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Editorial

Mobile safe injecting facilities in Barcelona and Berlin

Safe Injecting Facilities (SIFs) have been operating in various locations across the developed world for over 20 years (Kimber, Dolan, van Beek, Hedrich, & Zurhold, 2003; Kimber, Dolan, & Wodak, 2005). Typically physically located in close proximity to established drug market and drug injecting precincts, SIFs provide a sanctioned space for the injection of drugs (Rhodes et al., 2006). These 'enabling environments' (Moore & Dietze, 2005) have been shown to have a range of public health benefits, from improvements in the management and response to acute drug overdose (Van Beek, Kimber, Dakin, & Gilmour, 2004), through to successful referral to other services (Kimber et al., 2008; Wood, Tyndall, Montaner, & Kerr, 2006).

In spite of the evidence of the positive public health effects of SIFs, they remain controversial in some jurisdictions. Much of the controversy centres on perceived public amenity impacts of the facilities. However, there is no published research demonstrating any negative impacts of SIFs on measures of public amenity. In contrast, research has shown that the public amenity impacts of SIFs are either neutral or positive across a range of amenity measures such as those pertaining to drug related crime (Wood, Tyndall, Lai, Montaner, & Kerr, 2006), and public injecting (Rhodes et al., 2006). The absence of any negative public amenity impacts, coupled with demonstrated public health benefits appears to have produced positive perceptions of SIFs among staff (Kimber et al., 2005), and the wider community (Salmon, Thein, Kimber, Kaldor, & Maher, 2007).

SIFs are 'safe' in the sense of providing clean injecting equipment in a clean environment to people who inject drugs (PWID) with a ready service response in the case of an acute health event such as an overdose. However, they are also safe in the sense that they provide a secure environment for the injection of drugs, away from public scrutiny and potential intervention by law enforcement agencies.

Most SIFs described in the literature are located at a fixed site in close proximity to established drug markets (Kimber et al., 2003), with such a drug scene seen as a pre-requisite for the establishment of a SIF (Rhodes et al., 2006). The nature of these fixed-site facilities obviously precludes the possibility of responding to changes in drug market locations that may occur as a result of police operations or other drug market variables and require clients to adjust their drug use behaviours to comply not only with the rules and regulations of the facility, but also the geographic location of the service. This means that fixed-site services are ideally suited to geographically stable drug markets, but as Rhodes et al. (2006) point out, more dynamic situations may require mobile services to meet the needs of clients. Similar concerns around the provision of other harm reduction interventions has seen the development of outreach services, as alternatives to fixed-site service provision (Needle et al., 2005).

At the Barcelona International Harm Reduction Association Conference in 2008, workers from the Associació pel Benestar I el Desenvolupament NGO (Association for Well-being and Development) parked a mobile SIF outside of the conference venue. For many delegates, this was the first mobile SIF they had ever seen. Funded by Barcelona Public Health Agency the mobile SIF was able to operate in a variety of settings across the city. It subsequently came to light that the Fixpunkt NGO (the organisation at the forefront of naloxone distribution in the late 1990s; Dettmer, Saunders, & Strang, 2001) operates similar facilities in Berlin. In this Editorial we provide a preliminary description of the main characteristics of the mobile facilities in these two cities, along with some of the issues around their operation that require further investigation.

Setting

Both Barcelona (pop 1.5 million) and Berlin (pop 3.5 million) are major European cities with established drug markets that have run since the 1970s. Recent estimates suggest that there are around 7000 PWID in Barcelona (5000 regular injectors and 2000 occasional injectors; Sánchez-Niubò, Domingo-Salvany, Melis, Brugal, & Scalia-Tomba, 2007), and between 8000 and 10,000 in Berlin (Senatsverwaltung für Gesundheit, 2008). Neither city has one large public drug scene; rather in a number of locations in the cities, smaller scenes have become established in which dealing and, in some cases, consumption take place.

Mobile SIFs in Barcelona and Berlin

The mobile SIFs in both Barcelona (Figs. 1 and 2) and Berlin (Figs. 3 and 4) are comprised of especially fitted-out vans, with three injection booths. Two vehicles in Berlin are housed in Fixpunkt premises overnight and then currently head to one of two locations; Bahnhof Zoo (Friday–Saturday, 14.00–18.00) and Stuttgarter Platz (Monday, 14.00–18.00). Other sites (Kurfürstenstraße, Moritzplatz) have been served in the past, and possible additional locations are discussed from time to time. In contrast, while mobile, the Barcelona van is currently based in only one location, in an industrial area near the port that is close to an apartment block (commonly known as 'the pink panther') that is a well-known location for the dealing, distribution and use of illegal drugs.

Clients of the mobile SIFs are registered after an initial assessment, which provides an opportunity for further referral if required (in Berlin this may include referral to a mobile counselling and

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Fig. 1. Outside of mobile van: Barcelona.

Fig. 2. Injecting booth: Barcelona.

Fig. 3. Outside of mobile van: Berlin.

Fig. 4. Injecting booth: Berlin.

treatment van that accompanies each SIF, while in Barcelona this may include referral to the nearby community health centre). Following registration, there are no restrictions on access in Barcelona. Unfortunately, for legal reasons PWID who are in methadone treatment are not allowed to enter the Berlin SIF.

The mobile SIFs have nursing staff (1 nurse supplemented by 2 social workers in Barcelona, 2 nurses supported by 1 or 2 social workers in Berlin) who offer a range of harm reduction services including needle and syringe distribution, naloxone (for use in overdose response by nurses as well as part of bystander distribution programs), assistance in locating veins and assessment/referral to other services. While on-site vaccination for hepatitis B and tetanus is provided in Barcelona but not Berlin, blood borne virus testing combined with risk assessment and pre- and post-test counselling is provided in Berlin, but not Barcelona. In 2010, the Barcelona van and the main Berlin van accommodated 7755 and 4082 drug consumption visits respectively.

Community relationships

As indicated, the mobile SIFs are run by NGOs on behalf of municipal authorities. The mobile resources in Barcelona are coordinated with 'other drugs' resources under the umbrella of the Drug Action Plan of the City of Barcelona. This plan, approved by consensus of all political groups that make up the City Council of Barcelona, provides technical coordination among the Public Health Agency district councils' officials and security forces. Widespread consultation with all neighbourhood associations prior to the location of the mobile SIF was undertaken to minimise the potential for local problems. This consultation involved direct contact between district councils with neighbours through community meetings called 'health plenaries' which are the framework for discussing and resolving health issues in the community. In addition, two community outreach workers in the area inform local residents and businesses about available local resources, as well as encouraging PWID to use the facility where possible. Most neighbours reportedly have a history of contact with people who use drugs and are ambivalent about the van operating in the area that has been chosen.

As in Barcelona, the Fixpunkt SIFs in Berlin operate with the support of the local community along with clear *District Policy*

Agreements with local state and federal governments. The drug markets serviced have been in existence for some time, with clear recognition of the importance of the work undertaken by Fixpunkt. Good working relationships with the Department of Health, the Department of Inner Affairs, the administration of the Chief of Police, the local police officers and the senior Public Prosecutor mean that clear communication channels have been established; regular stakeholder meetings are held to discuss any arising issues such as interpretation and practice of legal regulations and questions or potentially problematic aspects (e.g., handling the (forbidden) sharing of substances inside a SIF or changes in the neighbourhood or public opinion). Occasional problems arise when new police officers come across the service then tend to hassle both staff and clients. More experienced officers are generally unproblematic.

General issues

The general principles behind the operation of the services we have described are the same as those evident in fixed-site SIFs (Kimber et al., 2005). However, there are obvious differences between the mobile facilities we have described and fixed-site services, highlighting questions in relation to mobile SIFs that require further research and evaluation.

First, with only 3 booths the throughput of PWID on any given day is more limited than these larger fixed-site services. For example, the typical throughput on a busy day in the Berlin facilities is around 20–30 injections per day (a total of 4082 in 2010, and average of 11 per day) which is far less than the average 172 injections per day reported in Sydney (MSIC Evaluation Committee, 2003). While it is likely that the public health and amenity benefits of SIFs will be similar for the injections in these mobile facilities as for the fixed sites evaluated in other jurisdictions (MSIC Evaluation Committee, 2003; Wood, Tyndall, Montaner, et al., 2006), at least on a 'per injection' basis, these have yet to be formally evaluated for mobile SIFs.

A second but related issue concerns the costs of the mobile facilities - the limited throughput occurs in the context of similar staffing levels to the fixed-site operations in both cities meaning that costs are necessarily higher. Indeed, the operating hours of the second mobile SIF in Berlin were recently cut from 28 h a week to 14 h a week after a major cut in funding.

Thirdly, the mobile SIFs described in this editorial operate as adjuncts to fixed-site services operating in the cities. It is not clear that mobile SIFs would be able to be run in the absence of this supportive local context. The local context is indeed crucial. In the case of Barcelona it should be noted that the first SIF opened in Barcelona in 2000 was a mobile bus. This mobile SIF was used initially as a more 'palatable' SIF option in comparison to a fixed-site service. This opened the door for the establishment of three other fixed-site services that currently operate in the city that in the last month have been complemented by four smaller fixed-site services. Therefore mobile SIFs can complement, connect and add value to fixed sites. A conducive local environment has been noted as a requirement for fixed site SIFs; this is obviously needed for mobile services too. The obvious advantage of mobiles is that mobiles can be moved to another site easily. Sometimes moving 100 m away is enough to lower (or enlarge) problems and discussions with the public.

Finally, the impacts on staff and clients of using the smaller, more confined spaces of the mobile facilities need to be better understood including impacts of external conditions such as weather on service provision and client experiences.

Concluding remarks

It is important for harm reduction interventions to adapt to different circumstances according to local conditions. Services need to evolve as drug market conditions change over time and/or place, for example as a result of police operations. In this editorial we have described two mobile SIFs that present as a specific response to questions raised about SIFs by Rhodes et al. (2006). The services operating in Berlin and Barcelona share many features and are clearly able to provide service to PWID with the support of local communities. Since commencing work on this editorial it has come to our attention that a mobile SIF has been operating in Copenhagen on an intermittent basis and that there are plans to open similar facilities in other cities. While it is likely that these mobile facilities will produce benefits for PWID and the wider community, further research is needed in order to determine whether or not this is the case.

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Paul Dietze [a,b,*]
Rebecca Winter [a,b]
Alisa Pedrana [a,b]
[a] *Centre for Population Health, Burnet Institute, Melbourne, Australia*

[b] *Monash University, School of Public Health and Preventive Medicine, Melbourne, Australia*

Astrid Leicht
Fixpunkt, Berlin, Germany

Xavier Majó i Roca
Ministry of Health, Government of Catalonia, Barcelona, Spain

M. Teresa Brugal
Agència de Salut Pública de Barcelona (ASPB), Barcelona, Spain

[*] Corresponding author at: Centre for Population Health, Macfarlane Burnet Institute for Medical and Public Health Ltd., 85 Commercial Rd, Melbourne, VIC 3004, Australia. Tel.: +61 3 9282 2134; fax: +61 3 9282 2138.
E-mail address: pauld@burnet.edu.au (P. Dietze)

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