Drug Consumption Rooms in Europe

Organisational overview

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Colophon

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Abstract

This report provides an overview of the organisation and working methods of drug consumption rooms (DCRs) in Europe It offers information about the functioning of DCRs as well as on the organisation and structure of such facilities and aims to benefit various groups of stakeholders.

Chapter 1 will commence with the definition, background and a brief history of DCRs in Europe, followed by the methodology of this study in chapter 2. In the third chapter of this report, some general aims and objectives and a breakdown into a number of specific objectives (Hedrich *et al*, 2011), the text continues with an elaboration on how the DCRs work on an environment for safer drug use (chapter 4) and improving the health status of drug users (chapter 5).

Moreover, in line with the survey tool employed in a previous survey among Dutch DCRs (Havinga & Van der Poel, 2011), which was adapted for use in the present study, this report elaborates on several other crucial aspects of the organisation and working methods of DCRs. The general services on offer at DCRs (chapter 6) will be discussed, particularly those addressing non-health related issues, and focusing more on the social status or well-being of drug users. Details on the differences in staff functions and the trainings offered to the staff (chapter 7) and the way facilities involve peers in various organisational elements of the DCR (chapter 8) are also examined.

After this European overview with insights into the way DCRs organise and structure their facilities and services, the final chapter pays some attention to the future of DCRs, and elaborates briefly on what those currently involved in the running of DCRs consider to be important when setting up a new facility (chapter 9). Our overview study concludes with some relevant remarks when considering the foundation of a new DCR service.

All in all this report, in its discussion of aims, objectives, services, organisational structure and points of importance, is primarily directed at all who are involved in DCRs in Europe and beyond, or those who wish to set up a DCR in a new location. However, it may also be of interest to anyone concerned with the provision of basic services to drug users in Europe.

Introduction

This report provides an overview of the organisation and working methods of drug consumption rooms (DCRs) in Europe. DCRs are defined here as 'professionally supervised healthcare facilities where drug users can use drugs in safer and more hygienic conditions' (Hedrich *et al.*, 2010). This report is based on a survey among managers of 39 DCRs in six countries, conducted by the Rainbow Group (RG) in Amsterdam, and integrates results from an earlier survey covering 30 DCRs in the Netherlands (Havinga & Van der Poel, 2011). The current study was carried out on behalf of The European Harm Reduction Network (EuroHRN), funded by the European Commission, DG Justice under its 'Drug Prevention and Information Programme (DPIP)'. It entailed drawing up a detailed inventory of current concepts, organisation and working methods as well as client experiences of European DCRs, to enable comparisons and professional inspiration on a transnational scale. The work was carried out in collaboration with Lancaster University (UK) and Akzept (DE). Together, they have developed and conducted two survey tools:

- A client survey on 'Quality of life (QoL) and DCR experience'. This has been conducted among visitors of DCRs in Amsterdam (3) and Rotterdam (1). This data is not referred to in this report, but has been reviewed in another document (Peacey, 2014).
- A DCR manager survey on service provision and organisational aspects of the DCR. This has been made available through an open source online survey application (Lime survey), and all DCRs in Europe, excluding the Netherlands, were requested to fill in the survey.

This report summarises the outcome of a survey among the managers of 39 (out of a total of 58) DCRs located in Denmark, Germany, Greece, Luxembourg, Norway, Spain and Switzerland, which were targeted by our study. Data about DCRs in the Netherlands were drawn from a survey conducted in 2010 among 30 out of 37 DCRs in the Netherlands. Where relevant, the data from our 2013 survey are reported alongside data from the Netherlands.

At the time of writing, Europe counted 88 official drug consumption rooms in eight countries: Denmark, Germany, Greece, Luxembourg, the Netherlands, Norway, Spain and Switzerland. Outside Europe, there are three DCRs; one in Australia and two in Canada. The MSIC in Sydney as well as the Dr. Peter Centre and SIS in Vancouver have been the subjects of large scale scientific evaluations, resulting in a significant amount of outcome data and evaluations published in peer-reviewed journals. In Europe, several comprehensive reports about DCRs have been published (e.g. Hedrich, 2004; Schatz & Nougier, 2012; Joseph Rowntree Foundation, 2006), but the use of monitoring data collected at the European facilities remains limited to internal evaluations or publications in grey literature (e.g. activity reports). Additionally, the number of publications in English is limited, and there is a dearth of evaluation studies, which indicates a need for this investigation.

1 Background

1.1 Definition

As noted in the introduction, this report uses the following definition of DCRs: 'professionally supervised healthcare facilities where drug users can use drugs in safer and more hygienic conditions' (Hedrich *et al.*, 2010). It is worth mentioning that this is only one of several possible definitions that define DCRs in a similar manner (Akzept, 2000; Hedrich, 2004; Joseph Rowntree Foundation, 2006). In this instance however, the Hedrich et al. definition is most appropriate as it approaches safety and hygiene in a relative rather than absolute terms. Their definition stresses the positive impact of the DCR environment in comparison to drug users' health and well-being situations without access to DCRs.

The term Drug Consumption Room is often used interchangeably with '(medically) supervised injecting centres', 'safe injecting facilities' and 'shooting galleries'. However, it is important to point out that 'shooting galleries' cannot be considered to be the same, as there is not guarantee of a hygienic space for consumption, and while drugs can be bought on location in shooting galleries, DCRs require the substances to be pre-obtained (Joseph Rowntree Foundation, 2006). Moreover, contrary to DCRs the other terms are more limited, as they refer *exclusively to rooms for drug injection*. This fails to highlight the fact that numerous facilities do not only provide for safe injection places, but also allow drug users to smoke their substance on location. All surveyed DCRs offered injection places (ranging between 1 and 13 slots), but more than two thirds of them (26/33) also provided places to smoke drugs, i.e. heroin and crack.

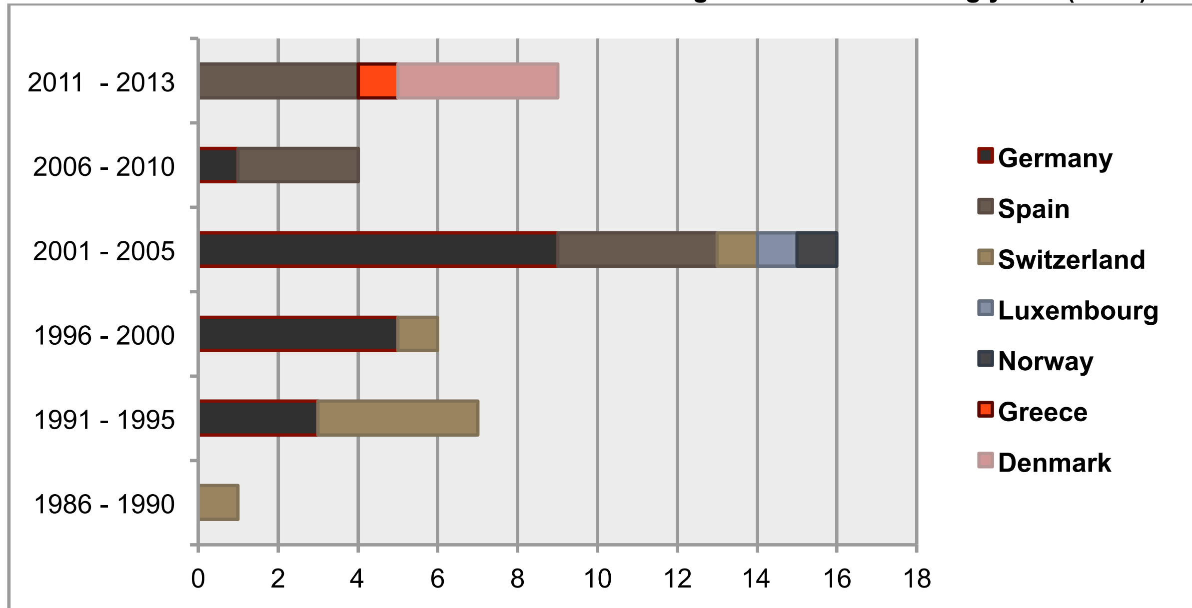
1.2 History of DCRs in Europe

In 1986, the first legally sanctioned DCR was established in Berne, Switzerland. Since then, more than 90 DCRs have been set up in Switzerland, the Netherlands, Germany, Greece, Spain, Luxembourg, Norway and Denmark, and countries including France, Romania, Portugal and the UK are reportedly preparing for their first DCR. Meanwhile, some facilities throughout the continent have closed their doors due to various reasons, but primarily because some countries have experienced a changed drug scene and support demand. For example, in the Netherlands, where DCRs used to mainly target homeless drug users, the reduced demand, due to decreasing levels of homelessness among drug users has led to a changed target group and seems to have played a major role in the closing down of several facilities.

The DCRs included in this survey were founded between 1986 and 2013, thus our study includes both the first DCR and facilities that were opened very recently. The survey does not include any DCRs that were no longer in operation at the time of writing. A total of 19 of the 58 facilities that had been identified in the preparatory phase as currently in operation did not respond to our survey (32.8%).

Figure 1.1 represents the year of establishment for 43 facilities in Europe, as identified during the preparatory phase for our study. Data from the Netherlands are not shown. The information, although categorized differently, can be compared to the data collected in the Netherlands by the Trimbos Institute, which show that DCRs in the Netherlands (N=29) were founded between 1995 and 2008, with a peak in 2004/2005 (Havinga & Van der Poel, 2011).

Figure 1.1 DCR founding years (N=43)



This figure includes information on Greece and several Spanish facilities as collected by Akzept e.V. to complement our survey.

2 Methodology

2.1 Online survey

This report provides an overview of the organisation and working methods of drug consumption rooms (DCRs) in Europe, based on a survey among managers of 39 DCRs in Denmark, Germany, Luxembourg, Norway, Spain and Switzerland. Moreover, the report integrates results from an earlier survey covering 30 DCRs in the Netherlands (Havinga & Van der Poel, 2011). The newly founded DCR in Greece did not answer the survey.

An assessment of DCRs in the preparatory phase through reports, websites and multipliers resulted in a number of 88 different DCRs located across 58 cities in eight European countries. In our survey, conducted in December 2013, we successfully reached 39 DCRs, representing two thirds (67.2%) of all 58 targeted facilities outside the Netherlands. This response rate is slightly lower than the one in the survey among Dutch DCRs, carried out in 2010 by the Trimbos Institute, where 30 out of a possible 37 DCRs responded (81%); however, this could be due to language issues. It is important to note that in recent years the number of DCRs in the Netherlands has decreased by approximately 19%: while there were 37 DCRs in 2010, this number had decreased to a mere 30 in 2013. The number of facilities and cities and their participation in the survey is listed in Table 2.1 below.

Table 2.1: Number and participation of DCRs in Europe

Country	Total No. of DCRs	No. of cities with DCR	Surveyed DCRs	Participation percentage
Denmark	5	3	4	80%
Germany	24	15	16	66.7%
Greece	1	1	0	0%
Luxembourg	1	1	1	100%
Netherlands	30	23	n.a.	n.a.
Norway	1	1	1	100%
Spain	13	6	5	38.5%
Switzerland	13	8	12	92.3%
Total	88	58	39	67.2%

The survey was made available to participants through an open source online survey application (Lime survey). Between October 2013 and January 2014 all DCRs were contacted with the request to fill in the survey. Where possible, the managers of each facility were contacted personally, and addressed in their preferred language. For consistency, validity, and reliability purposes it was required that the survey be completed in English. Assistance was available to participants upon request, such as the explanation or translation of specific questions by e-mail or support in completing the survey when encountering technical difficulties.

The survey addresses various topics relating to service provision and organisational aspects of the DCR. Following the structure of the Trimbos Institute's survey it covers seven themes:

1. Goals
2. Organisation, structure and environment
3. Target group and admission
4. Facilities
5. House rules
6. Staff
7. Statements

The complete survey is presented in the appendix.

This study is largely based on a survey developed by the Trimbos Insitute. While the questions and comments about a Dutch guide have been removed, and some questions have been adapted slightly to make them more comprehensive, the original Dutch survey has largely been left in tact; it was conducted in the Netherlands in 2010. This 2010 survey built upon two earlier studies of the Trimbos Institute, which were published in 2002 and 2004 (Havinga & Van der Poel, 2011). In 2002 the Trimbos Institute, together with the National Focal Point for Drug Users, developed a guide for the organisation and structure of DCRs. In 2004, this guide was followed up by a report on the Dutch DCR trends and developments between 2001 and 2003. Later, in 2010, the Trimbos Institute again surveyed Drug Consumption Rooms in the Netherlands with the following aims in mind:
1) to gain insight into the functioning of DCRs
2) to update the guide they developed in 2002
3) to spread information on the organisation and structure of DCRs
As the first and third aims correspond to those in our European project, the Trimbos Institute's survey has been translated and modified for the purpose of this study.

2.2 Limitations

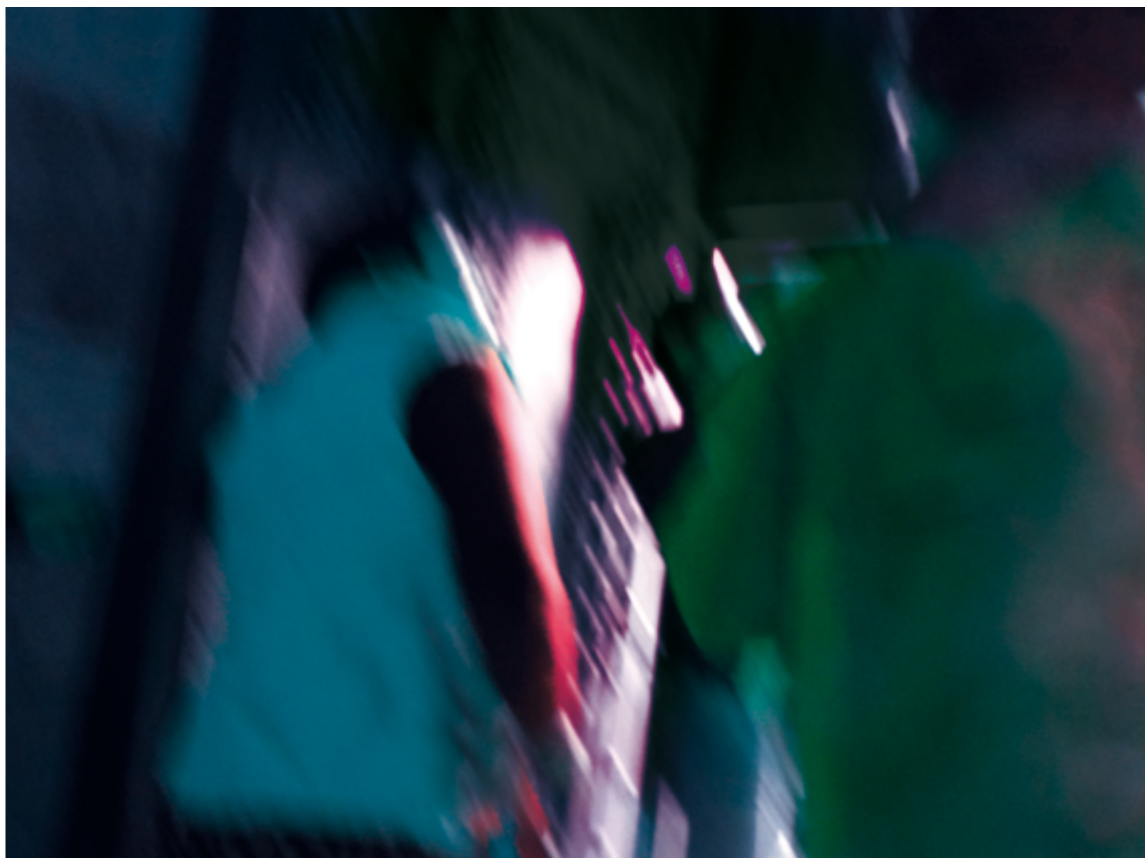
While presenting the reader with a general understanding of the arrangement and structure of DCRs in Europe, this study does have some noteworthy limitations.

First of all, our survey was developed and conducted in English. English is not the primary language of any of the respondents and this may have lead to a misunderstanding of some of the questions. As all participants were required to fill in the survey independently online, asking for clarification by e-mail might have been too burdensome for some respondents, thus possibly leaving in more misunderstandings. Moreover, it is reasonable to assume that this language barrier was partially responsible for a reduced response rate (67.2%).

Secondly, this survey allowed for bulk responses, meaning that 39 facilities were represented through 33 completed surveys, as managers were allowed to complete one survey for multiple facilities to avoid participant fatigue. Thus two managers (one in Switzerland, and one in Spain) filled in their respective surveys for several locations belonging to the same parent organisation. Consequently, their responses had to be excluded in the analysis of some

Also, there was a three-year interval between data collection in the Netherlands (2010) and other European countries (2013). The comparison of results between the two surveys, as discussed in the following chapters, supports observations noted in earlier texts that there are some interesting cultural differences between DCRs in the Netherlands and DCRs in other countries (Nougier & Schatz, 2012). However, it is necessary to consider that some influencing factors might have changed in the Netherlands over the course of three years, as differences in the structure and organisation of DCRs have previously been observed to alter over time (Havinga & Van der Poel, 2011).

Lastly, it is noted that there is potential for us to have been influenced by Dutch policies, as this survey was developed in part using the blueprints of a prior Dutch study, which may have reflected local interests. This might have resulted in the inadvertent overlooking of nationally relevant specifics for other DCRs. Although the study has paid careful attention to overcome this limitation and respondents were provided the opportunity to give open answers and additional comments, it cannot be ruled out that certain Dutch peculiarities weigh strongly in our question development.



3 Goals and objectives of DCRs

Firstly, DCRs were explicitly asked about their primary goal, prompting ‘nuisance reduction’ and ‘health damage reduction among drug users’, while leaving room for alternative answers. Only 1 out of 34 responded its primary goal to be ‘keeping those who do not fit in the streetscape off the streets’. Two respondents considered both nuisance reduction and health damage reduction to be their primary goals, and the vast majority (91.2%) solely named health damage reduction as the most important. This differs significantly from the Dutch figures, where nuisance reduction scored significantly higher (over 80% in 2003, and over 30% in 2010) and just the promotion of health significantly lower (20% in 2010, and even lower in 2003), while most respondents answered ‘both’ in 2010.

To the question on what the primary motivation for the foundation of the DCR was, 63.6% of our survey respondents cited improving the health status of the target group, often literally mentioning the term *harm reduction*. Contrastingly, 27.3% said that the reduction of public disorder was their primary motive. Moreover, 36.4% gave alternative responses, ranging from ‘responding to policy or client demands’ to ‘outreach work and social integration of DUs.’ In comparison, in the Netherlands, the majority of DCRs claimed their primary motivation for founding a DCR was nuisance reduction, and only 1/3 responded with ‘a safe place to use for the drug users’ (Havinga & Van der Poel, 2011: 12).

Considering the paragraph above, health improvement appeared to be of less importance (63.6%), and public disorder of higher importance (27.3%). This correlation suggests that nuisance reduction has become a less prominent goal over the course of time, as its decline has been reported both in the Dutch survey as in the European one. Furthermore, nuisance reduction appears to be more prominent in the Netherlands than other countries, but again we must point out that the Dutch data was collected three years prior to the other countries’ data.

Secondly, facilities were asked which of three social functions they fulfilled:
1) “*sweeper”* - DCR intends to keep those who do not fit in the streetscape off the streets
2) *“Safety net”* - DCR cares for DU, offers the opportunity to use drugs more safely, and provides for the most urgent/basic medical and social care
3) *“Springboard”* - DCR aims to improve the living situation of its visitors, refers to other (care) facilities and cooperates with third parties to strive for re-socialisation.

In table 3.1 the answers to these questions are presented.

Table 3.1 DCR’s social functions

What social functions does your DCR fulfil?		
Sweeper	22	64.7%
Safety net	32	94.1%
Spring board	31	91.2%
All of the above	20	58.8%

When asked which of these three functions the DCR considered to be of greatest importance, 82.4% responded *“safety net”*, and

14.7% *"spring board".* One DCR in Switzerland abstained, commenting that all three social functions are of equal importance. Similarly, in the Netherlands, in both 2003 and 2010, DCRs considered "providing for a safety net" to be the most important factor.

In the chapter 'Drug consumption facilities in Europe and beyond' Hedrich *et al* (2010) propose a list of aims and related objectives of DCRs as well as the relevant indicators, as presented in table 3.2 below. In their chapter they address each outcome objective separately, discussing its role and the measured effects in European facilities, while stressing that 'the balance of priorities attributed to DCRs varies, with some placing greater emphasis on health goals, and others on public order' (Hedrich *et al,* 2010: 307).

Table 3.2: Aims and Objectives of DCRs

AIMS	OUTCOME OBJECTIVES	INDICATORS
1. Provide an environment for safer drug use	a) Reach and be accepted by target groups	Client profiles, service use patterns, client satisfaction
	b) Gain acceptability	Responses of local residents, businesses, police, politicians
	c) Establish conditions for safe, hygienic use	Various process indicators
2. Improve health status of target group	a) Improve risk-related behaviours	Street drug use, risk awareness, injection hygiene, borrowing/lending
	b) Reduce morbidity	Injection inquiries, infectious disease transmission
	c) Reduce mortality	Overdose outcomes
	d) Improve access to healthcare and drug treatment	Treatment referral/ uptake
3. Reduce public disorder	a) Reduce public drug use	Self-reported rates op public injecting, ethnographic observations of the burden of public injecting
	b) Improve public perceptions	Perceived nuisance, discarded syringes
	c) No increases in local drug-related crime	Crime statistics

(Hedrich et al, 2010: 308)

The following two chapters will discuss some of the survey's results according to two of the three aims set out by Hedrich *et al* (2010), namely safer drug use and improved health. Due to the nature of our survey, this report addresses some objectives in more detail than others, while some are not addressed at all. As the objectives related to the third aim have not been covered in our survey, they are not included in this text. It should furthermore be noted that due to the nature of the survey, when discussing the second aim we will not elaborate on the actual improvement made by DCRs, but rather focus on how DCRs have organised their work in order to improve the health status of the target group.

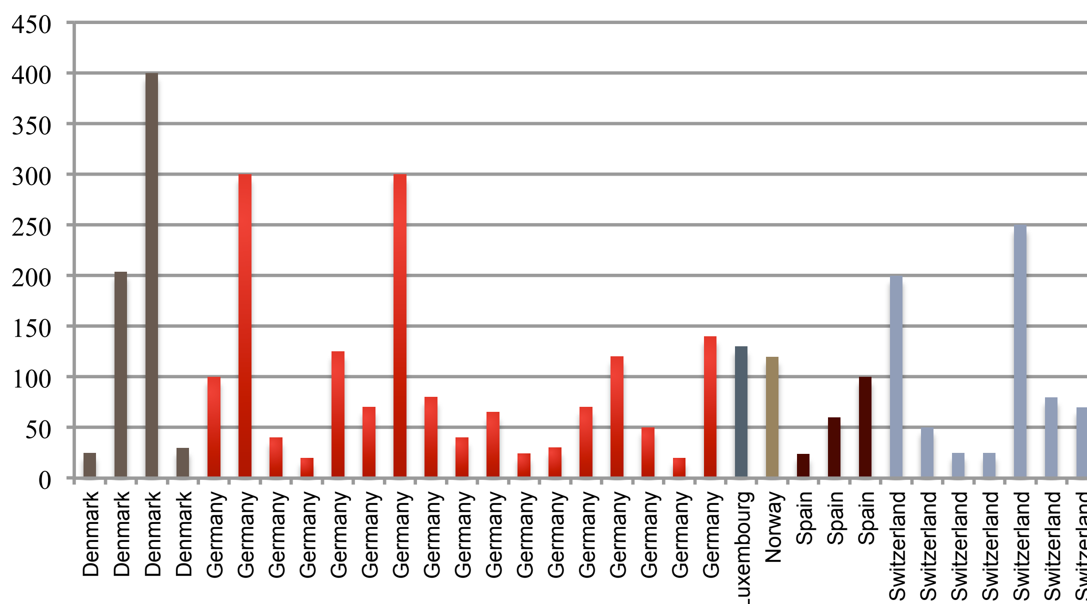
Since Hedrich *et al* (2010) have already presented a detailed report on their aims and objectives it was not our intention to cover their categories

conclusively, but merely to keep them in mind and compare them to our own survey findings. More detailed elaborations on the indicators can be found in the chapter. We will now address the first two aims as outlined by Hedrich *et al*, before continuing. From Chapter 6 onwards, we will focus on other highly relevant topics such as general services on offer, and staff and peer involvement.

4 Safer drug use environment

Most DCRs offer places for intravenous drug use as well as for smoking/inhaling substances. On average, DCRs offer between 7 and 8 (7.41) intravenous drug use places and between 6 and 7 (6.73) drug-smoking places. The amount of drug-smoking places on offer ranges from 2 to 14, with seven locations (21.2%) offering no smoking facilities at all. The IDU places on offer ranges from between 1 and 13. All locations included in this survey offered at least one place for IDU. This differs from the Netherlands in the sense that Dutch facilities offered an average of 14 smoking places and 5 IDU places. This difference can be explained by the fact that, compared to other European countries, the prevalence of injecting drug use in the Netherlands is among the lowest in Europe (0.2 per 1000 adult population; see http://www.emcdda.europa.eu/countries/data-sheets/netherlands).

Another remarkable difference between other European countries and the Netherlands is that the other European countries reach much larger groups of drug users on a daily basis. With an average of 103 visitors per day, the differences between locations are so big that the only meaningful way to present it is through the chart below, showing the individual amount of visitors per location.



As shown in the above chart, the number of visitors per day ranges from a minimum of 20 to a maximum of 400, with great differences within and between countries. In comparison to the Netherlands, where the average amount of visitors per day was 22 in integrated facilities and 24 in independent facilities, the facilities in other European countries generally deal with larger groups of visitors.

4.1 Admission criteria

Most DCRs do not work with a card system. Just 5 out of 32 respondents (15.6%) reported working with one. At the same time, all respondents said to adhere to a minimum age for visitors of the DCR. A minimum age of 18 years was the threshold reported by 90.6% of the DCRs. Three facilities, all in Germany, have a minimum age of 16 (2) or 17 (1) years. Similarly, 90% of the Dutch respondents in 2010 reported maintaining a minimum age limit. In table 4.1 some additional admission criteria are presented.

Table 4.1: admission citeria

DCR admission criteria	European DCRs excluding NL **2013 (N = 33)**	CH **N= 7**	DE **N= 17**	DM **N= 4**	FI **N= 1**	LX **N= 1**	ES **N= 3**	NL **2010 (N = 30)**
In possession of drugs before entering	72.7%	2	15	2	1	1	3	53%
Signing of contract	69.7%	2	13	3	1	1	3	67%
Not being in substitution treatment	45.5%		14			1		n.a.
Signing of disclaimer	27.3%		4	4		1		20%
Registered with the municipality	24.2%	4	3		1			70%
Residing in the vicinity of the DCR	15.2%	2	3					20%
Poor physical and mental condition	15.2%	2	3					17%
Homeless	6.1%		2					43%
Registered as a client with the managing institution	6.1%	1	1					67%
Registered as a client of a local facility	6.1%		2					37%
Having caused public nuisance	6.1%		2					40%
Known to police	0%							13%
TB check	0%							23%
Other	27.3%	4	3				2	n.a.

Most DCRs (87.9%) always hold an entry interview with new visitors to the facility.

4.2 Accessibility

With just one German facility reporting being closed on Wednesdays, all other facilities are open during weekdays. On Saturday 60.6% of the DCRs are open, and on Sunday 63.6% of the facilities open their doors. Around a third of the facilities report being closed on the weekend, and those that do open maintain slightly shorter opening times. The average duration of opening hours varies from day to day, with the longest average on Mondays (8.6 hours) and the shortest on Sunday (7.6 hours). The duration also varies greatly between facilities, with one German DCR being open for 20 hours per day during weekdays, and one Swiss facility being open for 3 hours and 35 minutes on five of the seven days that it opens. Similarly, the Dutch facilities were open 8 hours a day on average ranging between 3 and 15 hours per day.

87.1% of the facilities operate a maximum duration policy that visitors are allowed to stay in the smoking room, and 69.7% have a maximum duration

policy for the injecting room. In both rooms the average maximum lies just above 30 minutes, with an actual range of 15 to 90 minutes. The main reason stated for this time limit is to allow as many users as possible into the DCR. Most facilities have to deal with queues, so to keep the DCR accessible to all and adhere to their objective to reduce public drug use, a set time limit is utilised. It is with this same objective in mind that all but one facility allows their visitors to access facilities as often as they want. The only DCR reporting a maximum amount of times that visitors can access facilities per day also claims to do so because of a shortage in personnel. Again, the survey in the Netherlands presented similar results.

The table below illustrates which parties are involved in the guidance of clients towards the DCR. The police and addiction treatment facilities are the most involved players when it comes to referring new clients to the DCRs (73%). This is followed by shelters (67%) and outreach workers (58%). Neighbours (24%) are the least involved when it comes to guiding clients to a DCR, although this percentage is significantly higher than that reported in the Netherlands (3%).

Table 4.2

Parties involved in the guidance of clients towards the DCR	European DCRs excluding NL **2013 (N = 33)**	Netherlands **2010 (N = 30)**
Police	73%	47%
Addiction treatment facilities	73%	67%
Shelters	67%	63%
Outreach workers	58%	47%
Mental health services	55%	40%
DCR visitors	52%	50%
Neighbours	24%	3%
Other	27%	27%

The category 'other' includes: Municipal and state authorities, (governmental) health services, DCR staff: (e.g. social workers, paramedics and others), local and regional governmental officials, doctors, and local health authorities.

Moreover, 13 out of 32 respondents (40.6%) stated that there were target groups they would like to reach but currently do not. Generally speaking, these groups include young drug users, those who use a different substance, those with alternative routes or methods of use, and migrants or non-locals. In Germany, several facilities mentioned they would also like to reach drug users who are in substitution treatment, however German federal state regulations prohibit this.

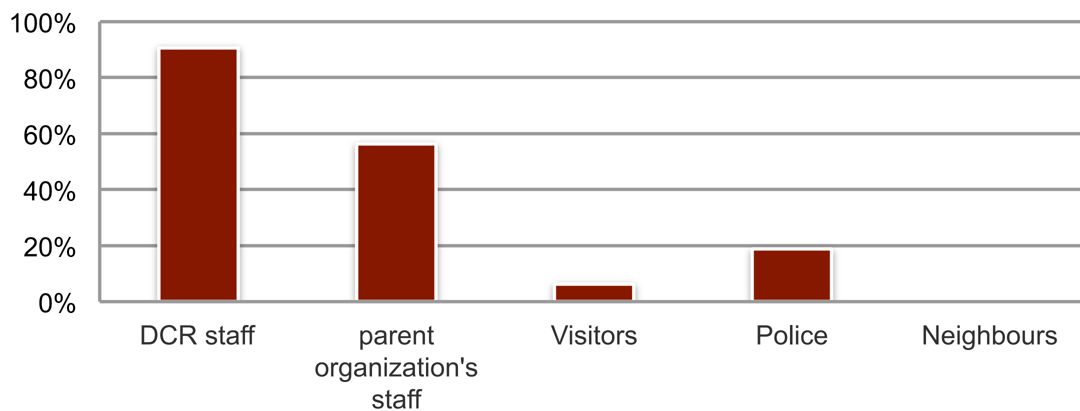
4.3 General rules and regulations

In 75.8% of the DCRs alcohol is prohibited, and in 39.4% tobacco is prohibited. The main reason provided for alcohol prohibition is to reduce violence and drug use risks. As for tobacco the most common reason to prohibit it is state legislation protecting the health of non-smokers. The facilities that do allow tobacco smoking primarily permit it in separate smoking areas.

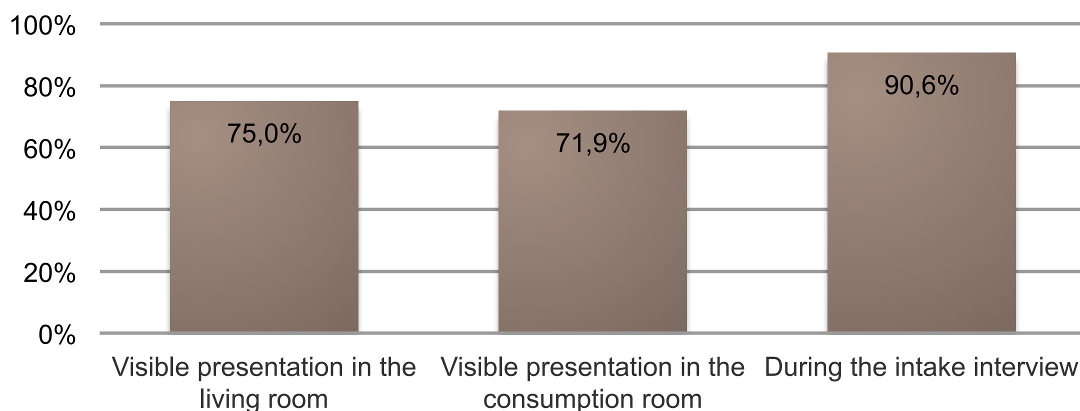
87.9% of the DCRs register some sort of data on visitors. This tends to be basic

information such as the date and frequency of visiting, and often including details on the substance the visitor is using. Some record this anonymously, while others also register personal details. Moreover, all but one Danish facility note down the details of the daily affairs (such as visitors' need for help, or a conflict between visitors).

When asked which parties are involved in the establishment of house rules, 90.6% responded that the DCR staff was involved in this process, often in collaboration with the staff of the parent organisation; 56.3% involved only the latter. 18.8% involved the police in the process, but merely 6.3% involved their visitors. No DCR reported involving the neighbours. In comparison to the Netherlands, the very low percentage of visitors' involvement is remarkable. For example, 40% of the Dutch facilities involved the visitors in the establishment of house rules, whereas just one facility in Denmark, and one in Spain said to do the same.



Besides the abovementioned, several facilities also cited additional parties involved in the establishment of house rules. In Luxembourg the DCR has a control group, several facilities in Germany and one in Spain mentioned the involvement of legal and governmental institutions, and another Spanish DCR establishes its house rules together with the public health services.

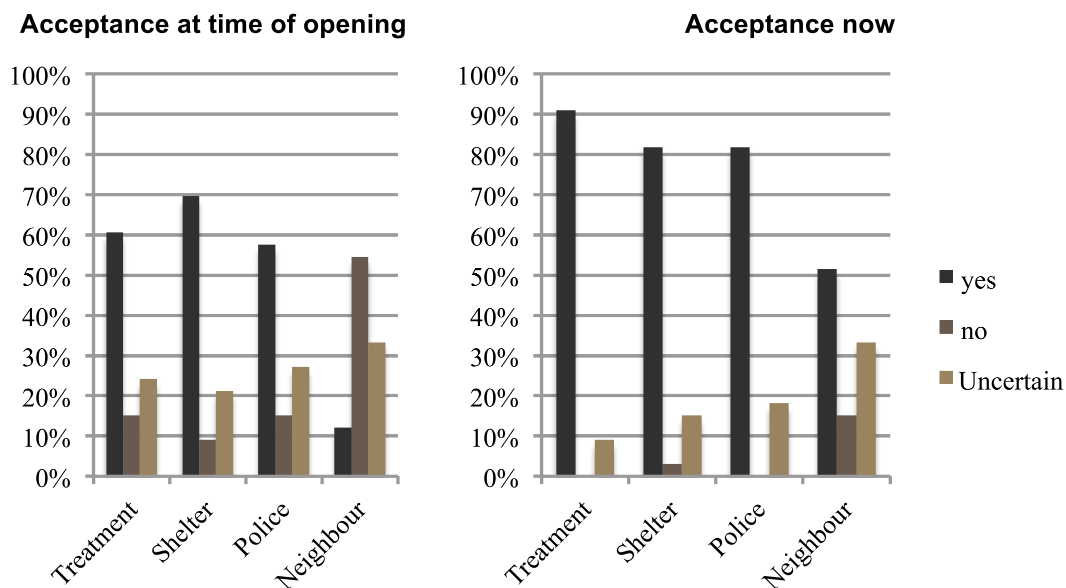


Once the house rules have been established, 90.6% of the DCRs communicate the house rules during the intake interview, while also having them printed out (e.g. as a poster) in the living room and/or consumption room. The few DCRs that do not present the house rules during an intake interview communicate them through posters. One DCR in Denmark reported imparting the house rules verbally.

When visitors break the rules, all but two facilities (one in Denmark and one in Germany) have sanction regulations. This also includes the facilities in the Netherlands. The most identified causes of sanctions are violence or drug dealing, and the most used sanction is suspension from the facility for varying amounts of time. While some facilities suspend for a lifetime in severe situations (e.g. Germany), the DCRs in Copenhagen, Denmark are known to use a model with very high tolerance, where it is impossible to get suspended for a longer period of time (Koberg, 2014).

4.4 Acceptability

As far as social acceptance of the DCR is concerned, all respondents were asked whether or not treatment facilities, shelters, police and neighbours accepted the DRC at both the time of establishment and at present. The two charts below demonstrate to what extent the respondents thought the DCR to be accepted.



A clear development visible in these two charts is the increase of acceptance over the course of time. In the earlier Netherlands' study, a similar development was noted regarding the neighbours, rising from 42% to 80%. In this survey, all parties involved had a higher resistance against DCRs at the time of foundation. In line with previous studies, this demonstrates that once a DCR is up and running the societal response towards these facilities tends to become more positive, and the initial resistance amongst neighbours decreases (Havinga & Van der Poel, 2011: 13).

5 Improving health status

As previously mentioned, this survey cannot provide any information on the actual impact experienced by drug users and their environment with regard to their health status or reduced morbidity and mortality. However, some statements can be made regarding the way DCRs work towards such improvements. DCRs support the improvement of client health status by offering services on location, as well as by referring clients to other health and support services.

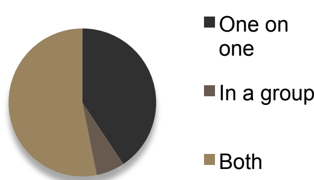
On location, 100% of the respondents reported providing needle exchange, with 96.9% providing drug paraphernalia. Health education is offered to drug users by 100% of reporting facilities, 59.4% have an office hour physician, and 84.4% have an office hour nurse. See chapter 6 for other services, and how this data compares to the Netherlands.

The table and graphs below give us some information on the themes and form of the health education provided at European facilities.

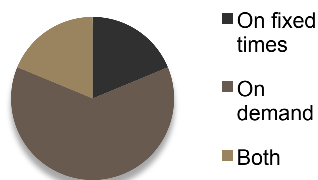
Table 5.1

Health education themes	European DCRs excluding NL **2013 (N = 32)**	Netherlands **2010 (N = 30)**
Safer drug use	96.9%	85%
Infectious diseases	100%	82%
Hygiene	96.9%	89%
Safe sex/ STDs	84.4%	56%
Other	34.4%	11%

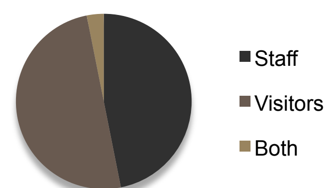
How do you provide health education?



When do you provide health education?



Who takes the initiative in the provision of health education?



Besides in house health care improvement, a very important aspect of DCRs is the potential for referral to other services. 'In providing low-threshold and acceptance-orientated contact opportunities, consumption rooms fill a bridging function to other health and psycho-social support services. Consumption rooms should, therefore, be embedded into the health and support services system within the community' (Akzept, 2000: 4). In our survey 87.5% of the facilities acknowledged referring visitors to other care and/or treatment facilities. Moreover, when asked whether or not the respondent thought that 'clients have greater use of other services and entry to treatment as a result of using the DCR'

all respondents said their visitors had greater access to at least one form of service or treatment (table 5.2).

Table 5.2: access to services

Which (treatment) services to visitors have greater use or access to as a result of visiting the DCR?	
Primary health care services	100.0%
Social services	93.8%
Drug treatment services	90.6%
Mental health care services	62.5%
Work/reintegration projects	56.3%
Other	3.1%

All facilities said that their visitors have greater access or use of primary health care services. This of course is a very important factor in the aim to improve the health status of the target group. Note that this may be achieved by offering the services of a nurse or doctor and health education on location as well as by referring the visitors to the services they may need.

Besides improved access to primary health services, the majority of DCRs also facilitate access and use of social, mental health care, drug treatment and work reintegration services. In the category marked “other”, one respondent added “supported housing”. Most of these factors contribute to the improved health status of clients, but DCRs also cover a more social function, which has been touched but not elaborated on in table 3.2, as based on the text by Hedrich *et al* (2010). This social function includes the improvement of social status and/or inclusion through work integration, housing support and socialisation. It will be discussed further in the following chapter where we look at the service facilities offered in a broader sense.

6 DCR services

In table 6.1 various services offered at European (and specifically Dutch) DCRs are listed. The previously mentioned 'health status improving services' are offered, along with several other services such as basic food and personal care facilities, practical support, and referral to or on location work and recreational activities.

Table 6.1: DCR services

DCR SERVICES	European DCRs excluding NL 2013 (N = 32)	Netherlands 2010 (N = 30)
Basic services		
Bread, coffee/tea	87.5%	97%
Warm meals	62.5%	83%
Needle exchange	100%	93%
Provision of drug paraphernalia	96.9%	100%
Personal care (e.g. shower and wash clothes)	78.1%	90%
Practical support		
Lockers	31.3%	57%
Postal address	46.9%	40%
Possibility to use phone	90.6%	87%
Support with financial and administrative affairs	81.3%	77%
Medical care and education		
Health education	100%	90%
Office hour physician	59.4%	63%
Office hour nurse	84.4%	57%
Care, support and daily activities		
Referral to care/treatment facilities	87.5%	93%
Work/reintegration projects	28.1%	73%
Referral to work/reintegration projects elsewhere	65.6%	77%
Recreational activities	40.6%	67%

Although a work, reintegration and recreational focus is far more common in the Netherlands than any other European country, and is considered to be a typical trait of the Dutch model, the majority of other European DCRs (65.6%) also refer to work and reintegration projects elsewhere. Besides, by offering basic services such as bread and coffee/tea (87.5%), the possibility to use a phone (90.6%) and support with financial and administrative affairs (81.3%) we see that basic needs are met, and social work is offered in order to support visitors in more than just their health status.

7 Staff

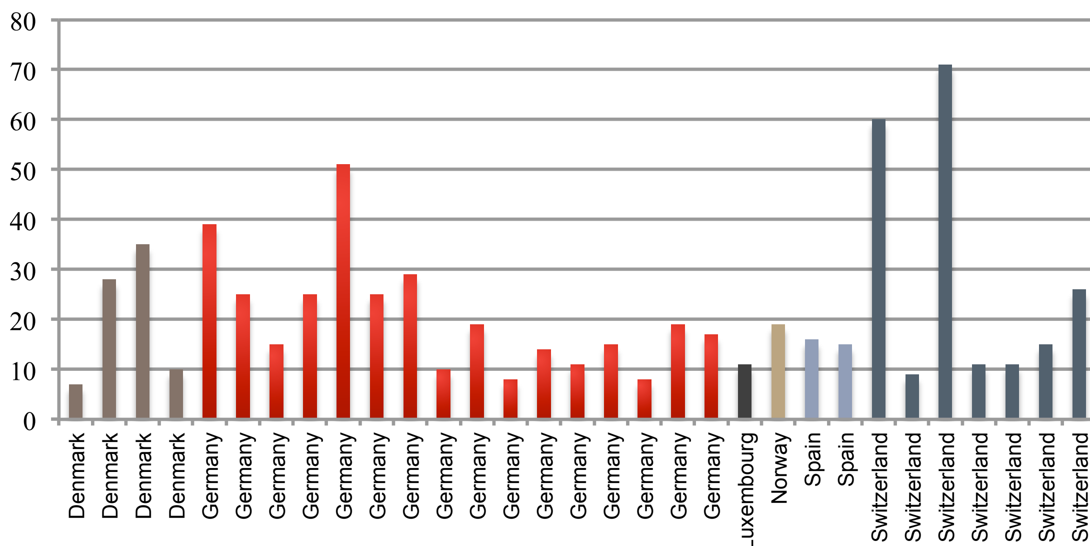
The broad social support offered to visitors of DCRs is also illustrated by the fact that 96.8% of the DCRs have at least one (full-time or part-time) social worker on location. Just one facility in Denmark reported not having a social worker among the staff members. However, this Danish DCR does have four nurses on location; 87.1% of the DCRs have–at least one full-time or part-time nurse among its staff members. In comparison, 53.3% of the Dutch DCRs had at least one nurse, and 73.3% had at least one social worker among its staff members.

Table 7.1: staff functions

Staff member functions at the DCR	European DCRs (N=31)
Social worker	96.8%
Nurse	87.1%
Guard	29.0%
Student	41.9%
Manager	58.1%
Former DU	22.6%
Other or unknown specification	64.5%

In response to the question whether or not the different functions at the DCR have been laid down in job descriptions, 87.1% responded with "yes" (vs. 60% in the Netherlands), 6.5% responded "yes for some, but not for all" (vs. 20% in the Netherlands) and 6.5% responded "no" (vs. 20% in the Netherlands).

Total number of DCR staff



Besides a variation in functions, there is also a great variety in the number of staff members working for each facility, with numbers ranging between 8 and

71. Note that these variances are not only due to the differences in capacity and visitors per day, but those with the greatest numbers of staff members primarily work with part-time employees. The diversity in the amount of personnel is demonstrated in the graph on the previous page.

Just like in the Netherlands all but one DCR (in Germany) have a structural offer of staff development training. Table 7.2 shows the different trainings offered to DCR employees.

Table 7.2: staff training

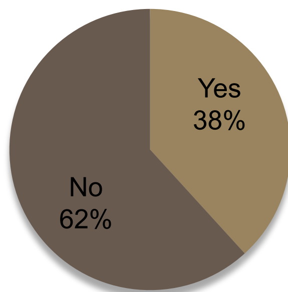
What staff trainings are offered structurally at the DCR?	European DCRs (N=30)
basic course on drugs and addiction	60.0%
basic course on first aid for drug related incidents	96.7%
motivational interviewing	50.0%
providing information services	50.0%
infectious diseases	73.3%
other	30.0%

The facilities that offer trainings other than those listed cover topics such as de-escalation (N=3), supervision (N=3) and trauma (N=1). These trainings enable the staff members to provide support to the visitors, while upholding professionalism and enhancing the safety of staff and visitors. Thus this contributes significantly to the aim to provide an environment for safer drug use, as discussed in Chapter 4.

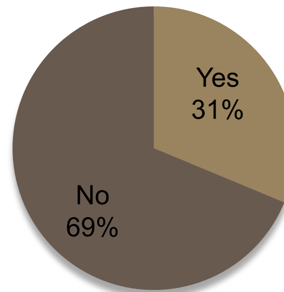
8 Peer involvement

As discussed in chapter 4.3, only 2 out of 32 facilities involved the visitors in the establishment of their house rules, in contrast to 40% of the Dutch facilities. As the four graphs below demonstrate, peer involvement is also low regarding other aspects of the DCR.

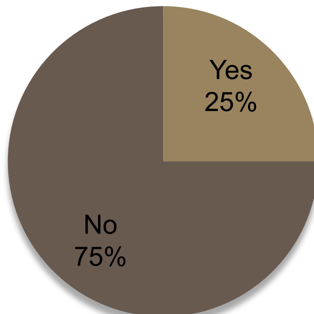
1. Have the DCR's goals been formulated in dialogue with visitors of your facility?



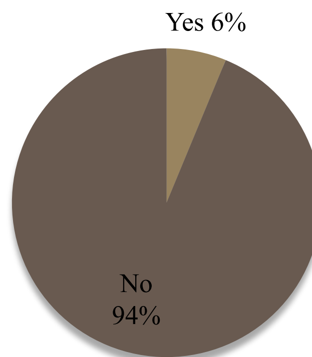
2. Are the DCR visitors involved in the establishment of the services on offer?



3. Do you also employ (former) drug users?



4. Are visitors included in the formulation of house rules?



As shown in the second graph, 31% reported involving visitors in the establishment of the services on offer. This, however, can be interpreted very broadly - when we asked what this involvement entailed, the responses were diverse. Five respondents involve their visitors through surveys, or as one German facility elaborated: “visitors are regularly interviewed on the user-friendliness of the DCR and services provided. The results of the evaluation are discussed by the DCR and the parent organisation. Users’ proposals for changes/improvements may be put into practice, if they make sense and if they correlate with state and federal state regulations.” Two locations offer different kinds of work, such as the Swiss location that has one working place behind the bar and several cleaning jobs. One German facility involves the visitors through projects, and another Swiss DCR considers their visitors involved because “it is all written down for them”. Lastly, table 8.1 shows different forms of organised

visitors' participation, table 8.2 shows the differences per country, and table 8.3 the DCRs' reasons for not having organised visitor's participation.

Table 8.1

Form of organised visitor's participation	% of DCRs (N = 33)	% of DCRs in NL (N = 30)
visitors are deployed for management and functioning of the DCR	21.2%	17%
visitor meetings are organised	36.4%	57%
meetings take place with visitor representatives	0%	40%
Visitors are involved in decisions regarding the organisation and internal affairs	12.1%	27%
None	45.5%	<25%

Table 8.2

Country	% offering some form of participation
Denmark (4)	75%
Germany (17)	41.2%
Luxembourg (1)	0%
Netherlands (30)	>75%
Norway (1)	0%
Spain (3)	66.7%
Switzerland (6)	83.3%

Table 8.3

Why is there no form of organised visitor's participation	% of DCRs (N = 15)
We are working on it	13.3%
Survey or inventory in another way	33.3%
Does not fit in the structure	40%
No answer	13.3%

Again, visitors' participation on average proves to be quite low in the European facilities, with large differences between countries. There is no organised visitor participation in Luxembourg and Norway, and in Germany most facilities also don't provide for it. In Denmark, the Netherlands, Spain and Switzerland, the majority of facilities have included visitor participation in their organisational structure.

When asked why respondents do not have any form of organised participation, the answers were as shown in table 8.3. It is vital to note that the reason no organised participation was reported by the Denmark facility is as follows: *"we work on the street and the democratic process is on the street; it is not structured, but demands and inputs are discussed among staff members, and we adapt to the demands."* Thus they do have participation, but it is not organised. The one Spanish respondent that stated they did not (yet) have organised visitors' participation was filling in the form for multiple facilities, and their more accurate response is that some facilities did have participation and others were in the process of setting it up

9 The future of DCRs

DCRs have always been, and continue to be, controversial services. Nevertheless, since the first one opened its doors in 1986, they have run successfully in many countries. This is not to say that it has always been easy: some pilot facilities have closed, whilst others have not even managed to open due to political sensitivity. At the time of writing, several countries are still considering opening a DCR in the near future. The possibility of introducing DCRs exists in France, the United Kingdom, Portugal and Romania, while Greece successfully opened one in 2013 and Luxembourg is preparing to open a second facility. Being such a controversial matter, Hedrich (2007) already established three broad factors in the future development of DCRs (box 9.1).

Box 9.1

Three broad factors that play a role in the future development of DCRs

1. Changing patterns of risky use.

The broader directions in which DCRs might develop are likely to be linked to changes in the patterns of risky use, to the types of drugs involved, drug markets, and to whether local drug scenes persist. Especially those countries which experienced the 'first wave' of the heroin epidemic in Europe are currently witnessing dramatically the effects of treatment policy changes towards high coverage of drug substitution treatment, as well as increases in cocaine use. These developments have an impact on overall drugs service provision, including on DCRs.

2. Priorities in local drugs policies.

DCRs initially evolved as a response to health- and public order problems linked to open drug scenes and drug markets, in cities where a network of drugs services already existed, which was unable to respond to these problems. Besides for heroin and cocaine injectors, they nowadays also play a role for the management of inner city heroin-crack using populations. DCRs are genuinely a 'local' response, closely linked to policy choices made by local stakeholders, based on an evaluation of local need and determined by municipal or regional options to proceed. The priorities of local response might change when higher treatment coverage is achieved.

3. Quality of services provided by DRCs.

DCRs have been and continue to be controversial services. This has however promoted the awareness for monitoring and evaluation. Critical assessment results and objective, reliable and comparable data on service provision, will –or at least should- have an important impact on the future development of DCRs.

Hedrich, 2007

In light of the ongoing interest in the establishment of DCRs, and building upon the abovementioned considerations, we presented our respondents with twenty statements. Respondents were asked to rank their answers according to importance, and to select three factors that they considered to be most important. The table lists respondent choices from most votes to least votes, with the last column showing the total ranking score of each statement. Those numbered bold in red (1, 2, 3, 5, 8 and 12) received the most votes in the Netherlands.

	If I were responsible for the establishment of a new DCR, I would consider the following points of importance:	votes	Score
1	Guarantee a comprehensive set of competences, skills and life experiences, while compiling a staff team.	16	148
2	Establish clear agreement with the police to protect the visitors, to normalise the contact between visitors and police and to gain local support.	14	147

3	To compile the assortment of drug paraphernalia based on a harm reduction perspective.	10	145
4	Consider the opening hours of other services and the needs of drug users, when determining the opening hours of the DCR.	9	141
5	To make explicit with all parties involved in the DCR the vision on addiction and adequate response.	8	135
6	Formulation of clear and unambiguous admission criteria.	7	135
7	Include the DCR visitors in determining the facilities and services on offer (e.g. coffee/tea, recreational activities, needle exchange, etc.)	4	121
8	Ensure that neighbours know where they can go with complaints and what the response is to these complaints.	3	137
9	Set up sanction regulations.	3	128
10	Enable DCR visitors to take up tasks and responsibilities.	3	116
11	Check what the concrete consequences of the targets will be for the organisation and facilities of the DCR.	2	136
12	To offer a wide range of drug paraphernalia.	2	134
13	Research the pros and cons of an integrated and a specific DCR.	2	132
14	Consider which groups are included and which groups are excluded though the application of admission criteria.	2	131
15	Chart which methods of supervision are needed to enforce house rules.	2	126
16	The inclusion of (potential) DCR visitors in the formulation of goals.	2	111
17	Set up job descriptions for all possible job functions in the DCR.	1	137
18	Consideration of pros and cons regarding comprehensive services (e.g. education, practical support, etc.)	0	135
19	Opening up the DCR for neighbours, for instance by organising an open day.	0	130
20	Involve DCR visitors in the establishment and practice of its regulations.	0	103

Additionally, several respondents added supplementary points of importance which are listed below by country.

Additional points of importance	Suggested by
Find a balanced flexible approach towards clients needs/ not too many regulations/ accessibility	CH, DE
Funding/ Ensure long-term financing	DE
Legal frame/ Ensure to stick to municipality and (federal) state regulations	DE
Considering a good location	DE
Establish an agreement about the necessity of a DCR with government and the public/ be considerate towards the complaints and viewpoints of neighbours	DE, NL
Drug checking on site	ES
Strengthen conditions for political support/ advocacy	ES
Establish a coordinating body with all stakeholders involved to ensure the proper implementation of the facility.	ES
Include temporary housing project for homeless users of the DCR to improve success of referral to treatment, social situation and health issues.	ES
Monitoring and evaluation of the services provided and their efficacy	ES, NL
Integrated facilities should make clear agreements with the drop-in regarding their collaboration, e.g. providing access to those suspended at the drop-in	NL
Continued commitment towards the visitors among the staff, as this is considered very important by the visitors and is an essential part of working low-threshold	NL
Try to get the staff team on the same page regarding the DCR's policy and the way you carry this out	NL
Consider evaluating the client's DCR indication periodically to consider whether the indication is still the most appropriate solution	NL
Establish clear rules about alcohol consumption in the facility	NL
Stay alert regarding new methods of drug consumption that might require a different organisation of the facility	NL
Pay attention to infectious diseases and link this to somatic check-ups	NL
Consider the pros and cons of a good cooldown room	NL

Conclusion

This report has provided an overview of the organisation and working methods of drug consumption rooms (DCRs) in Europe. In doing so gaining insight into the functioning of DCRs as well as spreading information on the organisation and structure of DCRs to benefit parties involved.

Chapter 3 started off with the general aims and objectives of DCRs, based on the questions and findings of our survey and the objectives structure developed by Hedrich *et al* (2011) set out in table 3.2 (p.12). Based on the three major aim categories in this structure, chapter five and six continued to elaborate on two of these: how the DCRs work on an environment for safer drug use (chapter 4) and improving the health status of drug users (chapter 5).

In chapter 4, some interesting findings were the large average of total visitors per day (103), the great differences between the facilities in the number of daily visitors as well as in their opening hours. Practically all European facilities adhere to a minimum age for visitors, and 'being in possession of drugs before entering' (72.7%) and 'signing a contract' (69.7%) were two admission criteria widely carried in Europe and in all countries. All other criteria were less common and not adhered to in every country. Most regulations and practices seem primarily directed at maintaining a safe environment and ensuring outreach and harm reduction to as many drug users as possible. Both in the Netherlands as in the rest of Europe social acceptance of DCRs seems to be lower at the time of foundation than when the facility has operated for a while.

In chapter 5 the different ways towards improving clients' health status were discussed. For instance, 100% of the facilities reportedly offered needle exchange as well as health education to clients, while 84.4% had an office hour nurse, and a little under sixty percent and office hour doctor. Besides in house health care improvement, a very important aspect of DCRs is the potential for referral to other services. In our survey 87.5% of the facilities acknowledged referring visitors to other care and/or treatment facilities.

Moreover, in line with the Dutch survey of Havinga & Van der Poel (2011) on which this study has been based, this report elaborated on several other crucial aspects of the organisation and working methods of DCRs. The general services on offer at DCRs (chapter 6) were discussed. Details on the differences in staff functions and the trainings offered to the staff (chapter 7) and the way facilities involve peer in various organisational elements of the DCR (chapter 8) were also examined.

Most of the factors discussed in chapter 4 and 5 contribute to the improved health status of clients, but DCRs also cover a more social function, which has been touched but not elaborated on in the objectives structure of Hedrich *et al* (2010). This social function includes the improvement of social status and/or inclusion through work integration, housing support and socialisation. Just how

this is addressed is discussed in chapter 6 through the service facilities offered in a broader sense.

The very low rate of peer involvement throughout the European facilities is remarkable. In chapter 4 it is already shown that 40% of the Dutch facilities involved the visitors in the establishment of house rules, whereas just one facility in Denmark, and one in Spain said to do the same. In chapter 8 this low rate of involvement is visible through several other facility traits. Particularly DCRs in Germany, Norway and Luxembourg do not seem to have peer involvement incorporated in their working methods.

The final chapter paid attention to the future of DCRs, and elaborated briefly on what those currently involved in the running of DCRs consider being important when setting up a new facility (chapter 9). Our overview study thus concluded with some relevant remarks when considering the foundation of a new DCR service.

Bibliography

Akzept Bundesverband & Carl von Ossietzky (*eds.)* (2000) *Guidelines for the operation and use of consumption rooms.* Lektorat: W. Schneider & H. Stöver, Materialien No. 4. Münster: Akzept.

Bransen, E., H. van 't Land & J. Wolf (2004) *Gebruiksruimten in Nederland; Trends en ontwikkelingen 2001 – 2003.* Utrecht: Trimbos Instituut.

Havinga, P. & A. van der Poel (2011) 'Gebruiksruimten in Nederland; update van de handreiking bij organisatie en inrichting'. [On-line] available at: http://www.trimbos.nl/webwinkel/productoverzicht-webwinkel/alcohol-en-drugs/af/af1051-gebruiksruimten-in-nederland

Hedrich, D. (2004) *European report on drug consumption rooms.* Lisbon: EMCDDA.

Hedrich, D. (2007) '¿En que sentido deberian evolucionar las salas de consumo supervisado?'. In: *BOLETIN CDD,* nº 144, 2007, págs. 10-15. Signatura: R.948 / Archivo. Loc.: DD / DFB Ref. 163657. [Translated to English by Hedrich].

Hedrich, D., T. Kerr & F. Dubois-Arber (2010) 'Chapter 11; Drug consumption facilities in Europe and beyond'. [On-line] available at: http://www.emcdda.europa.eu/publications/monographs/harm-reduction

Hunt, N. (2008) 'Guidance on standards for the establishment and operation of drug consumption rooms in the UK'. [On-line] available at: http://www.jrf.org.uk/publications/guidance-standards-establishment-and-operation-drug-consumption-rooms-uk

Joseph Rowntree Foundation (2006) 'The report of the Independent Working Group on Drug Consumption Rooms'. [On-line] available at: www.jrf.org.uk/sites/files/jrf/9781859354711.pdf

Koberg (2014) 'Mændenes hjem Denmark; the drug consumption rooms "the Copenhagen Model"'. Presentation at the 2nd European Harm Reduction Conference in Basel, Switzerland at May 7 - 9, 2014.

KPMG (2010) 'NSW Health; Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007 – 2011) Final report.' 14 September 2010. [On-line] available at: http://www.health.nsw.gov.au/mhdao/Documents/msic-fr.pdf

Nougier, M. & E. Schatz (2012) *Drug consumtion rooms; Evidence and practice.* London: International Drug Policy Consortium.

Poel, A. van der (2009) 'Low-threshold Care for Marginalised Hard Drug Users; Marginalisation and Socialisation in the Rotterdam Hard Drug Scene.' [On-line] available at: http://repub.eur.nl/pub/17719/

Appendix

Survey on the organisation and structure of Drug Consumption Rooms (DCRs)

This is a survey on the organisation and structure of the DCR where you work. The completion of this survey will take you an average of 30 minutes. You can fill in the survey digitally or print it out and return it by mail to the address on the last page of this questionnaire. If you choose to answer the questions digitally you may answer the open questions with a coloured font. The closed questions you may mark with a colour.

For example:
0 yes
0 no

If a question asks you to “please specify”, remember to fill in the required information. For some questions several answers are possible. In those cases it will be mentioned explicitly that this is possible. Thank you in advance for your cooperation!

General data

Your name:

Name of DCR:

City/Town:

Country:

E-mail address:

Name of parent organisation (if applicable):

Goals

The following questions address the set goals of your DCR. With 'your DCR' we mean the DCR that you work for.

1. What is the **primary** goal of your DCR?
0 Nuisance reduction
0 Health damage restriction among drug users
0 Other, namely ...

2. What social functions does your DCR fulfil?
You may select more than one answer
0 “**Sweeper**” (DCR intends to keep those who do not fit in the streetscape off the streets)
0 “**Safety net**” (DCR cares for DU, offers the opportunity to use drugs more safely, and provides for the most urgent/basic medical and social care)
0 “**Springboard**” (DCR aims to improve the living situation of its visitors, refers to

other (care) facilities and cooperates with third parties to strive for re-socialisation)
0 Other, namely …

3. Which of the abovementioned functions is most important in your DCR?
0 “**Sweeper**¨
0 “**Safety net**”
0 “**Springboard**”
0 Other, namely …

4. Have the DCR's goals been formulated in dialogue with (potential) visitors of your facility?
0 Yes
0 No
0 Do not know

Organisation, structure and environment

The following questions address the organisation, structure and environment of the DCR. Questions 5 to 9 concern the period of establishment of the DCR. Questions 10 to 20 concern the current organisation, internal affairs and environment of the DCR.

5. What was the founding year of the DCR? …

6. Please tell us in the box below ***what the primary motivation*** of the DCR’s establishment was at that time?

7. At that time, was there sufficient support for the DCR among local parties?

Addiction treatment services?	0 Yes	0 No	0 Uncertain
Shelters?	0 Yes	0 No	0 Uncertain
Police?	0 Yes	0 No	0 Uncertain
Neighbours?	0 Yes	0 No	0 Uncertain

8. At that time, where was the DCR situated?
0 In the centre of the city/town
0 On the periphery of a city/town
0 Elsewhere, namely …

9. At the time of foundation, was the DCR independent or integrated?
'Integrated' meaning that the DCR formed part of a, usually previously established, low-threshold service.
0 Independent
0 Integrated

9A. Were there any changes at a later date?
0 Yes, we moved to another location
0 Yes, we merged with another facility, namely …
0 Yes, other, namely …
0 No

10. What are the current opening hours of the DCR?

Opening hours	
Monday	0 From … Till … 0 Closed
Tuesday	0 From … Till … 0 Closed
Wednesday	0 From … Till … 0 Closed
Thursday	0 From … Till … 0 Closed
Friday	0 From … Till … 0 Closed
Saturday	0 From … Till … 0 Closed
Sunday	0 From … Till … 0 Closed

11. Presently the DCR offers how many places (fill in the number)?
… smoking places
… injecting places
… living room places
… TOTAL PLACES

12. The consumption of alcohol is allowed:
You may select multiple answers
0 Nowhere
0 In the smoking and injecting rooms
0 In the shelter/ living room

Please explain briefly why you have this policy:

12A. The consumption of tobacco is allowed:
You may select multiple answers
0 Nowhere
0 In the smoking and injecting rooms
0 In the shelter/ living room

Please explain briefly why you have this policy:

13. What is the maximum duration visitors are allowed to stay in the DCR?

Smoking	0 Unlimited 0 Limited, namely … minutes
Injecting	0 Unlimited 0 Limited, namely … minutes

14. What is the maximum amount of times a visitor may come to the DCR on one day?
0 Unlimited
0 Limited, namely … times

15. Why does the DCR work with a limited/unlimited duration of stay and/or visits per day?

16. How many visitors come to the DCR to use on an average day?
… visitors

17. Which data of DCR visitors do you register?
0 We do not register any data on visitors
0 The days that a visitor comes to the DCR
0 The days and frequency per day that a visitor comes to the DCR (thus allowing for multiple visits per day)
0 The days, frequency and duration of stay of the visitor in the DCR
0 Other, namely …

18. Are details of daily affairs noted down anywhere, for instance in a log?
For example, when a visitor asks for help in the application for social benefits, or if there is an argument between visitors.
0 Yes
0 No

19. Is there some form of organised visitor's participation?
You may tick multiple boxes
0 Yes, visitors are deployed for management and functioning of the DCR
0 Yes, visitor meetings are organised
0 Yes, meetings take place with visitor representatives
0 Yes, visitors are involved in decisions regarding the organisation and the internal affairs of the DCR.
0 Yes, other, namely …
0 No, because...

20. Are open days for neighbours organised?
0 Yes, when was the last time an open day was organised? …
0 No, why not? …

21. At present, do you think there is sufficient support for the DCR among local parties?

Addiction treatment services?	0 Yes	0 No	0 Uncertain
Shelters?	0 Yes	0 No	0 Uncertain
Police?	0 Yes	0 No	0 Uncertain
Neighbours?	0 Yes	0 No	0 Uncertain

22. Where is the DCR currently situated?
0 In the centre of the city/town
0 On the periphery of a city/town
0 Elsewhere, namely …

Target group and admission

The following questions concern the DCR's target group, and the admission procedure that is in place at present.

23. Which parties are involved in guidance towards the DCR?
You may tick multiple boxes
0 Police
0 Outreach workers
0 Neighbours
0 Addiction treatment facilities
0 Mental health services
0 Shelters
0 DCR visitors
0 Other, namely …

24. Do new DCR visitors always have an entry interview?
0 Yes
0 No

25. Which admission criteria do you have at this DCR?
You may tick multiple boxes
0 Having caused public nuisance
0 Homeless
0 Residing in the vicinity of the DCR
0 Registered as a client of a local facility
0 Known to police
0 Poor physical and mental condition
0 Minimum age
0 Registered with the municipality
0 In possession of drugs before entering the consumption room
0 Registered as a client with the managing institution
0 Signing of contract (house rules compliance statement)
0 Not being in substitution treatment (methadone/suboxone)
0 Signing of disclaimer
0 TB control
0 Other, namely …

26. Are there admission criteria which are practised flexibly, or which are not always applied?
0 Yes
Which one(s) and why?

0 No

27. Do you work with a card system at the DCR?
0 Yes
0 No

28. What is the minimum age at the DCR?
… years of age

Are there target groups that the DCR would like to reach, but does not?
0 Yes
Which group(s), and what could be the reason for its elusiveness?

0 No

Facilities

The following questions concern the current facilities on offer for the DCR visitors inside the building. For integrated DCRs 'inside the building' includes the drop-in centre which the DCR is part of.

Which services/facilities are on offer for visitors of the DCR inside the building?
You may tick multiple boxes
0 Warm meals
0 Bread, coffee/ tea
0 Needle exchange
0 Provision of drug paraphernalia (e.g. foil, filters, ascorbic acid)
0 Recreational activities
0 Work/ reintegration projects
0 Office hour physician
0 Office hour nurse
0 Personal care (e.g. shower, washing clothes)
0 Practical support: lockers
0 Practical support: postal address
0 Practical support: possibility to use phone
0 Support with financial and administrative affairs
0 Referral to care/treatment facilities (e.g. drug treatment, primary and mental health care facilities)
0 Referral to work/ reintegration projects elsewhere
0 Other, namely ...

A. Do you think clients have greater use of other services and entry to treatment as a result of using the DCR?

You may tick multiple boxes
0 Yes, to drug treatment services
0 Yes, to primary health care services
0 Yes, to mental health care services
0 Yes, to social services
0 Yes, to work/reintegration projects
0 Other, namely …
0 No

31. Are the DCR's visitors involved in the establishment of the services on offer?
0 Yes
In what way?

0 No

32. Does your facility actively provide for health education?
0 Yes
0 No (go to question 33)

A. Which subjects are addressed in the health education?
You may tick multiple boxes
0 Safer drug use
0 Infectious diseases
0 Hygiene
0 Safe sex/ STDs
0 Other, namely …

B. Who takes the initiative in the provision of health education?
0 DRC/drug treatment staff
0 DCR visitors/ drug treatment clients
0 Both staff and visitors/clients
0 Other, namely ….

C. When do you provide health education?
0 On fixed times, meaning the structural offer of health education, for example once a month
0 On request, meaning when there is a demand for it

D. How do you provide health education?
0 One on one
0 In a group
0 Both

House rules

The following question concern the house rules that currently apply for the DCR visitors inside the building.

33. Which parties are included in the formulation of house rules?
You may tick multiple boxes
0 Direct staff of the DCR
0 Staff of the DCR’s parent organisation
0 Visitors

0 Police
0 Neighbours
0 Other, namely …

34. How do you present the house rules to your visitors?
You may tick multiple boxes
0 Visible presentation (e.g. posters) in the living room
0 Visible presentation (e.g. posters) in the consumption room
0 During the intake interview
0 Other, namely …

35. Are there sanction regulations?
0 Yes, namely ….
0 No

Staff

The following questions address staff that is directly involved in the running of the DCR.

36. What is the current composition of the team directly involved in the running of the DCR?

Title of function	**How many work at the facility**
Nurse full-time (ft) Nurse part-time(pt)	… …
Social Worker ft Social worker pt	… …
Porter/ security guard ft Porter/ security guard pt	… …
Professional ft; background unknown Professional pt; background unknown	… …
Executive/manager ft Executive/manager pt.	… …
Intern/ student ft Intern/ student pt	… …
Other ft, namely... Other pt, namely..	… ..
Other ft, namely... Other pt, namely..	… …
Other ft, namely... Other pt, namely..	… …

37. Do you also employ former drug users?
0 Yes, how many? …
0 No

38. Do you have job descriptions for all positions in the DCR?
0 Yes
0 Yes, for some, but not for all

0 No

39. Is there a structural offer of staff development training?
You may tick multiple boxes
0 Yes, basic course on drugs and addiction
0 Yes, basic course on first aid for drug related incidents
0 Yes, motivational interviewing
0 Yes, providing information services
0 Yes, infectious diseases
0 Yes, other, namely …
0 No

Statements

Imagine being responsible for the establishment of a new DCR. Which specific points are important in its organisation and establishment? Below we present a couple of statements on focus points. Could you please indicate to what extent you agree with each statement?

1 = disagree completely 2 = disagree 3 = neutral 4 = agree 5 = agree completely

	If I were responsible for the establishment of a new DCR, I would consider the following points of importance:	1	2	3	4	5
		– –	–	+/-	+	+ +
1	The inclusion of (potential) DCR visitors in the formulation of goals.					
2	To make explicit with all parties involved in the DCR the vision on addiction and adequate response.					
3	Check what the concrete consequences of the targets will be for the organisation and facilities of the DCR.					
4	Research the pros and cons of an integrated and a specific DCR.					
5	Consider the opening hours of other services and the needs of drug users, when determining the opening hours of the DCR.					
6	Formulation of clear and unambiguous admission criteria.					
7	Consider which groups are included and which groups are excluded though the application of admission criteria.					
8	Include the DCR visitors in determining the facilities and services on offer (e.g. coffee/tea, recreational activities, needle exchange, etc.)					
9	Consideration of pros and cons regarding comprehensive services (e.g. education, practical support, etc.)					
10	To offer a wide range of drug paraphernalia.					
11	To compile the assortment of drug paraphernalia based on a harm reduction perspective.					
12	Set up sanction regulations.					
13	Involve DCR visitors in the establishment and practice of its regulations.					

14	Chart which methods of supervision are needed to enforce house rules.					
15	Guarantee a comprehensive set of competences, skills and life experiences, while compiling a staff team.					
16	Enable DCR visitors to take up tasks and responsibilities.					
17	Set up job descriptions for all possible job functions in the DCR.					
18	Establish clear agreement with the police to protect the visitors, to normalise the contact between visitors and police and to gain local support.					
19	Opening up the DCR for neighbours, for instance by organising an open day.					
20	Ensure that neighbours know where they can go with complaints and what the response is to these complaints.					

A. Which of the abovementioned points do you consider to be most important?
Please write them down here or mark the numbers above (max. 3)

B. Are there any other points of importance when founding a new DCR that have not been addressed in the abovementioned statements?

0 Yes
Which ones?

0 No

C. If you have any additional comments, information or suggestions which you have not mentioned in any of the abovementioned questions, please let us know!

Thank you for your collaboration!
Please send us a completed copy of this survey, either digitally to
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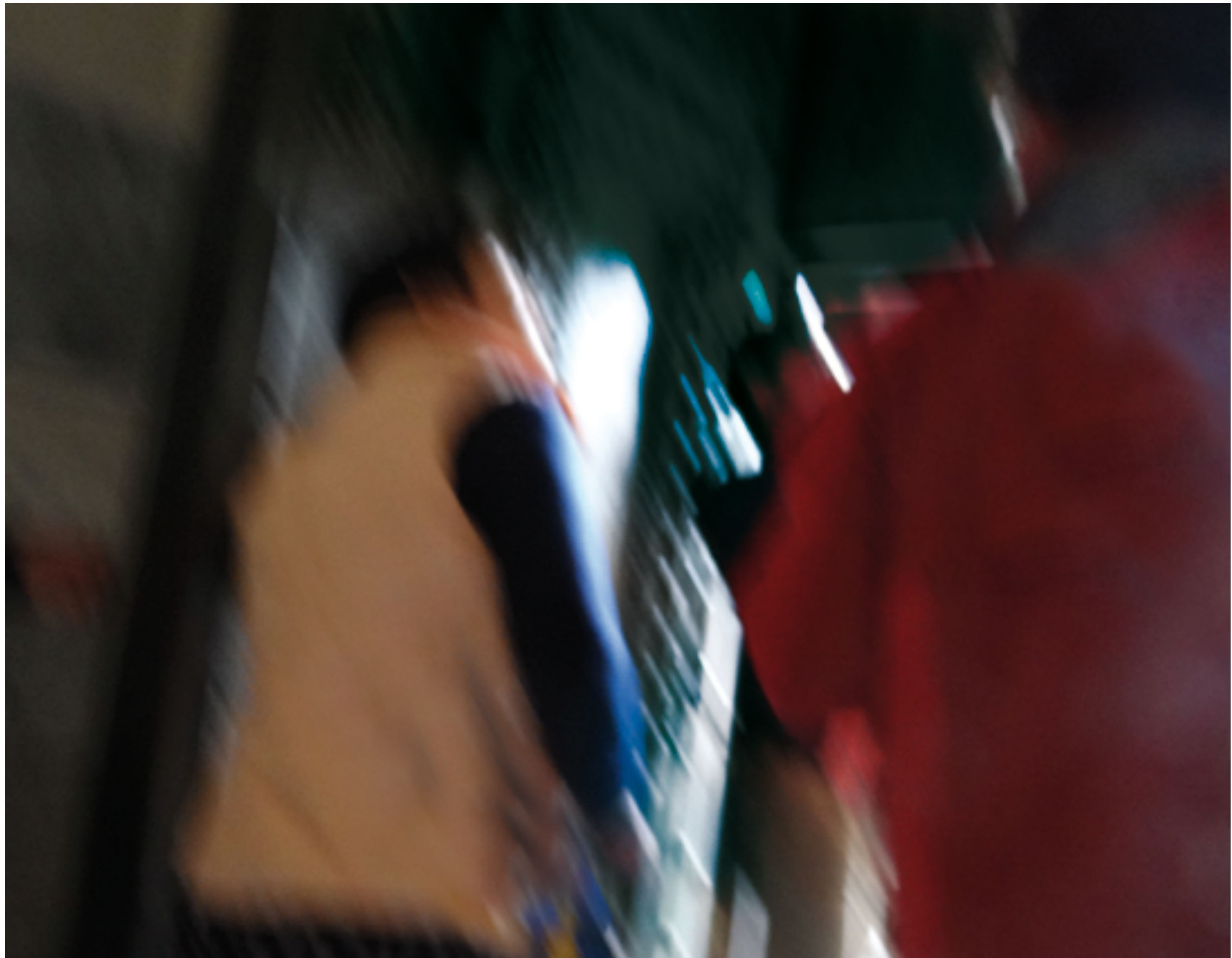

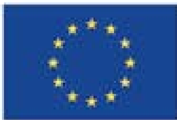

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