.3, 2009, pp.280-283.

⁵⁰ See van Beek I. & Gilmour S., "Preference to Have Used a Medically Supervised Injecting Centre Among Injecting Drug Users in Kings Cross, Sydney", Australian and New Zealand Journal of Public Health, Vol. 24, No.5, 2000, pp.540-542.; Wood E., Kerr T., Spittal P. M., Li K., Small W., Tyndall M. W., Hogg R. S., O'Shaughnessy M. V. and Schechter M. T., "The Potential Public Health and Community Impacts of Safer Injecting Facilities: Evidence from a Cohort of Injection Drug Users", Journal of Acquired Immune Deficiency Syndrome, Vol.32, 2003, pp. 2-8.; Kerr T., Wood E., Small D., Palepu A., and Tyndall M. W., "Potential Use of Safer Injecting Facilities Among Injection Drug Users in Vancouver's Downtown Eastside", Canadian Medical Association Journal, Vol. 169, No.8, 2003, pp.759-763.

giene, or even providing safer use training. These approaches assume that changing users' attitudes should lead to improved health behaviors⁵¹. DCRs also represent a secure environment for communication and developing relationships. Contact with users is established to provide the opportunity to talk openly about personal problems and the risk of consumption in an informal environment. Trusting atmosphere makes it possible to positively influence pessimism, emotions of depression and hopelessness and the willingness to change consumption behavior⁵². They show the users the nature of their own personal resources and explain the opportunities of drug help or other offers. Research looking at social inclusion and reintegration into the community reveals that DCRs are valuable in promoting positive social networks and improving the marginalized status of intravenous drug users in society⁵³.

It is also important to note that certain populations may face some challenges in using DCRs. For example, in many settings, some women are reliant on other people to inject drugs, others may have physical or mental disabilities that prevent them from consuming drugs independently. 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 population⁵⁴, to locate rooms on sites that are easily accessible and to ensure that opening hours are long enough to meet demand, especially in the evening⁵⁵.

⁵¹ See Stoever, Heino, "Concerns Consumption Rooms -A Middle Ground between Health and Public Order", *Journal of Drug Issues*, Vol. 32, 2002, p. 601.

⁵² See *Drug Consumption Rooms in Germany*, 2011, p.14.

⁵³ See Patel, p.740.

⁵⁴ Collective evidence from Europe, Australia and Canada indicates that the majority of DCR users are males in their late 30s to early 40s. See Hedrich, D., *European Report on Drug Consumption Rooms*, European Monitoring Centre for Drugs and Drug Addiction, 2004, pp.1-96.

⁵⁵ Rooms targeting drug-using sex workers also need to be appropriately situated and remain open in the evening and night. In Rotterdam and Hamburg, certain DCRs have been established that specifically aim at assisting drug-using sex workers, most of whom are women. See Schatz Eberhard & Nougier Marie, *Drug Consumption Rooms Evidence and Practice*, Briefing Paper International Drug Policy Consortium, June 2012, p.14, available at: http://www.aidshilfe.de/sites/default/files/IDPC_DCR_%20Briefing%20Paper_2012.pdf, 16.07.2014

c. Reduce Public Disorder

Illicit drug use is often associated with public nuisance, such as drug dealing, loitering with intent to purchase drugs, public injecting, intoxication and disposal of needles and syringes in public places⁵⁶. There is often considerable community concern regarding decreased public amenity and personal safety in areas where there is a visible concentration of illicit drug use⁵⁷. In an effort to address public health concerns and problems stemming from public injection drug use, a number of cities have opened consumption rooms where injection drug users can inject pre-obtained illicit drugs⁵⁸.

According to some⁵⁹, DCRs can reduce the level of drug use in public. The extent to which this is achieved depends on their accessibility, opening hours and capacity. Findings suggest that community members appear to be cognizant of both public health (potential reductions in blood-borne virus transmission and overdose) and public amenity (perceived reductions in public drug use and disposal of injecting equipment) benefits of the DCRs⁶⁰. In addition, DCRs improve access to and provide health and other welfare services. There is no evidence that the operation of consumption rooms leads to more acquisitive crime⁶¹.

⁵⁶ Taylor Avril, Cusick Linda, Kimber Jo, Hickman Matthew & Rhodes Tim, *The Social Impact of Public Injecting*, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006, p.8.

⁵⁷ Salmon A.M., Thein H.H., Kimber J., Kaldor J.M., & Maher L., "Five Years on: What Are the Community Perceptions of Drug-Related Public Amenity Following the Establishment of the Sydney Medically Supervised Injecting Centre?", *International Journal on Drug Policy*, Vol. 18, No.1, 2007, p.47.; Stoeber, 2002, p.603.

⁵⁸ See Wood E., Tyndall M.W., Li K., Lloyd-Smith, E., Small W., Montaner J.S., & Kerr T., "Do Supervised Injecting Facilities Attract Higher-Risk Injection Drug Users?", *American Journal of Preventive Medicine*, Vol. 29, Issue 2, 2005, p.126.

⁵⁹ See Zurhold Heike, Degkwitz Peter, Verthein Uwe and Haasen Christian, "Drug Consumption Rooms in Hamburg, Germany: Evaluation of the Effects on Harm Reduction and the Reduction of Public Nuisance" *Journal of Drug Issues* 2003, Vol.33, p.686. "With regard to reducing public nuisance, Hamburg study found that DCRs are indeed effective, particularly for high frequent visitors. For a considerable number of drug users, DCRs offer an alternative to public drug use and thus reduce public disturbance. These findings were generally confirmed by interviews with community residents, businesspeople, the police and politicians."

⁶⁰ The survey was completed by 515, 540 and 316 residents and 269, 207 and 210 businesses in the 3 years respectively, with response rates generally above 75%. See Salmon et al., 2007, p.52.

⁶¹ See Hedrich, 2004, p.82.; Studies found that the establishment of these rooms did not lead

However, facilities are not able to solve wider nuisance problems that result from near illicit drug markets⁶². Some⁶³ argue that DCRs 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.

4. HISTORY AND PRACTICE OF DRUG CONSUMPTION ROOMS

Drug consumption rooms have been introduced in many countries throughout Europe over a number of years. The first modern DCR appeared in Berne, Switzerland. This was at a time of growing concern about the spread of HIV/AIDS, rises in drug related deaths and the growth of public drug scenes in a number of European cities. Harm reduction approaches began to emerge in a policy landscape dominated by detoxification and drug-free residential programmes⁶⁴. Switzerland was followed by the Netherlands and Germany. German government, through an amendment of the German federal narcotics law (“Betaeubungsmittelgesetz”), legalized the operation of DCRs in February 2000, under certain legal and professional conditions. As a compromise, the amendment allowed each of the 16 federal states to operate DCRs within a legal framework.

Over the past several decades, the contexts and dynamics of socio-urban existence have undergone dramatic changes. More specifically, in many of the European metropolitan contexts, the illegal drug use problem presented itself in the form of large concentrated ‘urban drug scenes’. According to the predominant history account, DCRs emerged in European urban areas as a response to a major and intensifying mortality and morbidity crisis linked to

to an increase in crime in their area. See The Report of the Independent Working Group on Drug Consumption Rooms, 2006, p.103.

⁶² See Hedrich, 2004, p.69.

⁶³ See Hedrich, 2004, p.82.

⁶⁴ See Roberts M., Klein A. & Trace, M., Drug Consumption Rooms, The Beckley Foundation Drug Policy Programme, 2004, p.2.; Also, see history of drug abuse and policy in the United States. Musto D. F., Sloboda Z. “The Influence of Epidemiology on Drug Control Policy” Bulletin on Narcotics, Vol. 55, 2003, pp.9-22.

the phenomenon of injecting drug user populations⁶⁵.

DCRs have been established in Spain⁶⁶, Luxemburg, Norway, and are under consideration in several other European cities. The number of countries introducing DCRs is increasing, and by the beginning of 2009 there are 92 operational DCRs in 61 cities, including in 16 cities in Germany, 30 cities in the Netherlands and 8 cities in Switzerland⁶⁷. More recently a centre has also been opened in Denmark with additional centers to follow in other cities. In many other countries, efforts have been undertaken by service providers, politicians, researchers, grass-roots organizations and drug user advocates to introduce DCRs in their own country⁶⁸. DCRs have been established outside Western Europe; specifically, in the Kings Cross area of Sydney, Australia in 2001 and North America's first DCR, the East Side of Vancouver, Canada in 2003⁶⁹.

However, the establishment of DCRs has led to some controversy and disagreement between the International Narcotics Control Board (INCB) and some UN Member States. This has centered on the interpretation of the International Drug Conventions, 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 purposes⁷⁰. Even in some more resistant Western European countries, they are now considered a serious option and are part of the mainstream debate about drug policy⁷¹.

⁶⁵ See Fischer Benedikt, Turnbull Sarah, Poland Blake, Haydon, Emma, "Drug Use, Risk and Urban Order, Examining Supervised Injection Sites (SISs) as 'Governmentality' ", *International Journal of Drug Policy*, Vol.15, 2004, p. 359.

⁶⁶ See for Spain Anoro M., Ilundain E. & Santisteban O., "Barcelona's Safer Infecting Facility: A Harm Reduction Program Lacking Official Support" *Journal of Drug Issues*, Vol.33, 2003, pp.689-711.

⁶⁷ See Hedrich et al., 2010, p.309.

⁶⁸ Schatz & Nougier, 2012, p.2.

⁶⁹ See Roberts, Klein & Trace, 2004, p.2.

⁷⁰ See United Nations, Report of the International Narcotics Control Board for 2003, 2004, pp.48-51, available at: www.incb.org, 16.07.2014

⁷¹ See for France Jauffret-Roustide Marie, Pedrono Gaëlle, Beltzer Nathalie, "Supervised Consumption Rooms: The French Paradox", *International Journal of Drug Policy*, Vol.24, Issue 6, 2013, pp.511-638.; In the UK, there has been debate about the DCRs, See Hunt Neil, Guidance on Standards for the Establishment and Operation of Drug Consumption Rooms in the UK, December 2008.; Hunt Neil, Indicators of the Need for Drug Consumption

As discussed above, the nature and the legitimizing purposes of DCRs have varied from time to time, and place to place. In some countries the principal driving force behind the establishment of DCRs was health of users, in others it was public order and nuisance. Some consumption rooms target particular client groups (for example, homeless, female workers) and others do not. While some DCRs exclusively target drug injectors, an increasing number of European DCRs have generally successfully expanded their services to target oral drug users (e.g., heroin and crack smokers)⁷². In short, while all DCRs provide controlled environments for using illegal drugs and aim to reduce harm, they work differently and have developed for different reasons and in different ways in different countries⁷³.

a. Switzerland

The first drug consumption room appeared in Bern, Switzerland, in 1986⁷⁴. It was established as a means of reducing the nuisance associated with public injecting as well as public health problems such as HIV transmission and drug overdose. The room arose only after injecting drug users began to inject openly in the cafe, and in the decade that followed, injection and consumption rooms spread to other cities in Switzerland⁷⁵. Initially, the authorities in many Swiss cities did not want to support these facilities that were in conflict with the existing repressive way of dealing with drug users. This attitude changed in the second half of the 1980s when it became clear that Swiss drug

Rooms in the UK, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006.; Hunt Neil, Lloyd Charlie, Kimber Jo, Tompkins Charlotte, "Public Injecting and Willingness to Use a Drug Consumption Room among Needle Exchange Programme Attendees in the UK", *International Journal of Drug Policy*, Vol. 18, 2007, pp.62–65.; Lloyd Charlie, Hunt Neil, "Drug Consumption Rooms: An Overdue Extension to Harm, Reduction Policy in the UK?", *International Journal of Drug Policy*, Vol.18, 2007, pp. 5–9.

⁷² See Fischer Benedikt & Allard Christiane, Feasibility Study on 'Supervised Drug Consumption' Options in the City of Victoria, Centre for Addictions Research of British Columbia (CARBC), University of Victoria, 30 April 2007, p.5.

⁷³ See Roberts, Klein & Trace, 2004, p.2.

⁷⁴ See Hammig R.B., "Harm Reduction in Bern: from Outreach to Heroin Maintenance", *Bulletin of the New York Academy of Medicine*, Vol.72, 1995, pp.371-379.

⁷⁵ See Davies, 2007, p.10.; Haemmig R. and van Beek I., *Supervised Injecting Rooms, Injecting Illicit Drugs* Oxford, Blackwell Publishing, 2005, pp.160-169.

users were badly affected by the HIV epidemic.

Swiss drug policy consisted exclusively of activities intended to reduce the supply of drugs and to reduce demand⁷⁶. In the mid-1980s, several Swiss towns and cantons developed a new area of activity to counter the acute problems associated with an increase in the intravenous use of heroin and the spread of HIV/AIDS. This model was taken up by the Federal Government in the early 1990s and given official sanction in 1994 under the name of the ‘four-pillars policy’ of prevention, treatment, harm reduction and law enforcement⁷⁷.

In the 1990s Switzerland chose to reject two referendums which advocated drug policies with divergent objectives⁷⁸. In the early 1990s, although Switzerland had a variety of drug therapy programs, it was perceived that no treatment program seemed to fit for a group of heavily addicted people. In 1994, Switzerland began a three-year clinical trial with the medical prescription of narcotics. In 1998, Switzerland passed a bill that authorized the prescription of narcotics for a limited group of severely addicted drug users in specialized treatment centers. As a result of a national vote had taken in 1999, the bill was valid until December 2004⁷⁹.

The strategic model adopted by Switzerland, and now widely used in other parts of Europe and in Australia and Canada, is based on the identification of concrete problems associated with drug use (morbidity, mortality, social problems) and the development of the most effective measures for reducing them⁸⁰. Prevention, treatment, harm reduction and law enforcement consti-

⁷⁶ Zobel Frank, Dubois-Arber Françoise, *Short Appraisal of the Role and Usefulness of Drug Consumption Facilities in the Reduction of Drug-Related Problems in Switzerland*, Lausanne: University Institute of Social and Preventive Medicine, 2004, p.8.

⁷⁷ See Zobel & Dubois-Arber, 2004, p.8.

⁷⁸ “The first referendum, Youth Without Drugs, presented in 1993 and rejected by the Swiss voters in 1997, proposed a strict abstinence-oriented drug policy with elements of repression, prevention and therapy. The second referendum, For a Reasonable Drug Policy, presented in 1994 and rejected by popular vote in 1998, proposed the decriminalization of drug use, cultivation of plants used to produce drugs, possession of drugs and purchase of drugs for personal use”, See Green Cathy, *Minimising the Harm of Illicit Drug Use: Drug Policies in Australia*, Queensland Parliamentary Library, 2002, p.34.

⁷⁹ See Green, 2002, p.35.

⁸⁰ See Zobel & Dubois-Arber, 2004, p.8.

tute a broad range of complementary interventions. Harm reduction comprises both health measures (distribution and exchange of syringes, supervised drug consumption rooms, information on the dangers associated with substances and the different ways of using them) and social measures (contact and counseling, assistance in finding employment and accommodation). Today, all the Swiss cantons are implementing harm reduction measures⁸¹.

Most Swiss cantons have low-threshold facilities which distribute syringes, and in six cantons, at least one of these facilities has a drug injection room. The principal objectives of these facilities are: to reduce deaths, infectious diseases and other health problems affecting drug users; to provide a point of contact and social support; to facilitate access to the care and treatment network; to improve the situation in the neighborhood and get drug users off the streets⁸².

Most of the DCRs in Switzerland now also have a room where clients can inhale substances. The provision of these facilities is presented as a response to the emergence of new groups of drug users and changes in practice where drug use is concerned. The facilities provide a range of easy-access services (contact, meals, washing facilities, health services, distribution of syringes and condoms, etc.) for the worst affected drug users, and they also act as mediators with the general public in the districts most prone to drug problems. In addition, they are often the first point of access to the social-service and health-care network set up to manage drug-related problems⁸³.

Switzerland still has a large population of regular heroin users, even though this group seems to be ageing and gradually declining in numbers. Injection is still the principal mode of drug use, but inhalation has also become more widespread over the last ten years⁸⁴. The results of a number of evaluations, carried out in Switzerland, indicate that DCRs have a positive impact on some risk behaviors (syringe sharing, hygiene and cleanliness of injection materi-

⁸¹ de Jong and Weber, 1999, p.100.

⁸² See Zobel & Dubois-Arber, 2004, p.9.

⁸³ Features of DCRs in Switzerland see Zobel & Dubois-Arber, 2004, p.9.

⁸⁴ See Zobel & Dubois-Arber, 2004, p.12.

al) and helped to reduce some risk behaviors and keep them at a low level, particularly where the transmission of HIV is concerned. In addition, DCRs have contributed to this reduction in the death rate among drug users and, in particular, among those most seriously affected by drug-related problems⁸⁵.

b. Germany

Drug consumption rooms have officially existed in Germany for the past 20 years; there are a number of drug consumption rooms operating in 16 cities and six German states (Berlin, Hamburg, Hesse, Lower Saxony, North Rhine-Westphalia and the Saarland)⁸⁶. With the sudden danger of getting infected with the HIV virus and the rapid deaths due to AIDS, beginning in the mid-1980s the exchange of needles and pioneer projects with integrated drug consumption in Bremen or advice centers in Bonn were tolerated silently at times⁸⁷.

The first drug consumption room⁸⁸ in Germany was opened in 1994, response to the widespread visible 'open scene' of drug users in Frankfurt. At the end of the 1980s, Frankfurt was struggling with a large open drug scene in the city centre. It was accompanied by a lot of nuisance for city residents and a deteriorating state of health in the user population⁸⁹. Later, drug consumption rooms were opened in Hamburg, Bremen and Bonn.

The German Parliament adopted an amendment of the Narcotics Act in order to provide a clear legal basis for the establishment of drug consumption rooms, and this amendment came into force in April 2000⁹⁰. That change legalized the operation of DCRs under specified conditions and standards. A uniform German federal framework law was created that empowers the

⁸⁵ See Zobel & Dubois-Arber, 2004, p.15.

⁸⁶ Drug Consumption Rooms in Germany, 2011, p.4.

⁸⁷ See Michels I., Stöver H. & Gerlach R., "Substitution Treatment for Opioid Addicts in Germany", *Harm Reduction Journal*, 2007, Vol. 4, No. 1, p.5.

⁸⁸ In Germany, the term "drug consumption rooms" is used to describe these low-threshold, use-tolerant facilities. Synonymous terms include "health-rooms," "lane-rooms," "fix-rooms," and "safe injecting rooms," "supervised injecting center". See Stoever, 2002, p. 597.

⁸⁹ de Jong and Weber, 1999, p.101.

⁹⁰ See Zurhold et al., 2003, p.664.

states to “pass legal ordinances that regulate conditions of issuing permits”. The newly included §10a was the main standard, which describes the legal definition of drug consumption rooms in paragraph 1: “Anyone who wants to operate a facility that provides drug addicts with the opportunity or allows them to consume narcotics that have been brought with them and have not been prescribed by a physician on its premises requires the permission of the highest responsible state agency (drug consumption room).” The right to use the drug consumption room is regulated by the German Narcotics Law (BtMG), the respective legal regulation of the state and agreements by the local cooperation partners (politicians, police, state prosecutor and regulatory agency). Some cities have cooperation agreements with the binding stipulation that only persons who are registered in the respective city are allowed to use the drug consumption room⁹¹.

In Germany, the motivation for establishing drug consumption rooms was the growing health-related⁹² and social destitution of hard-core drug addicts on the open drug scene of the big cities⁹³. The conception of the drug consumption rooms has been developed in close cooperation between representatives of the municipal authorities, the police, and the administration of justice and of the organizations of drug-addict care services⁹⁴.

German policy toward DCRs can be described as low-threshold and acceptance-orientated facilities. German DCRs were not established for the sole purpose of offering a place to consume drugs, but rather, were integrated into already existing low-threshold service facilities. This policy of providing DCRs where services already exist emphasizes that the DCR is in addition to a broad range of services, from harm reduction to drug treatment and medical care

⁹¹ Drug Consumption Rooms in Germany, 2011, p.17.

⁹² See de Jong and Weber, 1999, p.101.

⁹³ See Fischer B., “‘Drugs, Communities, and ‘harm reduction’ in Germany: The New Relevance of ‘Public Health’ Principles in Local Responses” J. Public Health Policy, Vol. 16, Issue, 4, 1995, pp.389-411.

⁹⁴ See Drug Consumption Rooms, Background Information, Federal Ministry of Health and Social Security, Drug Commissioner of the Federal Government, Berlin, Germany, April 2003, p.2, available at: <http://www.druglawreform.info/images/stories/documents/GE-DrugConsumptionRooms.pdf>, 16.07.2014

which drug users are already offered and need⁹⁵.

The progress reports and evaluations by the individual DCRs prove that these offers are a successful component of the differentiated addiction support system at all locations that reduce acute adverse medical effects and prevent numerous drug-related deaths⁹⁶. In the open drug scene of big German cities, drug consumption rooms proved to be an efficient measure for providing assistance in surviving, stabilizing the drug users' health and delivering them from drug addiction⁹⁷. Drug consumption rooms in big cities are integrated into a well-developed and widespread network of measures providing counseling, assistance, treatment and social reintegration. They actually reinforce these measures and enable more and more addicts to abandon their illicit drug use and their drug addiction⁹⁸.

c. The Netherlands

The Netherlands has led Europe in the liberalization of drug policy. 'Coffee shops' began to emerge throughout the Netherlands in 1976, offering cannabis products for sale. Dutch policy is a de facto decriminalization of possession, buying and selling of amounts of cannabis for personal use, although, de jure, those activities are not allowed⁹⁹.

⁹⁵ Zurhold, et al., 2003, p.666.

⁹⁶ See Drug Consumption Rooms in Germany, 2011, p.34.; The results of survey, with 616 Hamburg drug users, indicate that clients who visited the DCRs are mainly by long-term drug addicts with a high frequency of daily and public drug use, as well as a tendency towards high-risk practices. With regard to the impact of DCRs on reducing harm and encouraging healthy behaviors, the findings show that nearly two-thirds of the drug users stated a greater awareness of both risk and health since visiting DCRs. Compared to this study, in Hamburg a very high number of drug users affirmed an increased harm reduction behavior. See Zurhold, et al., 2003, p.672.

⁹⁷ Statistics in Frankfurt have shown that the open drug scene has shrunk considerably (from 800 individuals in 1991:1992 to 150 in 1993). Further, that the number of drug-related deaths in 1993 has dropped by almost 50% compared to 1992 (from 127 to 68) and the number of complaints from neighbourhood residents about experiencing nuisance has also dropped greatly. See de Jong and Weber, 1999, p.101.

⁹⁸ Drug Consumption Rooms, Background Information, 2003, p.10.

⁹⁹ See Jelsma Martin, The Development of International Drug Control: Lessons Learned and Strategic Challenges for the Future, Working Paper, Prepared for the First Meeting of the Commission, Geneva, 24-25 January 2011, p.12.

Drug control policy in the Netherlands is based on the Opium Act. The Act, which dates back to 1919, was fundamentally amended in 1976 to introduce a differentiation in penalties between drugs and offences according to their potential medical, pharmacological, sociological and psychological risks. Possession, production and sale of cannabis had been criminalized in 1953, at a time when the substance was unknown to the general population. When cannabis became popular during the 1960s, the cannabis retail market was predominantly underground. Eventually police began to tolerate 'house dealers' in youth centers. The change was based on social and public health concerns, in particular the separation of markets of soft (cannabis) and hard drugs (heroin, cocaine etc.)¹⁰⁰. A revision of the Opium Act in 1976 introduced statutory decriminalization for cannabis. When the government decided to decriminalize cannabis and to tolerate the retail sale, they did not foresee the coffee shop phenomenon, which the authorities never intended to exist. Commercial coffee shops replaced the house dealers in youth centers, and the number of shops increased rapidly during the 1980s, creating uncontrollable situations in which the guidelines were regularly ignored¹⁰¹.

Over the years enforcement of the criteria by special police intervention teams became stricter, new laws and regulations were introduced to phase out coffee shops in municipalities. Restrictions on coffee shops in the proximity of schools and licenses for owners were also introduced. Since then, the number of coffee shops steeply declined from a peak of about 1,500 to 813 in 2000 and further to 737 in 2004 and down to 702 in 2007¹⁰². In 2005 a second initiative proposed to experiment regulating supply of cannabis to coffee shops, but the initiative failed¹⁰³. In 2007, the national guideline that coffee shops are not allowed to sell alcohol was finally implemented in Am-

¹⁰⁰ See de Kort Marcel, "The Dutch Cannabis Debate, 1968-1976." *The Journal of Drug Issues*, Vol.24, Issue 3, 1994, pp.417-427.

¹⁰¹ Blickman Tom & Jelsma Martin, "Drug Policy Reform in Practice: Experiences with alternatives in Europe and the US", *Nueva Sociedad*, No 222, July-August 2009, p.13.

¹⁰² Korf Dirk, *A Cannabis Reader: Global Issues and Local Experiences*, Monograph Series 8, Vol. 1, Eds. Sharon Rödner Sznitman, Börje Olsson, Robin Room, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2008, p.142.

¹⁰³ Blickman & Jelsma, 2009, p.21.

sterdam¹⁰⁴. The Dutch have made a serious commitment to harm reduction policy of preventing the potential harms related to drug use rather than trying to prevent the drug use itself¹⁰⁵. The harm reduction effort has particularly focused on the prevention of AIDS among intravenous drug users.

In the Netherlands, official DCRs were first set up in 1990 within a church operated service in Rotterdam but did not become a regular part of the services until 1994, official rooms became feasible after legal guidelines were issued in 1996¹⁰⁶. We can distinguish between periods in which drug consumption rooms played a part. The first period covers the years 1975-1986 in Amsterdam and the second period relates to the 1990s with the centers in Rotterdam, Arnhem and Amsterdam¹⁰⁷. While some facilities in Amsterdam closed down due to lack of official status or legal framework in the late 1980s, the argument for facilities for injecting drug users began to emerge again in the early 1990s. Consequently, these facilities and other low-threshold facilities were again promoted, this time as measures to reduce public nuisance and harms associated with increasing street-based injecting¹⁰⁸. In recent years, notably due to the local initiatives, interest in these facilities has also grown at the national level.

Most Dutch facilities are run by regional drug services, offering a wide range of services from low-threshold harm reduction measures to drug-free treatment. Often they are incorporated in existing low-threshold services with medical care, counseling, food, laundry and shower. Most facilities in the Netherlands have both smoking and injecting rooms¹⁰⁹. At some centers, users have to apply, and be approved; to use the rooms, and some centers limit access to the centre to residents of the area¹¹⁰. Because of this, the Nether-

¹⁰⁴ Korf, 2008, p.152.

¹⁰⁵ Duncan David F. & Nicholson Thomas, "Dutch Drug Policy: A Model for America?", *Journal of Health & Social Policy*, Vol.8, Issue 3, 1997, pp.1-15, available at: <http://www.druglibrary.org/schaffer/other/dutch.htm>, 16.07.2014

¹⁰⁶ Hunt, *An Overview of Drug Consumption Rooms*, 2006, p.9.; *European Report on Drug Consumption Rooms*, 2004, p.18.

¹⁰⁷ de Jong and Weber, 1999, p.102.

¹⁰⁸ See Dolan et al., 2000, p.339.

¹⁰⁹ See Hunt, *An Overview of Drug Consumption Rooms*, 2006, p.10.

¹¹⁰ See Dolan et al., 2000, p.338.

lands has experienced considerable problems with drug tourism. The majority of services serve a limited target group of 'chronic addicts' from a specific local area; the user must register with the municipality or local drugs agency and be a legal resident of the Netherlands¹¹¹.

d. Australia

The principle of harm reduction has formed the basis of the drug policy framework in Australia since 1985. Various drug strategies (drug diversion, drug courts, drug consumption rooms and heroin prescription) have received much prominence in the public debate on drug policy in recent years¹¹². Diversion programs offer an alternative way of dealing with drug dependent offenders rather than through the traditional criminal justice system¹¹³.

In Australia, like other countries, illicit drugs are a complex issue, affected by a multitude of factors¹¹⁴. While there is general consensus on the need for an integrated approach to the drug problem in Australia, there are divergent views about the effectiveness of current drug policies and strategies¹¹⁵. In response to pressure from the newly formed World Health Organization, the production and importation of heroin was prohibited in Australia in 1953. Injection drug use steadily increased in Australia during the last decades of the twentieth century, with an estimated 7% annual growth in the number of

¹¹¹ See Hunt, *An Overview of Drug Consumption Rooms*, 2006, p.9.

¹¹² See Bammer Gabriele, "What Can a Trial Contribute to the Debate about Supervised Injecting Rooms?", *Australian and New Zealand Journal of Public Health*, 2000, Vol.24, Issue 2, pp.214-215.

¹¹³ See Flick M., Eardley T., UNSW Evaluation Consortium, Social Policy Research Centre, *Evaluation of the NSW Youth Drug Court Pilot Program: First Implementation Review, A Report for the Youth Drug Court Monitoring and Evaluation Committee*, June 2001.

¹¹⁴ In the 2004 Report of the United Nations Office of Drug Control & Crime Prevention (ODCCP), Australia's statistics indicated the highest levels of illicit drug abuse amongst OECD countries.

¹¹⁵ Australia has signed and ratified the three major international drug treaties (1961, 1971, 1988), which serve as the basis of the global drug prohibition system. Like most other countries, these three treaties are the foundation for Australia's drug policy. See *Minimising the Harm of Illicit Drug Use: Drug Policies in Australia*, Queensland Parliamentary Library, 2002, p.1, available at: <http://www.parliament.qld.gov.au/parlib/research/index.htm>, 16.07.2014

injecting drug users¹¹⁶.

During an economic recession in the early 1990s, 'shooting galleries' were established in Kings Cross and by the mid-1990s, King Cross had approximately a dozen such facilities¹¹⁷. The shooting galleries had apparently represented a major dilemma for senior police who recognized their important public health benefits while also acknowledging their clearly illegal status. During the 1990s, increasing concern about corruption in the NSW Police Service led to the establishment of a royal commission. Consequently, an inquiry was established, and the committee heard evidence provided by supporters and opponents of drug consumption rooms and inspected various rooms throughout Europe. In the final report, the inquiry found strong arguments favoring the establishment of DCRs and only weak arguments against. Despite these findings, however, a majority of the inquiry members recommended against even a scientific trial of a DCR¹¹⁸.

As a result of some groups' effort, the first drug consumption room (known as a tolerance room or a supervised injection center) in Australia, opened in 1999, to intense national publicity. Conditions within Australia's first drug consumption room were far from ideal; the room operated with about a dozen volunteer staff and followed a medical protocol prepared in consultation with experienced staff of an official DCR in Europe. Most of the delay in opening the facility was due to a series of legal challenges¹¹⁹.

Drug consumption rooms (or safe injecting rooms) have been implemented in Australia to reduce the health and public order problems associated with illegal injection drug use. The expected benefits of such rooms relate to their

¹¹⁶ See Fitzgerald J., Dovey K., Dietze P., Rumbold G., "Health Outcomes and Quasi-Supervised Settings for Street Injecting Drug Use", *International Journal of Drug Policy*, Vol.15, 2004, pp.247–257.

¹¹⁷ See http://www.drugfree.org.au/fileadmin/library/Injecting_Rooms/DFAInjecting_Room_Correspondence.pdf, 16.07.2014.; Wodak Alex, Symonds Ann, Richmond Ray, "Injection Room Led to a Sanctioned, 'Medically Supervised Injection Center the Role of Civil Disobedience in Drug Policy Reform: How an Illegal Safer'", *Journal of Drug Issues*, Vol.33, 2003, p. 610.

¹¹⁸ Wodak et al., p. 614.

¹¹⁹ See Wodak et al., p. 617.

potential to help reduce some of the harms associated with injecting drug use¹²⁰, such as the incidence of fatal and non-fatal heroin overdose, blood-borne virus transmission (hepatitis C and B, and HIV) and the prevalence and impact of street-based injecting, in addition to improved access to health and welfare services for drug users¹²¹. DCRs findings appear to be positive, with decreases in the levels of public nuisance in some areas; the number of overdose deaths and complications from non-overdose deaths; risk behavior associated with the transmission of blood borne viruses and improvement in health and social functioning of clients¹²². All clients attending the centre are individually registered and a medical file is created wherein demographic information, relevant history and clinical progress are documented¹²³.

The suitability of drug consumption rooms in Australia has been debated at all levels of government, by researchers, professional bodies and advocates in the drug field, within the media and at the community level¹²⁴. In recent years, trials of drug consumption rooms have also been proposed in some cities in Australia¹²⁵.

e. Canada

In Canada, like other countries, injection drug use is a problematic activity¹²⁶. In the past, injection drug use was thought to be limited to Canada's largest urban centers (e.g., Vancouver, Toronto, and Montreal). However, there are large numbers of injection drug user across the country (e.g., Calgary, Winnipeg, and

¹²⁰ See Drug Policies in Australia, 2002, p.29.

¹²¹ See Kimber et al., 2000, p.338.

¹²² See Kimber et al., 2008, p. 610.; Kimber et al., 2000, p.338.; Medically Supervised Injecting Centre Evaluation Committee Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre, MSIC Evaluation Committee, Sydney, 2003.

¹²³ See Beek Ingrid van, Kimber Jo, Dakin Andy, Gilmour Stuart, "The Sydney Medically Supervised Injecting Centre: Reducing Harm Associated with Heroin Overdose", *Critical Public Health*, Vol.14, Issue 4, 2004, p.393.

¹²⁴ See Drug Policies in Australia, 2002, p.30.

¹²⁵ Trials of these rooms have been proposed in New South Wales, Australian Capital Territory and Victoria. See Drug Policies in Australia, 2002, p.30.

¹²⁶ See Small Dan, Palepu Anita, Tyndall Mark W., "The Establishment of North America's First State Sanctioned Supervised Injection Facility: A Case Study in Culture Change", *International Journal of Drug Policy*, Vol.17, 2006, pp.73–82.; Babor et al., 2010, p.330.

Halifax) and that this problem also exists in rural areas¹²⁷. In response to the morbidity and mortality consequences of injection drug use, a variety of therapeutic and public health interventions to reduce these harms have been implemented or proposed in several countries, including Canada over the past two decades. The rate of overdose deaths in British Columbia rose between 1988 and 1993, and the vast majority of HCV (Hepatitis C Virus) transmissions in Canada have been injection drug use related since the early 1990s¹²⁸.

In September 2003, Insite became the first legally operating DCR in North America, and several other Canadian cities have considered the establishment of these facilities, including Victoria and Montreal¹²⁹. Insite is located on Hastings Street in Vancouver's downtown eastside, a collage of working-class and working poor, activists, migrant workers, young families, artists and students¹³⁰. Target groups most vulnerable within the four drug using population are those men and women who suffer from mental illness, are of low socioeconomic status, aboriginals, and users of more than one drug and people who have experienced ineffective treatment in the past. After its initial three-year exemption, Insite received a prolongation until December 31, 2007 and subsequently until June 30, 2008. As the deadline for the renewal approached, however, the Minister of Health alluded to the fact that the government may not renew again. The British Columbia Court of Appeal upheld the trial decision: Insite should continue to operate free from federal drug prohibitions. The Court of Appeal determined that the federal drug laws were inapplicable to Insite under the doctrine of interjurisdictional immunity¹³¹. Insite was a provincial health care facility which did not undermine the federal govern-

¹²⁷ See Millar J., Hepatitis and Injection Drug Use in British Columbia-Pay Now or Later, Vancouver, Ministry of Health, 1998.; Roy D. & Cloutier R., Drug Use and the HIV Epidemic: A Framework for Prevention, Ministry of Health and Social Services, Quebec, 1998, pp.11-12, available at: <http://www.santecom.qc.ca/Bibliothequevirtuelle/santecom/35567000033545.pdf>, 16.07.2014

¹²⁸ See Cruz Firestone Michelle, Patra Jayadeep, Fischer Benedikt, Rehm Jürgen, Kalousek Kate, "Public Opinion Towards Supervised Injection Facilities and Heroin-Assisted Treatment in Ontario, Canada" International Journal of Drug Policy, Vol.18, 2007, p. 54.

¹²⁹ Bayoumi et al., 2012, p.5.

¹³⁰ Bouclin Suzanne & Vittal Priyanka, "The Insite Decision and the Case for Supervised Consumption Facilities in Ottawa", C.J. Poverty Law, Vol. 91, 2012, p.92.

¹³¹ See Bouclin & Vittal, 2012, p.100.

ment's objectives of protecting health and safety and eliminating the underground market which encouraged particular drug-related offences such as the importation, production or trafficking of illicit substances¹³².

Research shows that Insite has contributed to decrease in public drug use, a decrease of drug paraphernalia waste, and a decrease in overdose-related death¹³³. It has reached an at risk population and reduced the number of people injecting in public and the amount of drug paraphernalia on the streets¹³⁴.

As in most other countries, in Canada, matters on drug control or policy are highly controversial¹³⁵. While an integral aspect to Insite's success was broad-based and multi-level support from community residence and local politicians, the federal Conservative government has been explicit in its opposition to harm reduction programs since 2007¹³⁶. Some argue that in order to promote the social aims and effective operation of drug consumption facilities, governments must ensure adequate protection from criminal liability for clients accessing drug consumption facilities as well as managers and staff involved in the operation of the facilities¹³⁷.

¹³² See Bouclin & Vittal, 2012, p.100.; Calder Gillian, "Insite: Right Answer, Wrong Question" Constitutional Law Forum, Vol. 19 Issue 3, 2011, p.114.

¹³³ See Hooper et al., p.3.; Small Will, Moore David, Shoveller Jean, Wood Evan, Kerr Thomas, "Perceptions of Risk and Safety within Injection Settings: Injection Drug Users' Reasons for Attending a Supervised Injecting Facility in Vancouver, Canada", Health, Risk & Society, Vol.14, Issue 4, 2012, pp.307-324.; Bayoumi A. M., Zaric G. S., "The Cost-Effectiveness of Vancouver's Supervised Injecting Facility", Canadian Medical Association Journal, Vol.179, Issue 11, 2008, pp.1143-1151.; Pinkerton S. D., "Is Vancouver Canada's Supervised Injection Facility Cost-Saving?", Addiction, Vol.105, 2010, pp.1429-1436.; Andreson M. A., Boyd N., "A Cost-Benefit and Cost-Effectiveness Analysis of Vancouver's Supervised Injection Facility", International Journal of Drug Policy, Vol.21, 2010, pp.70-76.; Cruz et al., 2007, pp.54-61.; Wood E., Kerr T., Stoltz J., Qui R., Zhang R., Montaner, J. & Tyndall, M., "Prevalence and Correlates of Hepatitis C Infection among Users of North America's First Medically Supervised Safer Injection Facility", Journal of the Royal Institute of Public Health, Vol. 119, 2005, pp. 1111-1115.; See Small W., Rhodes T., Wood E., & Kerr T., "Public Injection Settings in Vancouver: Physical Environment, Social Context and Risk", International Journal of Drug Policy, Vol.18, 2007, pp.27-36.

¹³⁴ See Kerr T., Tyndall M., Zhang R., Lai C., Montaner J., & Wood E., "Circumstances of First Injection among Illicit Drug Users Accessing a Medically Supervised Safer Injection Facility", American Journal of Public Health Vol.97, Issue 7, 2007, pp.1228-1230.

¹³⁵ See Cruz et al., 2007, p.56.

¹³⁶ See Bouclin & Vittal, 2012, p.115.

¹³⁷ See Legislating on Health and Human Rights: Model Law on Drug Use and HIV/AIDS Module 4: Supervised Drug Consumption Facilities, Canadian HIV/AIDS Legal Network, 2006, p.23.

f. Norway

In recent years there has been considerable public concern and interest in the drugs problem in Norway¹³⁸. The debate on the establishment of drug consumption rooms in Norway began in the late 1990s. The immediate cause was the rise in drug-related deaths, a two-fold increase in the estimated number of injecting drug users, and reports confirming the poor health of large sections of the drug abusing population¹³⁹.

Norway has actively sought to limit drug-related harm. Since 1988, free syringes and needles have been distributed in a number of municipalities. Many local authorities have established low-threshold healthcare services; facilities where substance abusers can find food, shelter and an opportunity to shower and wash their clothes have also been established. Mobile outreach units have been set up and work among substance abusers wherever they congregate¹⁴⁰.

The first formal bid to enact legislation enabling drug consumption room to be set up in Norway was put forward in the parliament in 1999. In Norway, a Provisional Act relating to a trial scheme of premises for drug injection was approved by the Norwegian Parliament in December 2004 and a drug consumption room (or known public supervised drug injection facility) was opened in Oslo in February 2005¹⁴¹.

Drug abusers must be registered before using the premises, only heavy drug abusers aged at least eighteen may register, and a user may only bring one user dose into the drug injection premises. The staff shall be made up of healthcare and social work professionals. The person in charge of the Injection Rooms Scheme must be a healthcare professional, and all staff members shall be trained regularly to deal with the toxic effects of overdosing. Local authori-

¹³⁸ See Skretting Astrid, *The Norwegian Trial of Public Drug Injection Room*, Norwegian Institute for Alcohol and Drug Research, 2007, p.2, available at: http://www.issdp.org/conferences/2007/papers/Astrid_Skretting.pdf, 16.07.2014

¹³⁹ Skretting, 2007, p.4.

¹⁴⁰ Skretting, 2007, p.5.

¹⁴¹ See Hunt, *The Evaluation Literature on Drug Consumption Rooms*, 2006, p.14.; Skretting, 2007, p.1.

ties provide adequate guidance for staff, and the scheme is adequately staffed to undertake admission control, supervise injections, provide counseling and practical advice on injecting and offer medical assistance and monitor activity in the waiting room. The police may, on suspicion of illegal possession or use of drugs on the premises, and on request, receive information as to whether an identified person is a registered user of The Injection Rooms Scheme or not. The police may act to protect law and order, and according to the regulations; patient records must be kept, and patient information provided for evaluation purposes¹⁴². According to these regulations, Ministry of Health and Care Services may give permission to local authorities to run a supervised drug injection trial¹⁴³.

The prevention of deaths from illicit drug use has been one of the leading arguments for establishing DCRs in Norway¹⁴⁴. It is said that such facilities would give heroin users hygienic surroundings and professional guidance in which to administer the drug; toxic reactions could be dealt with on the spot by administering an antidote or calling the emergency services¹⁴⁵. It has also been suggested that injecting rooms could provide counseling and to make necessary referrals to treatment etc¹⁴⁶. Public injecting rooms have political support in Norway, despite the country's historically restrictive drugs policy¹⁴⁷.

5. INTERNATIONAL LAW AND DRUG CONSUMPTION ROOMS

The ultimate goal of the international drug control system is to limit the production, manufacture, export, import, distribution of, trade in, use and possession of the controlled drugs to exclusively medical and scientific purposes. Beginning with the enactment of the International Opium Convention in 1912, states began a serious effort to combat the problems associated with drug use on an international level. This united effort has continued with the

¹⁴² Skretting, 2007, pp.2-4.

¹⁴³ Skretting, 2007, p.4.

¹⁴⁴ Skretting, 2007, p.6.

¹⁴⁵ Skretting, 2007, p.6.

¹⁴⁶ Skretting, 2007, p.4.

¹⁴⁷ Skretting, 2007, p.9.

enactment of the Single Convention on Narcotic Drugs in 1961¹⁴⁸, the Convention on Psychotropic Substances in 1971¹⁴⁹, and the U.N. Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances in 1988¹⁵⁰.

Drug consumption rooms were not foreseen by the United Nation drug control conventions of 1961, 1971 and 1988. Indeed, these treaties were formulated before the extent to which the HIV epidemic would be fuelled by injection drug use was fully appreciated and before the rapid increase in illegal drug use of the 1990s¹⁵¹. With the changing nature of the health problems facing the international community, and in particular with the spread of HIV, some countries have begun to use harm minimization measures, including DCRs¹⁵².

The International Narcotics Control Board (INCB)¹⁵³, which oversees the implementation of the conventions, but which does not have the authority to issue binding legal interpretations of them, has expressed concern about drug consumption rooms. INCB has been critical of Canada and other countries for considering the implementation of DCRs. Although the INCB accepts some harm reduction measures such as needle exchange and opiate substitution treatment, it does not consider other harm reduction measures (including coffee shops and drug consumption rooms) to be in conformity with the conventions. The Annual Report of the International Narcotics Control Board 2003 comments that “the Board on numerous occasions [has] expressed its concerns regarding the operation of drug injection rooms, where persons can inject drugs acquired with impunity on the illicit market. The Board reiterates

¹⁴⁸ 1961 Single Convention on Narcotic Drugs (amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs) ratified by 148 states, including Australia, Canada, Germany, The Netherlands, Spain, Switzerland, and the United States.

¹⁴⁹ 1971 Convention on Psychotropic Substances ratified by 172 states, including Australia, Canada, Germany, The Netherlands, Spain, Switzerland, and the United States.

¹⁵⁰ 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances ratified by 167 states, including Australia, Canada, Germany, The Netherlands, Spain, and the United States.

¹⁵¹ See Legislating on Health and Human Rights, 2006, p.9.

¹⁵² See Malkin, Elliott & McRae, 2003, p.545.

¹⁵³ The Board is “the independent and quasi-judicial control organ for the implementation of the United Nations drug control conventions ...[and] is independent of Governments as well as the United Nations”. Malkin, Elliott & McRae, 2003, p.564.

its view that such sites are contrary to the fundamental provisions of the international drug control treaties, which oblige State parties to ensure that drugs are used only for medical and scientific purposes”¹⁵⁴. The view expressed by the INCB that DCR might be regarded as aiding, abetting, facilitating or counseling the illegal use of drugs for personal use, contrary to Article 3 paragraph 1(c) (iv) of the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances¹⁵⁵. Contrary to the views expressed by the INCB, some¹⁵⁶ argue that there is nothing in the 1988 Convention and other conventions that prevent states from establishing DCRs.

Firstly, international human rights law establishes an obligation on states to respect, protect and fulfill the right to the highest attainable standard of health¹⁵⁷ of all persons, including those who use drugs¹⁵⁸. The United Nations member states have committed to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups¹⁵⁹. Moreover, some¹⁶⁰ argue that customary international law includes a general obligation on the part of states to protect and promote the health of their nationals. The right to health has also been recognized in

¹⁵⁴ See Roberts, Klein & Trace, 2004, p.3.

¹⁵⁵ See Legislating on Health and Human Rights, 2006, p.10.

¹⁵⁶ Malkin, Elliott & McRae, 2003, pp.539-578.; Legislating on Health and Human Rights, 2006, p.11.

¹⁵⁷ See Article 25 of the Universal Declaration of Human Rights, which provides for the right to “a standard of living adequate for the health and well-being of himself” including “medical care and necessary social services.” Article 35 of the Charter of Fundamental Rights of European Union states: “Everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.”

¹⁵⁸ Malkin, Elliott & McRae, 2003, p.542. “Two international treaties, of particular relevance in the context of harm minimization and the right to health, further define the basic parameters of international human rights law. These treaties are (1) the International Covenant on Civil & Political Rights (1976), ratified by 148 states and (2) the International Covenant on Economic, Social & Cultural Rights (1976), ratified by 145 states. The Constitution of the World Health Organization, a treaty adopted in 1948, also recognizes that “enjoyment of the highest attainable standard of health” is a “fundamental right.”

¹⁵⁹ Declaration of Commitment on HIV/AIDS, UN General Assembly, Res/S-26/2, 27 June 2001, para. 58, available at: www.un.org/ga/aids/docs/aress262.pdf, 16.07.2014

¹⁶⁰ See Malkin, Elliott & McRae, 2003, p.545.

domestic law, a growing number of states, including several developing countries, make reference to this right, in one form or another, in their constitutions, often with express indications that such legislative measures are taken in pursuit of that states' obligations under international human rights law¹⁶¹. State practice¹⁶² in a number of jurisdictions supports the claim that the introduction of DCRs can be seen as implementing the right to health, as well as perhaps pointing the way to the inclusion of such measures as a recognized element of state obligation.

Secondly, it is claimed that several articles in the international drug control treaties can be interpreted as permitting or even supporting harm reduction efforts, requiring states to implement particular policies that are not concerned with criminal penalty¹⁶³. According to this view, the 1961 Convention and the 1971 Convention expressly allow states to permit the use and possession of drugs in the pursuit of medical and scientific purposes¹⁶⁴ and, further, require signatory states to "take all practicable measures to provide treatment, education, aftercare, rehabilitation and social reintegration of drug users"¹⁶⁵. Moreover, article 3(2) of the 1988 Convention is often misinterpreted as requiring the blanket criminalization of possession for personal use, and the Convention only requires signatory states to criminalize possession for personal consumption that is "contrary to the provisions" of the 1961 and 1971 conventions. Possession for personal consumption is treated distinctly from clearly more serious offenses, such as the manufacture, sale, and trafficking of drugs. In this sense, first of all, the obligation to impose criminal sanctions goes no further than the equivalent obligations in earlier conventions and stipulates that states may individually decide how this behavior should be addressed. Besides, according to Article 3(2), this obligation of a state under the 1988 Convention to criminalize possession is "subject to its constitution-

¹⁶¹ See Malkin, Elliott & McRae, 2003, p.547.

¹⁶² See Malkin, Elliott & McRae, 2003, pp.549-554.

¹⁶³ See Malkin, Elliott & McRae, 2003, p.556.

¹⁶⁴ See Single Convention on Narcotic Drugs, 1961, UN, 520 UNTS 204, art. 4(c); Convention on Psychotropic Substances, 1971, UN, 1019 UNTS 175, art. 7(a).

¹⁶⁵ See Single Convention on Narcotic Drugs, 1961, art. 38.; Convention on Psychotropic Substances, 1971, art. 20.

al principles and the basic concepts of its legal system.” Therefore, uniform measures and responses are not required with respect to punishing, prosecuting, and criminalizing the possession of narcotics and psychotropic substances for personal use. Both the 1988 Convention (Articles 2(1), 3(1)(a)) and the earlier 1961 Convention are essentially directed at ‘trafficking’, and states have the discretion to determine the policies they wish to adopt for drug consumption rooms¹⁶⁶. Lastly, the Legal Affairs Office of the UNDCP recognized in 2002, that the health objectives of ‘drug-injection rooms’ demonstrated an intent that could be seen to be consistent with the spirit of the conventions¹⁶⁷.

Finally, in the face of the evidence regarding the serious and widespread ill health associated with unsafe injection of drugs, some have argued that harm reduction policies can meet the obligations of the conventions to promote “treatment, education, aftercare, rehabilitation and social reintegration” of injecting drug users¹⁶⁸. An increasing number of countries are recognizing that DCRs represent a practicable measure aimed at protecting and promoting the health of those who use illegal drugs. States have the obligation to ameliorate or prevent the negative health consequences of injection drug use, such as the spread of infectious disease¹⁶⁹.

¹⁶⁶ See Malkin, Elliott & McRae, 2003, p.562.

¹⁶⁷ The relevant report states: “It would be difficult to assert that, in establishing drug injection rooms, it is the intent of parties to actually incite or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs. On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug [users], thereby reducing risk of infections with grave transmittable diseases and, at least in some cases, reaching out to them with counseling and other therapeutic options.” See UNDCP, Flexibility of treaty provisions as regards harm reduction approaches, UN document E/INCB/2002/W.13/SS.5, 30 September 2002, at paras. 23-28, available at: www.tni.org/drugsreformdocs/un300902.pdf, 16.07.2014

¹⁶⁸ See Kerr T., Safe Injection Facilities: Proposal for a Vancouver Pilot Project, Harm Reduction Action Society, 2000, pp.1-75.; Gilmour G., The International Covenants “Prohibiting” Drug Activities, Paper Submitted to Canada’s Senate Standing Committee on Legal and Constitutional Affairs, December 1995.

¹⁶⁹ See Ka Hon Chu Sandra, Brief to the Toronto Board of Health regarding Supervised Injection Services in Toronto, Canadian HIV/AIDS Legal Network, Toronto, July 2013, p.5, available at: <http://www.toronto.ca/legdocs/mmis/2013/hl/comm/communicationfile-39008.pdf>, 16.07.2014

CONCLUSION

Drug dependence is a complex health condition that has a mixture of social, psychological and physical problems. Countries that implemented harm reduction and public health strategies early have experienced consistently low rates of HIV transmission among people who inject drugs. Drug consumption rooms have been implemented in several European countries and some other countries as an important measure for harm reduction and health promotion. These rooms have been established in a growing number of countries, in response to the escalating epidemics of HIV and hepatitis C among people who use drugs, the fact that large numbers of people who use drugs were not being reached by existing services, and the health and public order challenges associated with the use of illegal drugs, especially in public places. In most cases, DCRs arose during times of converging epidemics when problems related to both public disorder and public health were perceived to be out of control. With regard to public disorder, open drug scenes and street drug markets were characterized by threatening congregations of addicts, rampant criminal activity, public injecting of drugs, and improperly discarded syringes and other detritus.

When examining DCRs in operation, it is important to recognize the varying designs and models as well as the different contexts in which they operate, which are mainly due to national drug policies and law regulations. A review of the literature would indicate that the provision of DCRs provides a range of definite health advantages, not least of which is a reduction in risk behavior associated with public injecting. The evidence shows that in some countries, DCRs can have an important role to play in tackling the whole range of harms, including crime and public nuisance, drug-related deaths, health and social problems and the damage inflicted on local urban environments by public drug scenes. In this sense, they would serve a useful function in minimizing the public nuisance associated with intravenous drug use in public places, while also contributing to a reduction in the number of non-sterile injecting equipment and syringes disposed of inappropriately.

Drug consumption rooms were not foreseen by the United Nation drug

control conventions of 1961, 1971 and 1988. Although the International Narcotics Control Board accepts some harm reduction measures such as needle exchange and opiate substitution treatment, it does not consider some harm reduction measures, including drug consumption rooms, to be in conformity with the conventions. On the other hand, some claim that there is nothing in the conventions that prevents states from establishing these rooms. Furthermore, human rights treaties and customary international law impose obligations requiring states to protect and promote health, and this includes adopting all necessary measures within a state's means that can reasonably be expected to achieve these ends. They consider that these legal obligations arguably require states to provide, or at least remove barriers to the operation of drug consumption rooms, and trials of these rooms do not infringe states' obligations under international drug control treaties.

In conclusion, it should be stated that existing evidence suggests that DCRs may offer the potential to reduce risks and harms to injecting drug users, specifically by reducing various risks associated with injecting as well as public nuisance consequences related to public drug use. The benefits of DCRs can outweigh the risks in some countries, while acknowledging that it would be unrealistic to expect them to solve the wider problems of drug. They do not change the fact that users buy their drugs in illicit markets, nor can they aim to change the drug market itself. They would, however, be an effective public health intervention providing a 'safer environment' to reduce risks inherent in public drug use in some countries. The viability and effectiveness of DCRs would depend on local contexts and circumstances, and these include co-operation between relevant services (police, housing, health services, treatment providers, etc), high levels of support from the community.



BIBLIOGRAGHY

Aceijas C., Stimson G.V., Hickman M., Rhodes T., "Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users", *AIDS*, Vol. 18, No.17, pp.2295-2303.

Andreson M. A., Boyd N., "A Cost-Benefit and Cost-Effectiveness Analysis of Vancouver's Supervised Injection Facility", *International Journal of Drug Policy*, Vol.21, 2010, pp.70-76.

Anoro M., Ilundain E. & Santisteban O., "Barcelona's Safer Infecting Facility: A Harm Reduction Program Lacking Official Support" *Journal of Drug Issues*, Vol.33, 2003, pp.689-711.

Babor T.F., Caulkins J.P., Edwards G., Fischer B., Foxcroft D.R., Humphreys K., Obot I.S., Rehm J., Reuter P., Room R., Rossow I. & Strang J., *Drug Policy and the Public Good*, Oxford, United Kingdom, Oxford University Press, 2010.

Bammer Gabriele, "What Can a Trial Contribute to the Debate about Supervised Injecting Rooms?", *Australian and New Zealand Journal of Public Health*, Vol.24, Issue 2, 2000, pp.214-215.

Bayoumi A. M., Zaric G. S., "The Cost-Effectiveness of Vancouver's Supervised Injecting Facility", *Canadian Medical Association Journal*, Vol.179, Issue 11, 2008, pp.1143-1151.

Bayoumi A.M. and Strike C. (co-principal investigators), Jairam J., Watson T., Enns E., Kolla G., Lee A., Shepherd S., Hopkins S., Millson M., Leonard L., Zaric G., Luce J., Degani N., Fischer B., Glazier R., O'Campo P., Smith C., Penn R., Brandeau M., Toronto, Report of the Toronto and Ottawa Supervised Consumption Assessment Study, Ontario: St. Michael's Hospital and the Dalla Lana School of Public Health, University of Toronto, 2012.

Beek Ingrid van, Kimber Jo, Dakin Andy, Gilmour Stuart, "The Sydney Medically Supervised Injecting Centre: Reducing Harm Associated with Heroin Overdose", *Critical Public Health*, Vol.14, Issue 4, 2004, pp.391-406.

Blickman Tom & Jelsma Martin, "Drug Policy Reform in Practice: Experiences

with alternatives in Europe and the US”, *Nueva Sociedad*, No. 222, July-August 2009.

Bouclin Suzanne & Vittal Priyanka, “The Insite Decision and the Case for Supervised Consumption Facilities in Ottawa”, *C.J. Poverty Law*, Vol. 91, 2012, pp.91-120.

Broadhead R.S., Grund J.C., Kerr T.H. and Altice F.L., “Safer Injection Facilities in North America: Their Place in Public Policy and Health Initiatives”, *Journal of Drug Issues*, Vol.32, No.1, 2002, pp.330-356.

Calder Gillian, “Insite: Right Answer, Wrong Question” *Constitutional Law Forum*, Vol. 19 Issue 3, 2011, pp.113-117.

Cook Catherine, Bridge Jamie and Stimson Gerry V., “The Diffusion of Harm Reduction in Europe and Beyond”, *Harm Reduction: Evidence, Impacts and Challenges*, European Monitoring Centre for Drugs and Drug Addiction, 2010, pp.37-56.

Cruz Firestone Michelle, Patra Jayadeep, Fischer Benedikt, Rehm Jürgen, Kaulousek Kate, “Public Opinion Towards Supervised Injection Facilities and Heroin-Assisted Treatment in Ontario, Canada” *International Journal of Drug Policy*, Vol.18, 2007, pp.54-61.

Csete Joanne, Kaplan Karyn, Hayashi Kanna, Fairbairn Nadia, Suwannawong Paisan, Zhang Ruth, Wood Evan, Kerr Thomas, “Compulsory Drug Detention Center Experiences Among a Community-Based Sample of Injection Drug Users in Bangkok, Thailand” *BMC International Health and Human Rights*, Vol. 11, Issue 12, 2011, pp.1-6.

Davies Garth, “A Critical Evaluation of the Effects of Safe Injection Facilities” *The Journal of Global Drug Policy and Practice*, Vol. 1, Issue 3, Fall 2007, pp.1-10.

De Beck Kora, Kerr Thomas, Bird Lorna, Zhang Ruth, Marsh David, Tyndall Mark, Montaner Julio, Wood Evan, “Injection Drug Use Cessation and Use of North America’s First Medically Supervised Safer Injecting Facility”, *Drug and Alcohol Dependence*, Vol.113, 2011, pp.172-176.

de Jong W. & Weber U., “The Professional Acceptance of Drug Use: A Closer

Look at Drug Consumption Rooms in the Netherlands, Germany and Switzerland”, *International Journal of Drug Policy*, Vol. 10, Issue 2, 1999, pp.99-108.

de Kort Marcel, “The Dutch Cannabis Debate, 1968-1976.” *The Journal of Drug Issues*, Vol. 24, Issue 3, 1994, pp.417-427.

Dolan K., ‘Injecting Rooms in Switzerland’, *NSW Public Health Bulletin*, Vol. 10, No. 6, June 1999, pp. 59-60.

Dolan Kate, Kimber Jo, Fry Craig, Fitzgerald John, McDonald David, Trautman Franz, “Drug Consumption Facilities in Europe and The Establishment of Supervised Injecting Centres in Australia” *Drug and Alcohol Review*, Vol. 19, 2000, p.337-346.

Drucker E., “Drug Prohibition and Public Health: 25 Years of Evidence”, *Public Health Reports*, Vol.114, No.1, 1999, pp.14-29.

Drug Consumption Rooms in Germany, A Situational Assessment by the AK Konsumraum, Ed.Dirk Schaffer, Heino Stover, September 2011.

Duncan David F. & Nicholson Thomas, “Dutch Drug Policy: A Model for America?”, *Journal of Health & Social Policy*, Vol.8, Issue 3, 1997, pp. 1-15.

Fast D., Small W., Wood E. and Kerr T., “The Perspectives of Injection Drug Users Regarding Safer Injecting Education Delivered through a Supervised Injecting Facility”, *Harm Reduction Journal* 2008, Vol. 5, Issue 32, pp.5-32.

Fischer B., “Drugs, Communities, and ‘harm reduction’ in Germany: The New Relevance of ‘Public Health’ Principles in Local Responses” *J. Public Health Policy*, Vol. 16, Issue, 4, 1995, pp.389-411.

Fischer Benedikt & Allard Christiane, Feasibility Study on ‘Supervised Drug Consumption’ Options in the City of Victoria, Centre for Addictions Research of British Columbia (CARBC), University of Victoria, 30 April 2007.

Fischer Benedikt, Turnbull Sarah, Poland Blake, Haydon, Emma, “Drug Use, Risk and Urban Order, Examining Supervised Injection Sites (SISs) as ‘Governmentality’ ”, *International Journal of Drug Policy*, Vol.15, 2004, pp. 357-365.

Fitzgerald J., Dovey K., Dietze P., Rumbold G., “Health Outcomes and Qua-

si-Supervised Settings for Street Injecting Drug Use”, *International Journal of Drug Policy*, Vol.15, 2004, pp.247–257.

Flick M., Eardley T., UNSW Evaluation Consortium, Social Policy Research Centre, Evaluation of the NSW Youth Drug Court Pilot Program: First Implementation Review, A Report for the Youth Drug Court Monitoring and Evaluation Committee, June 2001.

Fry C. L., Cvetkovski Stefan & Cameron Jacqui, “The Place of Supervised Injecting Facilities within Harm Reduction: Evidence, Ethics and Policy”, *Addiction*, Vol.101, 2006, pp.465-467.

Fry C., Fox S, Rumbold G., “Establishing Safe Injecting Rooms in Australia: Attitudes of Injecting Drug Users”, *Australian and New Zealand Journal of Public Health*, Vol. 23, No. 5, October 1999, pp. 501-504.

Gilmour G., The International Covenants “Prohibiting” Drug Activities, Paper Submitted to Canada’s Senate Standing Committee on Legal and Constitutional Affairs, December 1995.

Green Cathy, Minimising the Harm of Illicit Drug Use: Drug Policies in Australia, Queensland Parliamentary Library, 2002.

Gunaratnam Praveena, Drug policy in Australia: The Supervised Injecting Facilities Debate, Asia Pacific School of Economics and Government, The Australian National University, 2005.

Haemmig R. and van Beek I., Supervised Injecting Rooms, *Injecting Illicit Drugs* Oxford, Blackwell Publishing, 2005, pp.160-169.

Hammig R.B., “Harm Reduction in Bern: from Outreach to Heroin Maintenance”, *Bulletin of the New York Academy of Medicine*, Vol.72, 1995, pp.371-379.

Hedrich Dagmar, Kerr Thomas and Dubois-Arber Françoise, “Drug Consumption Facilities in Europe and Beyond”, *Harm Reduction: Evidence, Impacts and Challenges*, European Monitoring Centre for Drugs and Drug Addiction, 2010.

Hedrich, D., European Report on Drug Consumption Rooms, European Monitoring Centre for Drugs and Drug Addiction, 2004.

Howard J. and Borges P., "Needle Sharing in The Haight: Some Social and Psychological Functions", *Journal of Psychedelic Drugs*, Vol. 11, 1970, pp. 220-230.

Hunt Neil, *A Review of the Evidence-Base for Harm Reduction Approaches to Drug Use*, Forward Thinking on Drugs, 2003.

Hunt Neil, *An Overview of Models of Delivery of Drug Consumption Rooms*, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006.

Hunt Neil, *Guidance on Standards for the Establishment and Operation of Drug Consumption Rooms in the UK*, December 2008.

Hunt Neil, *Indicators of the Need for Drug Consumption Rooms in the UK*, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006.

Hunt Neil, Lloyd Charlie, Kimber Jo, Tompkins Charlotte, "Public Injecting and Willingness to Use a Drug Consumption Room among Needle Exchange Programme Attendees in the UK", *International Journal of Drug Policy*, Vol. 18, 2007, pp.62-65.

Hunt Neil, *The Evaluation Literature on Drug Consumption Rooms*, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006.

Jauffret-Roustide Marie, Pedrono Gaëlle, Beltzer Nathalie, "Supervised Consumption Rooms: The French Paradox", *International Journal of Drug Policy*, Vol.24, Issue 6, 2013, pp.511-638.

Jelsma Martin, *The Development of International Drug Control: Lessons Learned and Strategic Challenges for the Future*, Working Paper, Prepared for the First Meeting of the Commission, Geneva, 24-25 January 2011.

Ka Hon Chu Sandra, *Brief to the Toronto Board of Health regarding Supervised Injection Services in Toronto*, Canadian HIV/AIDS Legal Network, Toronto, July 2013.

Kerr T., Safe Injection Facilities: Proposal for a Vancouver Pilot Project, Harm Reduction Action Society, 2000.

Kerr T., Tyndall M., Zhang R., Lai C., Montaner J., & Wood E., “Circumstances of First Injection among Illicit Drug Users Accessing a Medically Supervised Safer Injection Facility”, *American Journal of Public Health* Vol.97, Issue 7, 2007, pp.1228-1230.

Kerr T., Wood E., Small D., Palepu A., and Tyndall M. W., “Potential Use of Safer Injecting Facilities Among Injection Drug Users in Vancouver’s Downtown Eastside”, *Canadian Medical Association Journal*, Vol. 169, No.8, 2003, pp.759-763.

Kimber J, Dolan K, Wodak A., International Survey of Supervised Injecting Centres 1999-2000, National Drug and Alcohol Research Centre, Sydney, 2001.

Kimber Jo, Mattick Richard, Kaldor Jhon, Beek Ingrid Van, Gilmour Stuart, Rance Jake A., “Process and Predictors of Drug Treatment Referral and Referral Uptake at the Sydney Medically Supervised Injecting Centre”, *Drug and Alcohol Review*, Vol. 27, November 2008, pp. 602–612.

Kimber Jo, Palmateer Norah, Hutchinson Sharon, Hickman Matthew, Goldberg David and Rhodes Tim, “Harm Reduction among Injecting Drug Users-Evidence of Effectiveness”, *Harm Reduction: Evidence, Impacts and Challenges*, European Monitoring Centre for Drugs and Drug Addiction, 2010.

Kimber, J., Dolan K., Beek, V., Hedrich, D., and Zurhold H. “Drug Consumption Facilities: an update since 2000’, *Drug and Alcohol Review* Vol.22, 2003, pp.227-233.

Korf Dirk, A Cannabis Reader: Global Issues and Local Experiences, Monograph Series 8, Vol. 1, Eds. Sharon Rödner Sznitman, Börje Olsson, Robin Room, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2008.

Legislating on Health and Human Rights: Model Law on Drug Use and HIV/AIDS Module 4: Supervised Drug Consumption Facilities, Canadian HIV/AIDS Legal Network, 2006.

Liang Bin, Lu Hong, Taylor Melanie, “Female Drug Abusers, Narcotics Offend-

ers and Legal Punishment in China”, *Journal of Criminal Justice*, Vol.37, 2009, pp.133-141.

Lloyd Charlie, Hunt Neil, “Drug Consumption Rooms: An Overdue Extension to Harm, Reduction Policy in the UK?”, *International Journal of Drug Policy*, Vol.18, 2007, pp.5-9.

Malkin Ian, Elliott Richard & McRae Rowan, “Supervised Injection Facilities and International Law”, *Journal of Drug Issues*, Vol.33, Issue 3, Summer 2003, pp.539-578.

Marlatt, G. Alan, Larimer Mary E., Witkiewitz Katie, *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*, The Guilford Press, 2012.

Medically Supervised Injecting Centre Evaluation Committee Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre, MSIC Evaluation Committee, Sydney, 2003.

Michels I., Stöver H. & Gerlach R., “Substitution Treatment for Opioid Addicts in Germany”, *Harm Reduction Journal*, 2007, Vol. 4, No. 1, pp.4-5.

Millar J., *Hepatitis and Injection Drug Use in British Columbia-Pay Now or Later*, Vancouver, Ministry of Health, 1998.

Minimising the Harm of Illicit Drug Use: Drug Policies in Australia, Queensland Parliamentary Library, 2002.

Musto D. F., Sloboda Z. “The Influence of Epidemiology on Drug Control Policy” *Bulletin on Narcotics*, Vol. 55, 2003, pp.9-22.

Patel Kiran, “Exchange Programs Research Note: Drug Consumption Rooms and Needle and Syringe”, *Journal of Drug Issues*, Vol. 37, 2007, pp.737-747.

Pinkerton S. D., “Is Vancouver Canada’s Supervised Injection Facility Cost-Saving?”, *Addiction*, Vol.105, 2010, pp.1429-1436.

Report of the International Narcotics Control Board for 2003, United Nations, 2004,.

Report on the Global AIDS Epidemic, UNAIDS, May 2006.

Rhodes Tim, Watts Louise, Davies Sarah, Martin Anthea, Smith Josie, Clark David, Craine Noel, Lyons Marion, "Risk, Shame and The Public Injector: A Qualitative Study of Drug Injecting in South Wales", *Social Science & Medicine*, Vol.65, Issue 3, 2007, pp.572-585.

Rhodes, T., Kimber, J., Small, W., et al., "Public Injecting and the Need for "Safer Environment Interventions" in the Reduction of Drug-Related Harm', *Addiction* Vol. 101, 2006, pp.1384-1393.

Roberts M., Klein A. & Trace, M., *Drug Consumption Rooms*, The Beckley Foundation Drug Policy Programme, 2004.

Roy D. & Cloutier R., *Drug Use and the HIV Epidemic: A Framework for Prevention*, Ministry of Health and Social Services, Quebec, 1998.

Salmon A.M., Thein H.H., Kimber J., Kaldor J.M., & Maher L., "Five Years on: What Are the Community Perceptions of Drug-Related Public Amenity Following the Establishment of the Sydney Medically Supervised Injecting Centre?", *International Journal on Drug Policy*, Vol. 18, No.1, 2007, pp.46-53.

Salmon A.M., Van Beek, I., Amin J., Grulich A., & Maher L., "High HIV Testing and Low HIV Prevalence among Injecting Drug users Attending the Sydney Medically Supervised Injecting Centre" *Australian and New Zealand Journal of Public Health*, Vol.33, No.3, 2009, pp.280-283.

Schatz Eberhard & Nougier Marie, *Drug Consumption Rooms Evidence and Practice*, Briefing Paper International Drug Policy Consortium, June 2012.

Skretting Astrid, *The Norwegian Trial of Public Drug Injection Room*, Norwegian Institute for Alcohol and Drug Research, 2007.

Small Dan, Palepu Anita, Tyndall Mark W., "The Establishment of North America's First State Sanctioned Supervised Injection Facility: A Case Study in Culture Change", *International Journal of Drug Policy*, Vol.17, 2006, pp.73-82.

Small W., Rhodes T., Wood E., & Kerr T., "Public Injection Settings in Vancouver: Physical Environment, Social Context and Risk", *International Journal of Drug Policy*, Vol.18, 2007, pp.27-36.

Small Will, Moore David, Shoveller Jean, Wood Evan, Kerr Thomas, "Perceptions of Risk and Safety within Injection Settings: Injection Drug Users' Reasons for Attending a Supervised Injecting Facility in Vancouver, Canada", *Health, Risk & Society*, Vol.14, Issue 4, 2012, pp.307-324.

Solai, S., Dubois-Arber, F., Benninghoff, F., & Benaroyo, L., "Ethical Reflections Emerging during the Activity of a Low Threshold Facility with Supervised Drug Consumption Room in Geneva, Switzerland", *International Journal of Drug Policy*, Vol.17, No.1, 2006, pp.17-22.

Stoever, Heino, "Concerns Consumption Rooms -A Middle Ground between Health and Public Order", *Journal of Drug Issues*, Vol. 32, 2002, pp.597-606.

Strang, J., and Fortson, R., "Supervised Fixing Rooms, Supervised Injectable Maintenance Clinics-Understanding the Difference" *British Medical Journal*, Vol. 328, No.7431, pp.102-103.

Szuba J.Tadeusz, "International Comparison of Drug Consumption: Impact of Prices", *Social Science Medicine*, Vol. 22, No. 10, 1986, pp. 1019-1025.

Taylor Avril, Cusick Linda, Kimber Jo, Hickman Matthew & Rhodes Tim, *The Social Impact of Public Injecting*, Independent Working Group on Drug Consumption Rooms, York, Joseph Rowntree Foundation, 2006.

The Report of the Independent Working Group on Drug Consumption Rooms, Joseph Rowntree Foundation, 2006.

van Beek I. & Gilmour S., "Preference to Have Used a Medically Supervised Injecting Centre Among Injecting Drug Users in Kings Cross, Sydney", *Australian and New Zealand Journal of Public Health*, Vol. 24, No.5, 2000, pp.540-542.

van der Poel Agnes, Barendregt Cas, van de Mheen Dike, "Homelessness and other Living Condition Characteristics of Drug Users 2003 – 2007, in Rotterdam, the Netherlands", *European Journal of Homelessness*, Vol. 2, December 2008, pp.235-257.

Watson Tara Marie, Strike Carol, Kolla Gillian, Penn Rebecca , Jairam Jennifer, Hopkins Shaun , Luce Janine, Degani Naushaba, Millson Peggy, Bayoumi Ahmed M., "Design Considerations for Supervised Consumption Facilities

(SCFs): Preferences for Facilities Where People Can Inject and Smoke Drugs”, *International Journal of Drug Policy* Vol. 24, 2013, pp.156-163.

Webster Christopher D., “Compulsory Treatment of Narcotic Addiction”, *International Journal of Law and Psychiatry*, Vol. 8. 1986, pp. 133-156.

Weekes John, Percy Leah & Cumberland Karen, *Supervised Injection Facilities (SIFs)*, Canadian Centre on Substance Abuse, 2004.

Wodak Alex, *Demand Reduction and Harm Reduction*, Global Commission on Drug Policies, Geneva, Working Paper, 24-25 January 2011.

Wodak Alex, Symonds Ann, Richmond Ray, “Injection Room Led to a Sanctioned, ‘Medically Supervised Injection Center the Role of Civil Disobedience in Drug Policy Reform: How an Illegal Safer’”, *Journal of Drug Issues*, Vol.33, 2003, pp.609-623.

Wolf, J., Linssen, L., de Graaf, I., van Dam, T. “Drug Consumption Facilities in the Netherlands”, *Journal of Drug Issues*, Vol.33, 2003, pp.649-661.

Wood E., Kerr T., Spittal P. M., Li K., Small W., Tyndall M. W., Hogg R. S., O’Shaughnessy M. V. and Schechter M. T., “The Potential Public Health and Community Impacts of Safer Injecting Facilities: Evidence from a Cohort of Injection Drug Users”, *Journal of Acquired Immune Deficiency Syndrome*, Vol.32, 2003, pp.2-8.

Wood E., Kerr T., Stoltz J., Qui R., Zhang R., Montaner, J. & Tyndall, M., “Prevalence and Correlates of Hepatitis C Infection among Users of North America’s First Medically Supervised Safer Injection Facility”, *Journal of the Royal Institute of Public Health*, Vol. 119, 2005, pp. 1111-1115.

Wood E., Tyndall M.W., Li K., Lloyd-Smith, E., Small W., Montaner J.S., & Kerr T., “Do Supervised Injecting Facilities Attract Higher-Risk Injection Drug Users?”, *American Journal of Preventive Medicine*, Vol. 29, Issue 2, 2005, pp.126-130.

World Drug Report 2013.

Wright, N. M. J., “Supervised Injecting Centres”, *British Medical Journal*, Vol. 328, No.7431, 2004, pp.100-102.

Zobel Frank, Dubois-Arber Françoise, Short Appraisal of the Role and Usefulness of Drug Consumption Facilities in the Reduction of Drug-Related Problems in Switzerland, Lausanne: University Institute of Social and Preventive Medicine, 2004.

Zurhold Heike, Degkwitz Peter, Verthein Uwe, Haasen Christian, "Drug Consumption Rooms in Hamburg, Germany: Evaluation of the Effects on Harm Reduction and the Reduction of Public Nuisance", Journal of Drug Issues, Vol.33, 2003, p.663-668.

INTERNET SOURCES

http://www.aidshilfe.de/sites/default/files/IDPC_DCR_%20Briefing%20Paper_2012.pdf, 16.07.2014

<http://www.ccsa.ca/Resource%20Library/ccsa-010657-2004.pdf>, 16.07.2014

<http://www.druglawreform.info/images/stories/documents/GE-DrugConsumptionRooms.pdf>, 16.07.2014

<http://www.druglibrary.org/schaffer/other/dutch.htm>, 16.07.2014

http://www.issdp.org/conferences/2007/papers/Astrid_Skretting.pdf, 16.07.2014

<http://www.parliament.qld.gov.au/parlib/research/index.htm>, 16.07.2014

<http://www.santecom.qc.ca/Bibliothequevirtuelle/santecom/35567000033545.pdf>, 16.07.2014

<http://www.toronto.ca/legdocs/mmis/2013/hl/comm/communication-file-39008.pdf>, 16.07.2014

<http://www.unaids.org/en/>, 16.07.2014

http://www.drugfree.org.au/fileadmin/library/Injecting_Rooms/DFAInjectingRoomCorrespondence.pdf, 16.07.2014

www.incb.org, 16.07.2014

www.tni.org/drugsreformdocs/un300902.pdf, 16.07.2014

www.un.org/ga/aids/docs/aress262.pdf, 16.07.2014

