



Online census of  
Drug Consumption  
Rooms (DCRs)  
as a setting  
to address HCV:  
current practice and  
future capacity

Report



International Network of Drug Consumption Rooms

**Publisher:**

International Network of Drug Consumption Rooms  
drugconsumptionroom-international.org

Hosted by:  
CORRELATION Network  
Foundation De REGENBOOG GROEP  
Amsterdam, the Netherlands  
correlation-net.org/

and

Uniting Medically Supervised Injecting Centre  
PO Box 293 Kings Cross Sydney NSW 1340, Australia  
uniting.org/msic

**Suggested citation:**

Belackova, V., Salmon, A. M., Schatz, E., Jauncey, M. (2017).  
Online census of Drug Consumption Rooms (DCRs) as a setting to address HCV:  
current practice and future capacity, Amsterdam, Sydney: International Network of Drug  
Consumption Rooms, Correlation Network, Uniting Medically Supervised Injecting Centre

ISBN: 978-90-828109-0-5

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Correlation Network receives funding by the European Union and by  
Gilead Sciences Ltd.

# **Online census of Drug Consumption Rooms (DCRs) as a setting to address HCV: current practice and future capacity**

## **Report**

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## **ACKNOWLEDGEMENTS**

The authors would like to thank the managers and other employees of the drug consumption rooms who participated in this online survey. They would also like to thank Dr Libby Topp for revision of the survey tool, to Dr Kari Lancaster and Dr Monica Barratt for advice on ethical aspects of the survey and to Mr Conrad Köckert for assistance with dissemination of the survey.

# CONTENTS

TABLES AND FIGURES.....	5
EXECUTIVE SUMMARY .....	7
BACKGROUND .....	8
AIMS.....	8
METHODS.....	9
HCV-specific section of the online survey focused on the following areas.....	9
The general questions of the DCR HCV survey addressed the following areas.....	9
FINDINGS ON HCV-RELATED SERVICES IN SIFs/DCRs.....	10
Survey population .....	10
HCV prevalence and testing.....	10
HCV support and treatment.....	12
CHARACTERISTICS OF THE SIFs/DCRs WHO ANSWERED THE SURVEY .....	14
Service operation.....	14
Conditions on service use.....	17
SERVICES OFFERED AT SIFs/DCRs.....	20
SIF / DCR CLIENT CHARACTERISTICS.....	22
LIMITATIONS .....	26
CONCLUSIONS .....	26
REFERENCES .....	27



## List of tables and figures

Figure 1: Provision of HCV-related information.....	11
Figure 2: HCV testing onsite. ....	11
Figure 3: HCV treatment provided onsite at DCRs. ....	12
Figure 4: The year when the DCR/SIF opened to clients.....	14
Figure 5: Service location.....	15
Figure 6: Service operation. ....	16
Figure 7: Service staffing. ....	17
Figure 8: Rules pertaining to each DCR visit.....	18
Figure 9: Bans and exclusions from the service.....	19
Figure 10: Client characteristics. ....	23
Figure 11: Number of overdoses per DCR.....	24
Figure 12: Number of visits per DCR.....	25
Figure 13: Drugs consumed most commonly. ....	25
Table 1: Estimated ratio of DCR clients tested for HCV and HCV positive. ....	10
Table 2: HCV support services provided at the DCR. ....	12
Table 3: Needs with respect to enhanced HCV services in DCRs. ....	13
Table 4: Service funding.....	16
Table 5: Eligibility criteria.....	18
Table 6: Rules and regulations applying to the service use.....	19
Table 7: Services provided onsite and referred to offsite. ....	21
Table 8: Data collected at DCRs/SIFs.....	22
Table 9: Data collection about visits.....	23



## EXECUTIVE SUMMARY

Drug consumption rooms (DCRs) and supervised injecting facilities (SIFs) target the most vulnerable people who use drugs (PWUD) – particularly people who use opioids, people who inject drugs (PWID), people who use drugs heavily<sup>1</sup> or high-risk drug users (HRDI)<sup>2</sup>. While decreases in risky injecting behaviours are an outcome of DCR use, HCV prevention and treatment in these settings haven't been adequately described. There are no international DCR standards for HCV practice and surveys are yet to address HCV prevention, treatment or sero-prevalence status of DCR clients. This online survey provides a 'snapshot' of DCR clients' HCV status; approaches to HCV in DCRs, and what DCRs need to expand these services.

Fifty-one responses were collected from representatives of the 92 operating DCRs in Australia, Canada, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland participated in the survey; thus over half of the DCRs were directly represented (55 %) and several respondents had filled the survey on behalf of several DCR's within their organisation. All countries where DCRs are operated were represented.

An estimated mean 71% of SIF/DCR clients had been tested for HCV and about 58% were HCV positive. Most DCRs provided HCV testing onsite (67%); of these majority tested via blood samples (65%) and several used finger prick (31%) or saliva (31%). Several DCRs referred to offsite HCV testing (75%). Only four European DCRs provided HCV treatment onsite at the time of the survey; two were providing DAAs ("new treatment") and two were providing both interferon and DAAs treatments. The majority of SIFs/DCRs referred clients offsite for treatment (96%). Several offered disease self-management support (50%) or monitoring liver health (24%). Overall, DCRs reported that HCV support (94%), new treatments (92%) or treatment with interferon (50%) were available for their clients at other services.

To provide further HCV-related services, DCR indicated that they need more staff time (51%) and staff training (45%), that they would have to expand staff qualifications (30%) and that further funding for equipment and services would be needed (38%). A change in national HCV treatment guidelines for active drug users was also identified as a need (23%). When it comes any additional funding, the respondents indicated they would use it on employing additional medical staff (52%), develop client education (52%) or on additional staff training (46%).

DCR involvement in HCV prevention and treatment is crucial. SIFs/DCRs should to be supported to provide an entry point to HCV treatment as they are working on the frontline with the most marginalised PWID and are capable of removing barriers to HCV treatment in this population. Also, options for co-location of HCV services at DCRs or provision of HCV treatment onsite should be considered.

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<sup>1</sup> Please see [www.npsieurope.eu](http://www.npsieurope.eu) for the definition.

<sup>2</sup> Indicator adopted by the European Monitoring Centre for Drugs and Drug Addiction which replaced the former "problem drug use (PDU)" indicator.

## BACKGROUND

Drug consumption rooms (DCRs) / safe injecting facilities (SIFs) provide a space for self-administration of drugs in hygienic conditions and under the supervision of qualified staff (EMCDDA, 2016). SIFs are evidence-based harm reduction interventions; their effectiveness has been summarised in several reviews of scientific literature surrounding the operation of SIFs (Hedrich & Hartnoll, 2015; Hedrich, Kerr, & Dubois-Arber, 2010; Kerr, Kimber, DeBeck, & Wood, 2007; J. Kimber, Dolan, Van Beek, Hedrich, & Zurhold, 2003; Jo Kimber et al., 2010; Milloy & Wood, 2009; Monico, 2015; Potier, Lapr v te, Dubois-Arber, Cottencin, & Rolland, 2014; Semaan et al., 2011).

DCRs generally target the most vulnerable populations of (injecting) drug users and several studies have documented the impact of DCRs on Hepatitis C Virus (HCV) and HIV notifications (KPMG, 2010; MSIC Evaluation Committee., 2003; Salmon, van Beek, Amin, Grulich, & Maher, 2009). While decreases in risky injecting behaviour has been observed in several studies as an outcome of DCR participation (Bravo et al., 2009; Petrar et al., 2007; Salmon AM, 2007; Stoltz et al., 2007; Wood et al., 2005), the particular attention to HCV prevention in these settings hasn't been adequately described in a cross-national context. None of the DCR/SIF surveys that were conducted in the past addressed the topic of HCV prevention and treatment among DCR clients (J. O. Kimber, Dolan, & Wodak, 2005; Woods, 2014).

DCR involvement in HCV prevention and treatment is crucial, as recent research literature shows high completion rates of HCV treatment among people who inject drugs (PWID) (Dimova et al., 2013) and low rates of re-infection (Grady, Schinkel, Thomas, & Dalgard, 2013). With their access to most marginalised populations, DCRs can be an important entry point to HCV treatment and help remove barriers to entering it (McGowan & Fried, 2012).

DCRs often operate in vulnerable policy climates due to a controversy surrounding their work with active drug users (and the provision of space for drug use to be specific). This research aimed to highlight the (increasing) number of DCRs worldwide as well as the extent to which they service the marginalized populations in different countries in health service provision and other aspects of their work.

## AIMS

The study aimed to answer the following questions:

- [a] What is the awareness of HCV risks, prevention and treatment within DCRs, as reported by DCR Service Managers?
- [b] What are the existing approaches to HCV awareness, prevention and treatment by DCR, as reported by DCR Service Managers?
- [c] What are the gaps, needs and/or resource requirements for HCV awareness, prevention and treatment at DCRs, as reported by DCR Service Managers?
- [d] What factors do/would contribute to greater HCV awareness, prevention and treatment among DCRs?
- [e] What are the characteristics of DCR clients and how they differ across the different facilities and countries, as reported by DCR Service Managers (or similar contact)?
- [f] What is the range of services currently offered at DCRs and what are their operational capacities?

## METHODS

An online survey was set up in a secure internet interface (SurveyMonkey.com) and was accessible between September – December 2016. The survey was available in English; a German translation was available and when completed, the answers were back-translated and were entered into the online tool by the study team. The online survey covered two areas - HCV-related questions and questions on general DCR services, operational rules and client characteristics. The survey aimed to collect aggregated figures related to the operation and performance of each DCR (e.g. the number of visits per a period of time, aggregated client socio-demographic characteristics, substances used). The survey took approximately 45 min to complete; none of the questions in the survey was “obligatory”, i.e. the study participants could choose which questions they answered and which ones they skipped.

### **HCV-specific section of the online survey focused on the following areas:**

- [a] HCV-related in-house interventions and referrals (scope, count)
- [b] DCR client characteristics in relation to HCV
- [c] barriers and needs in expansion of HCV-related services.

### **The general questions of the DCR HCV survey addressed the following areas:**

- [a] organisation structure and environment
- [b] admission criteria and process
- [c] facilities
- [d] house rules
- [e] staff composition (in terms of the professions represented)
- [f] client characteristics.

The project used exhaustive sampling method, thus a total of 91 DCRs operating in the ten following countries were invited to participate: Norway (n=1), Denmark (n=5), Germany (n=24), Luxembourg (n=1), Spain (n=13), Switzerland (n=13), Greece (n=1), Netherlands (n=30), Australia (n=1), Canada (n=1) and France (n=2). An invitation email was sent to each DCR, asking one key staff member per organisation (Service Manager, or similar, see inclusion criteria below) to complete the online survey. After the initial email, follow-up emails were sent in order to maximise the response rate. Participants were asked to formally decline participation on behalf of their organisation if they wished not to receive any further emails. All participants were asked to approve their consent to the online Participant Information Sheet and Consent Form (PISCF). Participants could withdraw from the study at any time and it was stated that this will not affect any relationships they have with the research team. Also, respondents could choose to allow presentation of the data in aggregate figures only, with no country-level breakdown.

The recruitment was coordinated by the Regenboog Groep, Amsterdam, host of the Correlation Network and the International Network of Drug Consumption Rooms (INDCR), in close cooperation with the Uniting Medically Supervised Injecting Centre in Sydney, Australia (MSIC). The Regenboog Groep conducted the 2013 General DCR Online survey (as outlined above) and the methodology was partially replicated (see Woods, 2014). The study was approved by the South Eastern Sydney Local Health District Human Research Ethics Committee on 24<sup>th</sup> August, 2016 (HREC ref no: 16/258 LNR/16/POWH/482).

# FINDINGS ON HCV-RELATED SERVICES IN SIFs/DCRs

## Survey population

In total, 86 responses were collected in the online survey tool. From these, duplicate entries, entries with >50% missing data and those without completed consent were excluded. There were n=49 valid responses which represented 54% of the DCRs that currently operate in Australia, Canada, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland (each country was represented in the survey where at least one SIF/DCR operate at the time of the survey).

## HCV prevalence and testing

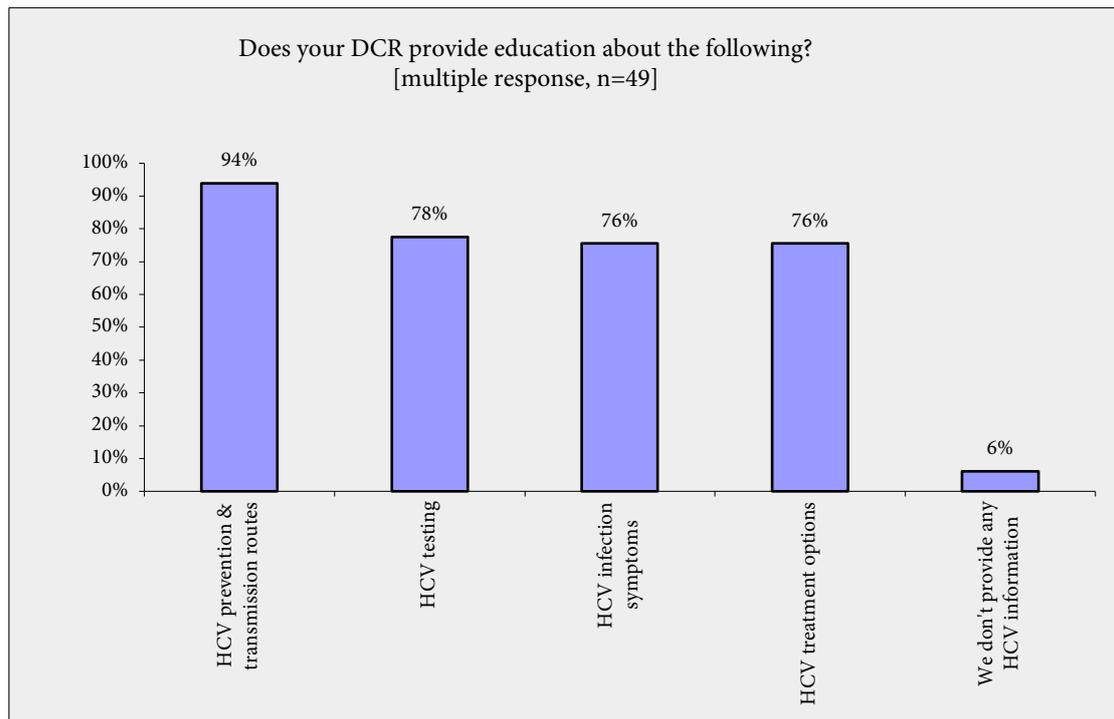
Several survey participants noted that they had no information about the proportion of their clients that had been tested or were HCV positive (n=10), others provided data from recent surveys or an informed guess of what the percentage might be (n=41). It was estimated that a mean of 71% of DCR clients had been tested for HCV (80% median) and that a mean of 57% of DCR clients were HCV positive (60% median), please see Table 1 for details.

**Table 1: Estimated ratio of DCR clients tested for HCV and HCV positive.**

	What proportion (%) of your clients/visitors do you estimate have been tested for HCV?	What proportion (%) of your clients/visitors do you estimate are HCV positive?
No information available	n=6	n=4
Provided an estimate	n=41	n=41
MIN	15	1
MAX	100	90
MEAN	71.1	57.1
MEDIAN	80	60
25 perc	50	50
75 perc	90	73

Majority of DCRs that provided HCV-related information at their facility (n=49) indicated that they informed the clients about HCV prevention and transmission routes (94%), HCV testing (78%) and HCV infection symptoms or treatment options (76%), see Figure 1.

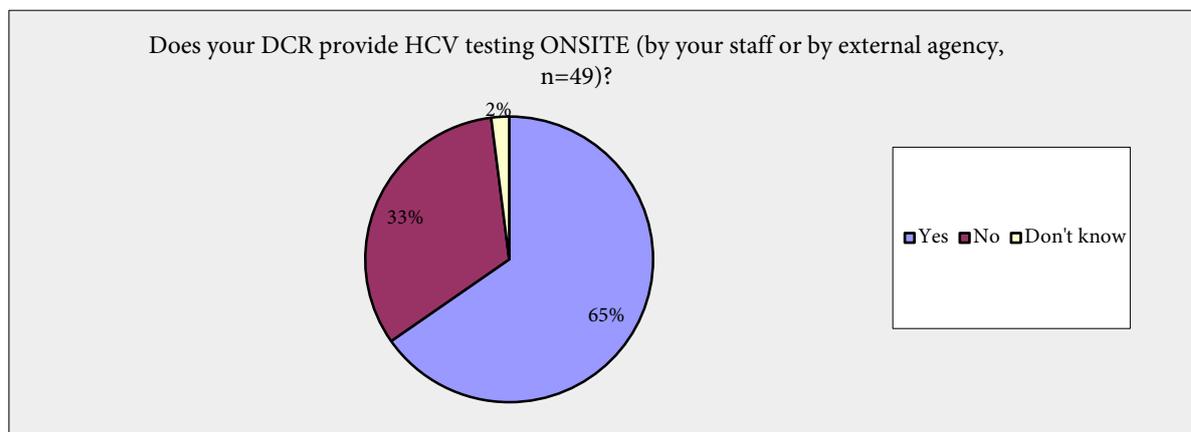
Figure 1: Provision of HCV-related information.



The dominant way of providing HCV-related information was through brochures and pamphlets (89%), individual client consultations (88%) and posters (70%). Less frequently, DCRs used digital resources (20%), group educational sessions (17%) or other means (20%) such as educational campaigns or quizzes.

Overall, 65% of DCRs provided HCV testing onsite; see Figure 2. Of those who provided HCV testing onsite, this was most commonly through a blood sample taken from the vein (68%) or via saliva (32%) or with a finger prick test (32%). Twenty percent of DCRs specified “other” means of HCV testing, among them was Polymerase Chain Reaction (PCR) testing (n=2). In the majority of DCRs where HCV testing was conducted, pre- (65%) and post-test (68%) counselling was provided.

Figure 2: HCV testing onsite.



Several DCRs (n=7) said that they were planning to expand the range of HCV testing they provided as well as their pre- and post-test counselling. From those that currently weren't providing HCV testing onsite (n=17), eight said that they were planning to provide HCV testing onsite in the future. At the same time, a number of DCRs were referring their clients to HCV testing offsite (57%).

## HCV support and treatment

Beyond testing, HCV-related support was offered by majority of the DCRs (39 of the 46 that provided answer to this question). In most cases, this was via referring clients to HCV treatment programs (80%), via disease self-management support (50%) or via liver-cirrhosis monitoring (24%), see Table 2.

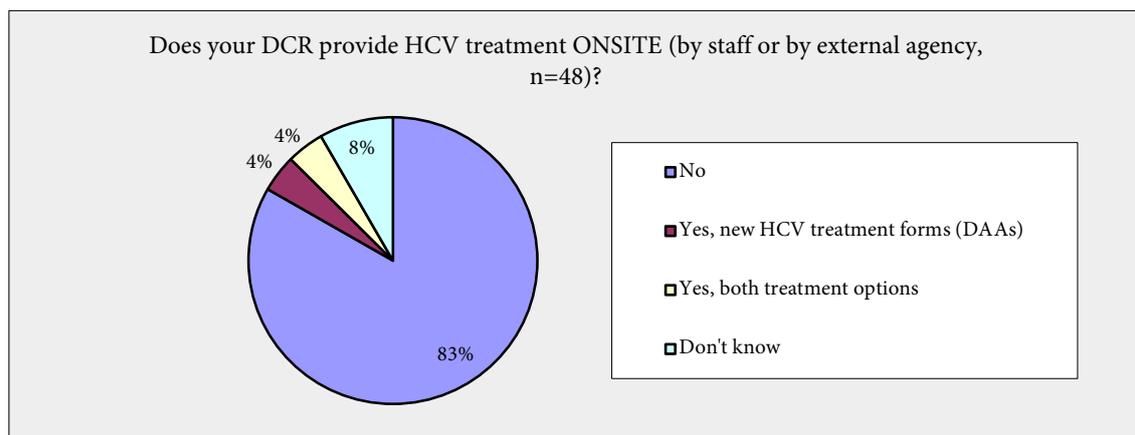
Table 2: HCV support services provided at the DCR.

Does your DCR provide support to HCV positive clients ONSITE? [multiple response]		
Answer Options	Response Percent	Response Count
Yes, referral to other services that can provide HCV treatment	96%	44
Yes, disease self-management support (e.g. alcohol consumption, healthy diet, obesity)	50%	23
Yes, liver health/cirrhosis monitoring/assessments (e.g. Fibroscan, blood test)	24%	11
No, we don't offer any support services to HCV positive clients ONSITE	15%	7
Other (please specify)	7%	3
<b>answered question</b>		<b>46</b>
<b>skipped question</b>		<b>5</b>

Beyond the DCR-provided HCV services, most respondents said that HCV support was available for their clients elsewhere (94%) and that they referred their clients to these services (n=96%). About half of the DCRs (51%) said that they were planning to expand their HCV support services in future (24 of the 47 who answered that question).

HCV treatment was rarely available onsite at the DCRs; only two of those that participated in the survey provided new HCV treatment (4%), additional two provided both new and interferon HCV treatment (4%); none of the DCRs provided interferon treatment only; see Figure 3. Additional four (8 %) said that they were planning to offer HCV treatment onsite in the future.

Figure 3: HCV treatment provided onsite at DCRs.



Most said that the new treatment was available for their clients elsewhere (92%) and so was interferon-based treatment (50%). The DCRs often served as a referral point to these treatments (96%).

When asked about what would the SIFs/DCRs need to allow them provide more HCV-related services, the most common answer was staff time (51%), followed by staff training (45%) and hiring staff with different qualifications (30%). Funding for equipment and services was also mentioned high up on the list (38%) and so were educational materials for staff (38%) and for clients (30%). Also, the capacity of peer workers to contribute to HCV services provided at the DCR was mentioned (21%). Change in national-level policies on HCV treatment for active drug users would also be needed in order for more HCV services to be provided in SIFs/DCRs (23%) or specific approvals to the DCR/SIF to be able to provide these (15%). The less commonly mentioned factors were more external programs providing these services within their reach (8%), more services to refer the clients to (8%) or better understanding of client needs would be needed to enhance HCV-related services (4%). Several DCRs stated that HCV services were not part of their formal purpose / objectives (6%); see Table 3.

**Table 3: Needs with respect to enhanced HCV services in DCRs.**

<b>What would your service need to allow you to provide MORE HCV services at your DCR? [multiple response]</b>		
<b>Answer Options</b>	<b>Response Percent</b>	<b>Response Count</b>
More staff time	51%	24
More staff training	45%	21
More funding for equipment and services	38%	18
More educational and training materials for staff	38%	18
More educational materials for clients	30%	14
Hire staff with different qualifications	30%	14
Change in national-level treatment guidelines that encourage HCV treatment for active drug users	23%	11
Capacity for peer workers to contribute	21%	10
Specific approvals to provide services on our site	15%	7
Change in national-level policies to facilitate access to health care reimbursement to our clients	17%	8
Other (please specify)	17%	8
Not applicable - We DON'T need anything further to support HCV services and support	11%	5
Need more external programs within reach of our DCR	9%	4
Need (more) services to refer our clients to	9%	4
We CAN'T support HCV services any further as it is not within our formal purpose / objectives	6%	3
Need to understand client needs further	4%	2
	<b><i>answered question</i></b>	<b>47</b>
	<b><i>skipped question</i></b>	<b>4</b>

When asked how they would spend any additional HCV related funds, most DCR representatives who answered the question (n=46) said that they would employ additional medical staff (52%) or spend it on additional staff training (46%) or on policies and procedures for staff (26%). Further on, they would develop client education around HCV (52%), fund educational materials for clients (41%) and/or employ peer support workers (26%). Answers also included funding a needs-assessment (24%) or to develop referral pathways to a specialist (24%). Two organisations mentioned that they would purchase a fibroscan and one organisation mentioned that they would fund advocacy for the possibility of providing HCV treatment to “clandestine” persons.

More detailed comments related to the provision of enhanced HCV services were that the site was already very busy or the setting simply didn't allow (n=2), that the DCR approach was non-medical and that the current referral pathways work well (n=1). One DCR mentioned that rapid test kits were rather expensive for them and also that undocumented migrants who attend the service couldn't access treatment, even if found to be HCV positive. Other DCRs, however, mentioned that HCV-related campaigning was very topical for them and that they had been lately focusing their efforts in this area (n=3).

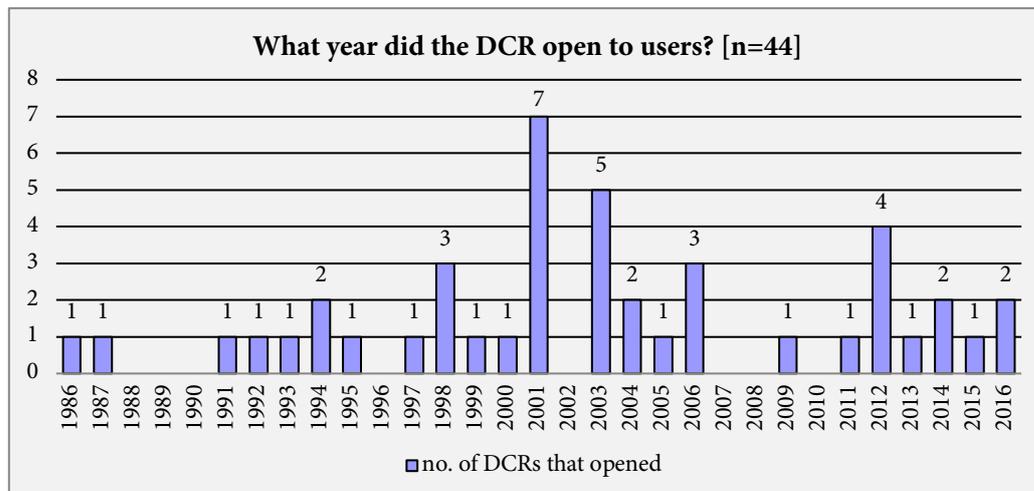
## CHARACTERISTICS OF THE SIFs/DCRs WHO ANSWERED THE SURVEY

The survey collected information on the major characteristics of operation among the SIFs and DCRs who answered the survey, i.e. service location, operational rules and client characteristics.

### Service operation

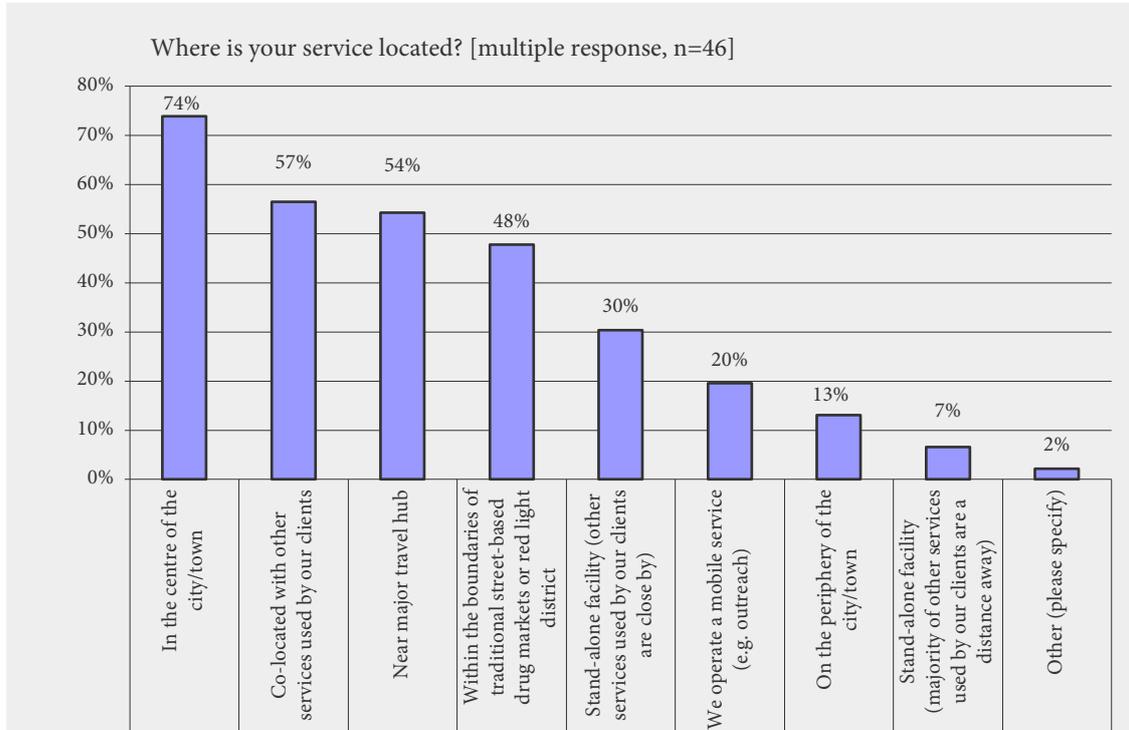
Most participating DCRs opened between 2000 and 2004 (28%), between 2010 and 2014 (16%) or in the fifteen years between 1980 – 1994 (16%). Three services that participated in the survey (6%) were founded in 2015 and later; seven respondents (14%) didn't specify their year of establishment at all; see Figure 4.

Figure 4: The year when the DCR/SIF opened to clients.



When asked about how likely they think their DCR will continue to operate in the next five years, >50% estimated a 95% likelihood (median; mean=85%); only seven of the 45 respondents who provided an answer said that their DCR/SIF continuation in five years was certain (100%) and five said that the probability was lower than 50%.

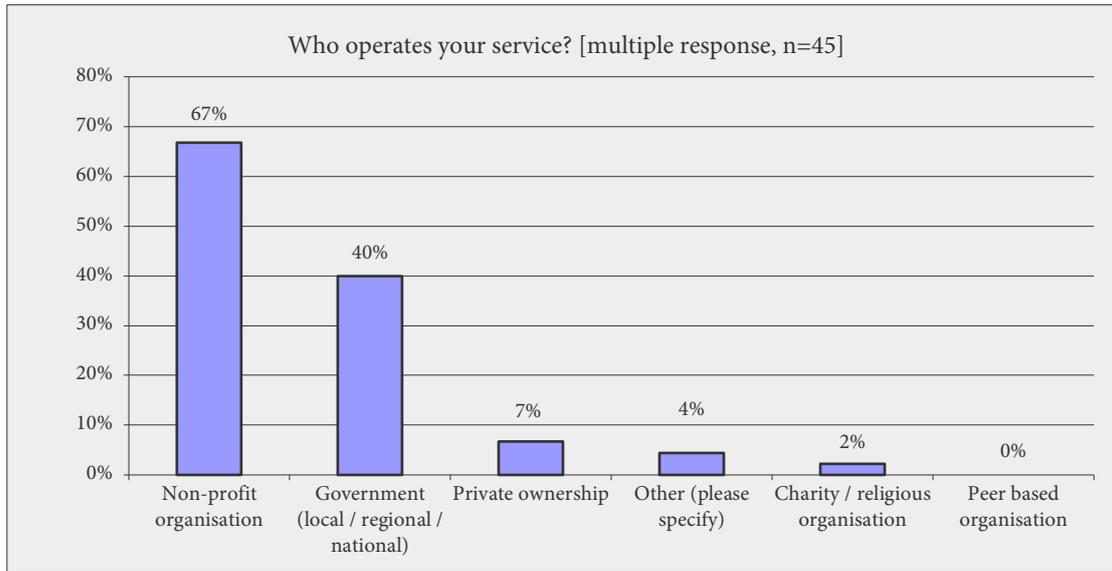
Figure 5: Service location.



Majority of the SIFs/DCRs were located in the centre of town (74%), and/or near a major travel hub (54%) as well as within the boundaries of an established street-based drug scene (48%). Also, a high proportion of them were co-located with other services used by the DCR clients (57%). A minority of DCRs were a stand-alone program (30%), operated a mobile service (20%) or were situated on the periphery of a city/town (13%), see Figure 5.

The majority of the DRCs/SIFs in the survey were operated by a not-for profit organisation (67%), followed by local, regional or national government (40%); additional 4% were operated under a contract with a government. A rather small proportion of DRCs/SIFs in the survey were operated by a private entity (7%) and only one program was operated by a charity / religious organisation. There were no primarily peer-driven DCRs in the survey, see Figure 6.

Figure 6: Service operation.



Notwithstanding the service operator, majority of the SIFs/DCRs were funded from a local (municipal) government budget (71%), followed by a state/regional government (36%) and, lastly, national government (13%). 9% had funding from a charity or religious organisation or through social or drug service subsidies (4%). Among “other” sources, the confiscated proceeds of crime were mentioned (n=1) and so were profit company (n=1) or donations (n=1); see Table 4.

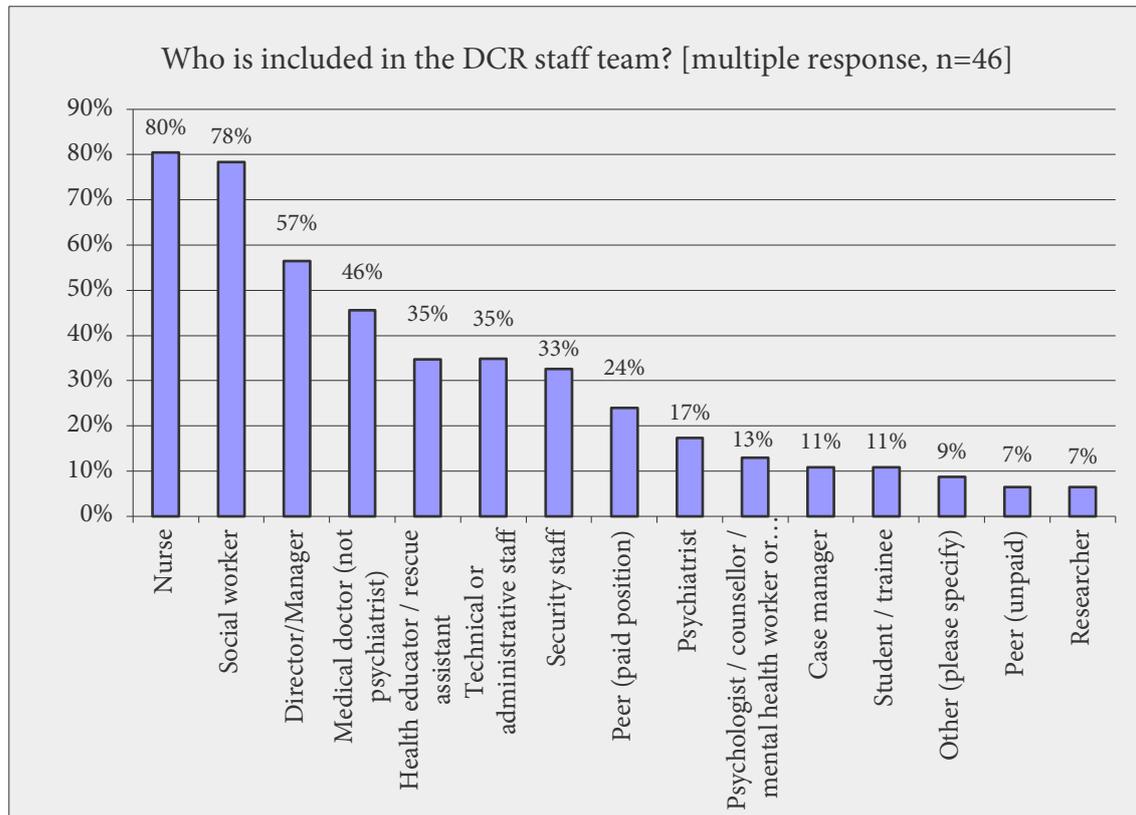
Table 4: Service funding.

How is your service funded? [multiple response]		
Answer Options	Response Percent	Response Count
Local government	71%	32
State/jurisdictional/regional government	36%	16
National government	13%	6
Charity / religious organisation	9%	4
Social or drug service subsidies	4%	2
Health care insurance (reimbursement per client)	2%	1
Health service subsidies	2%	1
Ministry of Interior/Justice funding	2%	1
Other (please specify)	13%	6
	<b>answered question</b>	<b>45</b>
	<b>skipped question</b>	<b>6</b>

Most SIFs/DCRs that participated in the survey employed nurses (80%) and/or social workers (78%). Another front-line profession that was employed in DCRs was health educator / rescue worker (35%), a paid peer-worker (24%), a psychologist (13%), a case manager (11%) and students or trainees (11%). Over half employed a Director or Program Manager (57%). Less than half had a doctor/clinician onsite (46%) and some employed a psychiatrist (17%). About one third of DCRs/SIFs employed technical or administrative staff (35%) or security personnel (33%). Minority of DCRs employed unpaid peers (n=3) or researchers (n=3), see Figure 7.

Respondents were asked to estimate the number of employees present on an average day of DCR/SIF operation; in the 42 SIFs/DCRs who provided an answer to this question, the mean number of paid employees on an average day was 7 (min=1, max=26, p25=3, p50=4, p75=10). Also, the DCR representatives said that there were mean 1 unpaid workers present onsite on an average day (min=0, max=4).

Figure 7: Service staffing.



### Conditions on service use

Several criteria for service use were reported. The majority pertained to a minimum age (87%), to having an established drug dependence or drug use (67%) and to previous experience in injecting drug use (20%). In about half of the SIFs/DCRs, the use of the service was limited to a specific drug (49%) and/or to the residents of a specific area (27%). While most DCRs/SIFs were anonymous, about one third of them required clients to present with a national ID (31%). Other requirements included: homelessness (n=2), no pregnancy (n=3) or no current medication-assisted treatment (n=3). The clients often had to undergo an entry interview (62%) or a registration survey (56%) and in some services, to sign a “terms of use” document upon their first visit (56%); see Table 5.

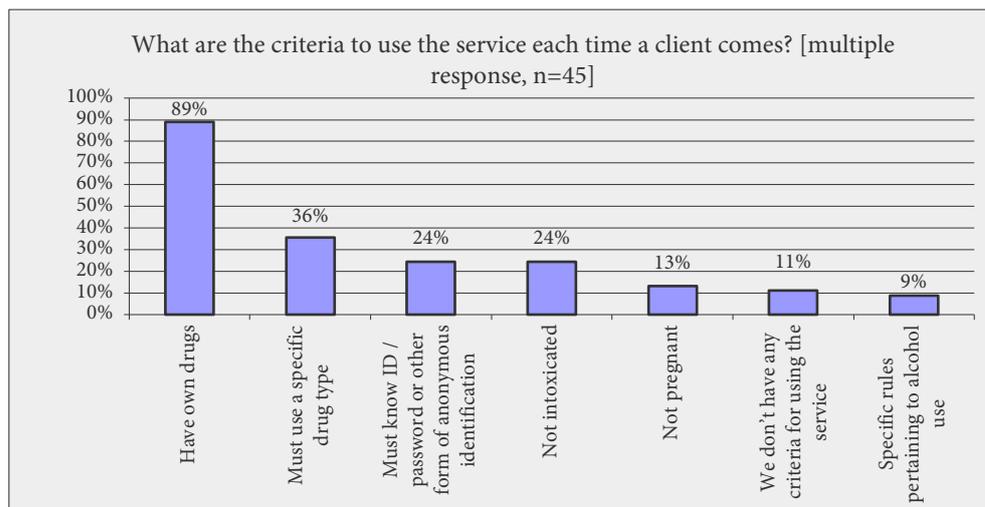
Additionally, in one instance, it was stated that the clients had to be established with a related organisation; also, one respondent outlined that minimum age didn't apply to waiting in the ante-room and another one explicitly stated that the means of drug administration weren't a criterion for entry (several DCRs accommodated for drug smoking/inhalation or even for drinking of alcohol, see the following section for details).

Table 5: Eligibility criteria.

What are the eligibility criteria to become a client of your DCR? [multiple response]		
Answer Options	Response Percent	Response Count
Must be a certain age	87%	39
Must undergo an entry interview	62%	28
Drug dependent / established drug user	67%	30
Complete a “registration” survey	56%	25
Sign a ‘terms of use’ document	56%	25
Must use a specific drug	49%	22
Must present with a national ID / driving license (non-anonymous identification)	31%	14
Must be a resident of a certain area	27%	12
Previous injecting drug use	20%	9
Not in/on OST treatment	7%	3
Not pregnant	7%	3
Homeless or causing public nuisance	4%	2
Other	7%	3
<b>answered question</b>		<b>45</b>
<b>skipped question</b>		<b>6</b>

Several other criteria applied to each DCR/SIF visit – most notably, these were clients having their own drugs (89%). In some DCRs, using the service required that people came with a specific drug (36%) and/or that they had an ID or a unique identifying number at each entry (24%). Restrictions on using the service at each time included not being intoxicated (24%) or not being pregnant (13%). Several programs didn’t have any criteria for using the service (11%); see Figure 8.

Figure 8: Rules pertaining to each DCR visit.



In a majority of services (but not all) sale of drugs was prohibited (96%) as was drug sharing (60%). Injecting other people wasn’t allowed in most DCRs (64%); 80% of DCR/SIF representatives said staff were not allowed to inject the clients. In some DCRs/SIFs, injecting in certain parts of the body was prohibited (29%). Time limits often applied to each visit (58%) and at times the number of visits per day

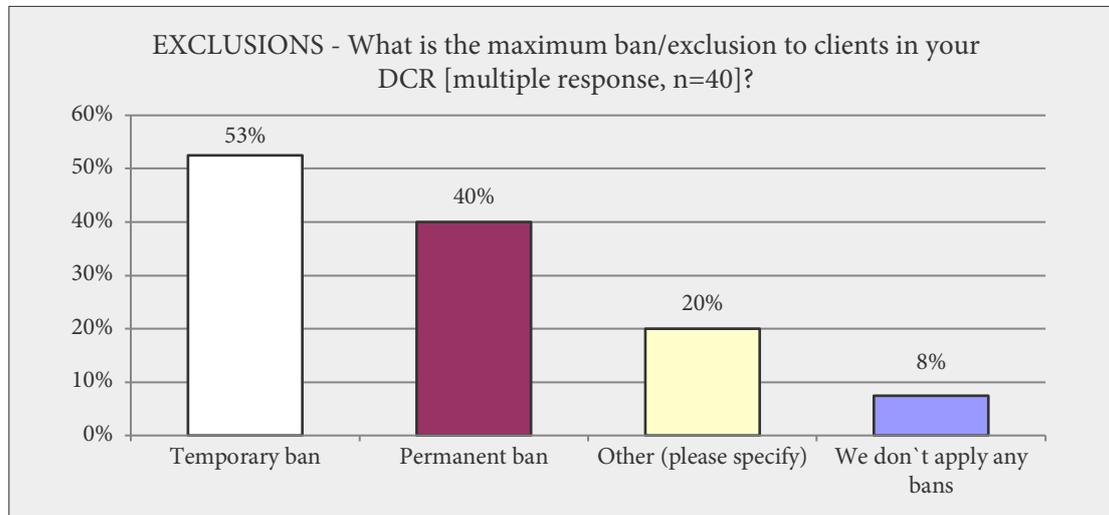
was limited (7%). Finally, use of alcohol wasn't allowed in most services (76%) and the use of tobacco was banned in many (49%). Other regulations pertaining to client visits included no violence (n=2) or no use of electronic devices (n=1); see Table 6.

Table 6: Rules and regulations applying to the service use.

What rules do clients/visitors need to follow while at the DCR [multiple response]?		
Answer Options	Response Percent	Response Count
Do not sell drugs onsite	96%	43
Do not use alcohol onsite	76%	34
Do not inject other people	64%	29
Limit their time in the service per visit	58%	26
Do not share drugs onsite	60%	27
Do not use tobacco onsite	49%	22
Do not inject in certain areas of the body	29%	13
Limit their number of visits to the service per day	7%	3
Other (please specify)	11%	5
<b>answered question</b>		<b>45</b>
<b>skipped question</b>		<b>6</b>

When the clients didn't adhere to the rules, the most severe sanction in many DCRs/SIFs has been a temporary ban (53%), although a permanent ban was option in others (40%). In some services, there was no ban (8%) or it was under consideration (reported under the option "other" – 20%); see Figure 9.

Figure 9: Bans and exclusions from the service.



In majority of the services, the clients didn't participate in the management of the service (63%); however there were regular meetings with DCR representatives in about a quarter of services (26%) and one in 10 had clients take part in the DCR/SIF management (9%). Other forms of client participation involved helping in the kitchen/cooking (n=2) or in day labour projects, cleaning and peer projects (n=3).

## SERVICES OFFERED AT SIFs/DCRs

From the DCRs/SIFs that answered a set of questions on service provision (n=43), all except two provided spaces for injecting (n=41), the majority also had spaces for smoking (n=31) and about half had spaces for sniffing (n=22). Of the 34 services in the sample who allowed for at least two different means of drug administration (injecting combined with sniffing and/or smoking), 20 of them (58%) had separate spots for each and four services made it explicit that they had them placed in separate rooms.

The mean number of spaces for safe and hygienic drug consumption in the DCRs/SIFs was 11 (min=1, max=63, median=10). For injecting, the maximum number of spaces was 23 (min=1, max=23, mean=6, median=5), for smoking it was 40 (min=1, max=40, mean=6, median=4) and for inhaling or sniffing it was 16 (min=1, max=16, mean=6, median=4).

Most DCRs provided overdose management onsite (89%). Condoms were provided onsite too (89%) together with HIV-related counselling (70%) and HIV testing (54%). Out-patient counselling (46%), mental health care (44%), Hepatitis B vaccination (41%), legal counselling (39%) and take-home naloxone (37%) were provided onsite in about two thirds of DCRs. In about quarter of DCRs/SIFs, opioid substitution treatment was available onsite too (24%) and in some, short term (n=5) or long-term (n=4) abstinence treatment were available. Beyond the health and social services listed above, an array of support was provided onsite. Almost all DCRs in the survey provided referrals to treatment and distributed clean paraphernalia for take-away (94%); also, clients could use a phone and get coffee or tea (91%). In majority of DCRs, personal care was available (shower, washing clothes, 76%) and so was support with financial and administrative affairs (74%). More than half of DCRs provided meals (61%) and recreational activities (57%). In some SIFs/DCRs, work and reintegration projects were available to clients (41%) as well as postal address (39%); the clients could sometimes use lockers (26%). Among the “other” services provided onsite, the DCR representatives mentioned medical and GP services (n=3), provision of clothing/wardrobe (n=2), and, interestingly, sleeping facilities, overnight shelters and housing collocated with the DCR (n=4); see Table 7.

Finally, almost half of the services offered tours or open days to the public (49%). These were done outside operating hours (n=7), upon an appointment (n=4) or regularly (n=3); two DCRs stated that a tour is possible only after a person has registered to use the service.

Only in two DCRs, HIV treatment could be accessed onsite (n=2) – slightly less than the number of DCRs who were able to provide HCV treatment at the time of the survey (n=4; see Figure 3). At the same time, each service that was not available onsite was usually compensated by referring people offsite – 85% DCRs referred to HIV treatment, 83% to long-term abstinence-oriented treatment and 70% to opioid substitution treatment.

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Table 7: Services provided onsite and referred to offsite.

<b>Are these offered to your clients onsite or do you refer them elsewhere? [multiple response]</b>				
<b>Answer Options</b>	<b>Onsite</b>	<b>Percentage</b>	<b>We refer our clients elsewhere</b>	<b>Percentage</b>
Condom provision	41	89%	6	13%
Overdose management Health emergency / ambulance	41	89%	12	26%
HIV-related counselling	32	67%	19	41%
Case management	29	63%	18	39%
HIV testing / screening	25	54%	25	54%
Out-patient counselling	21	46%	24	52%
Mental health care	20	44%	27	59%
HBV vaccination	19	41%	31	67%
Legal counselling	18	39%	24	52%
Take-home Naloxone provision	17	37%	13	28%
Opioid substitution therapy	11	24%	32	70%
Short-term abstinence treatment	5	11%	35	76%
Long-term abstinence treatment	4	9%	38	83%
HIV treatment	2	4%	39	85%
<b>Applicable to onsite only</b>	<b>Onsite</b>	<b>Percentage</b>	<b>We refer our clients elsewhere</b>	<b>Percentage</b>
Referral to care/treatment facilities (e.g. drug treatment, primary and mental health care facilities)	43	94%	n.a.	n.a.
Needle/syringe distribution (clean equipment to take away)	43	94%	n.a.	n.a.
Provision of drug paraphernalia (e.g. foil, filters, ascorbic acid)	43	94%	n.a.	n.a.
Use of a phone, phone charging facilities	42	91%	n.a.	n.a.
Coffee/ tea	41	89%	n.a.	n.a.
Personal care (e.g. shower, washing clothes)	35	78%	n.a.	n.a.
Support with financial and administrative affairs	34	74%	n.a.	n.a.
Meals	28	61%	n.a.	n.a.
Recreational activities (e.g. art projects, reading, colouring)	26	57%	n.a.	n.a.
Work/ reintegration projects	19	41%	n.a.	n.a.
Postal address	18	39%	n.a.	n.a.
Lockers	12	26%	n.a.	n.a.
Other (please specify)	9	20%	n.a.	n.a.
			<b>answered question</b>	<b>46</b>
			<b>skipped question</b>	<b>5</b>

## SIF/DCR CLIENT CHARACTERISTICS

A variety of data about clients was collected at DCRs/SIFs when the clients first attended (only two of the 45 DCRs who answered this question said they didn't collect any data; in one case, this was because they only registered clients of another service where they had collected the relevant data already). This was mostly age (93%) / gender (91%); 78% of DCRs collected name or initials that served for unique client identification. Two thirds collected data about accommodation status and some asked about the place of residence (7%). Data on the history of injecting (51%) and length of injecting (40%), on treatment history (47%) and on other drug use (9%) were collected. Health-related data including blood born disease status was collected too (7%) alongside with a range of other characteristics (18%), see Table 8.

**Table 8: Data collected at DCRs/SIFs.**

Does your DCR collect any of the following data about clients when they first attend [multiple response]?		
Answer Options	Yes	Response Count
Age (or date of birth)	93%	42
Gender	91%	41
Name (in full or abbreviated)	7.8%	35
Accommodation status	67%	30
History of injecting	51%	23
History of treatment	47%	21
Years of injecting	40%	18
Other (please specify)	18%	8
History of drug use*	9%	4
Health / blood born disease status*	9%	4
Place of residence*	7%	3
None	4%	2
	<b>answered question</b>	<b>45</b>
	<b>skipped question</b>	<b>6</b>

\*The items under asterisk were retrieved from the open-ended answers that the respondents provided under the option "other" (i.e. the respondents were not directly probed on this parameter).

The majority of DCRs/SIFs collected information about client visits (only one service representative stated that they didn't collect any data on client visits). This was mostly data on whether an overdose occurred (87%) and how it was managed (78%) and whether any other help or supporting services were provided to clients (58%). Further on, information on what drug was used was collected (84%), as well as how much time the visit took (58%) and what the means of consumption on that day were going to be (9%), see Table 9.

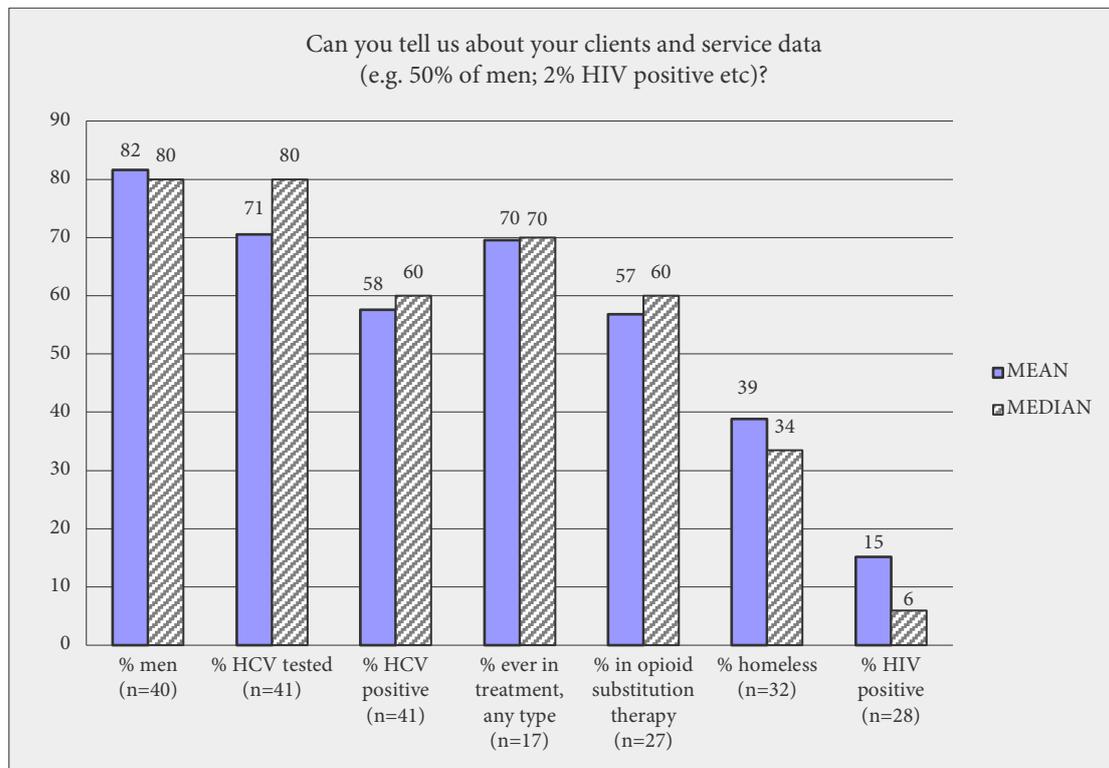
Table 9: Data collection about visits.

Does your DCR collect any of the following data about each visit to the service [multiple response]?		
Answer Options	Yes	Response Count
If an overdose occurred	87%	39
What drug will be used for the attendance/visit	84%	38
How an overdose was managed	78%	35
Time the attendance/visit took	58%	26
If help provided by staff or peers to the client	51%	23
Type of consumption (intravenous, smoking, inhaling)*	9%	4
Other (please specify)	4%	2
None	2%	1
	<b>answered question</b>	<b>45</b>
	<b>skipped question</b>	<b>6</b>

\*The item(s) under asterisk were retrieved from the open-ended answers that the respondents provided under the option “other” (i.e. the respondents were not directly probed on this parameter).

When it comes to the client characteristics reported by DCRs/SIFs, the majority of the clients were reported to be men (82% mean, 80% median, min=73%, max=99%) – the percentage excludes one German DCRs which offered services exclusively to women. As reported previously, 71% service clients were HCV positive (median 80%), 70% had ever attempted treatment (min=5%, max=99%) and 57% (median 60%, min=0%, max=100%) were in substitution therapy. Further on, 39% were homeless (median 34%, min=1%, max=100%) and mean 15% were estimated to be HIV positive (6% median, min=0%, max=80%); see Figure 10. The average age of clients was 40 years (the minimum age stated was 30 and the maximum was 55 years).

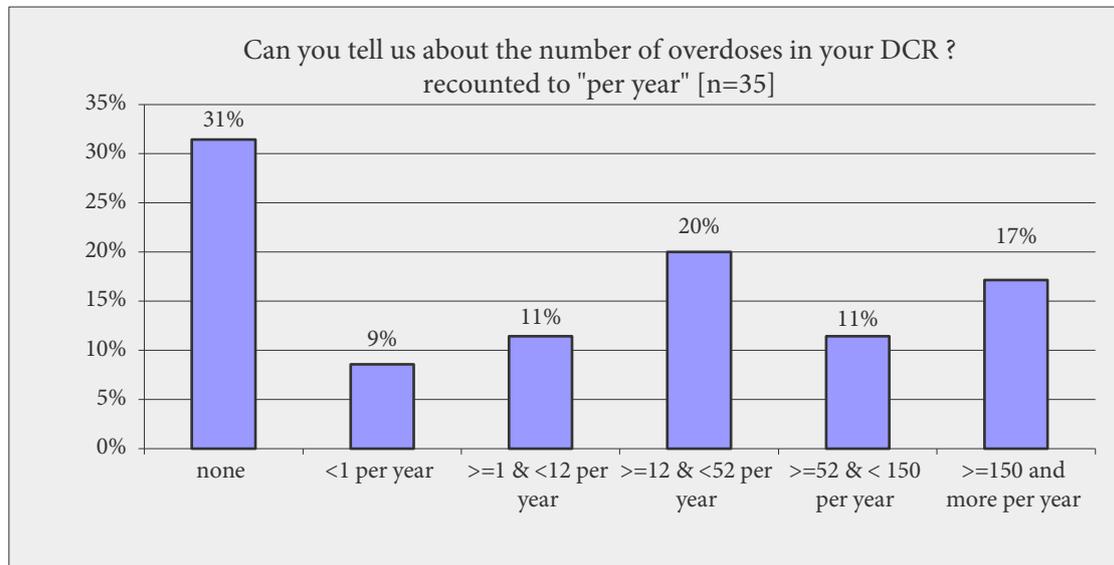
Figure 10: Client characteristics.



On average, there was one overdose at the service every three days, but there was a great variability across the different services (median 1 in 47 days, min=0, max=3 per day). When re-counted to a per-year basis, 17 % of the DCRs who provided an answer stated that they assist in 150 and more overdoses, 11 % experienced between 52 and 150 overdoses yearly (i.e. 1 – 3 per week), 20 % reported 12 to 52 per year (i.e. approximately 1-3 per month) and 40 % of DCRs reported they experience none or less than one overdose yearly; see Figure 11.

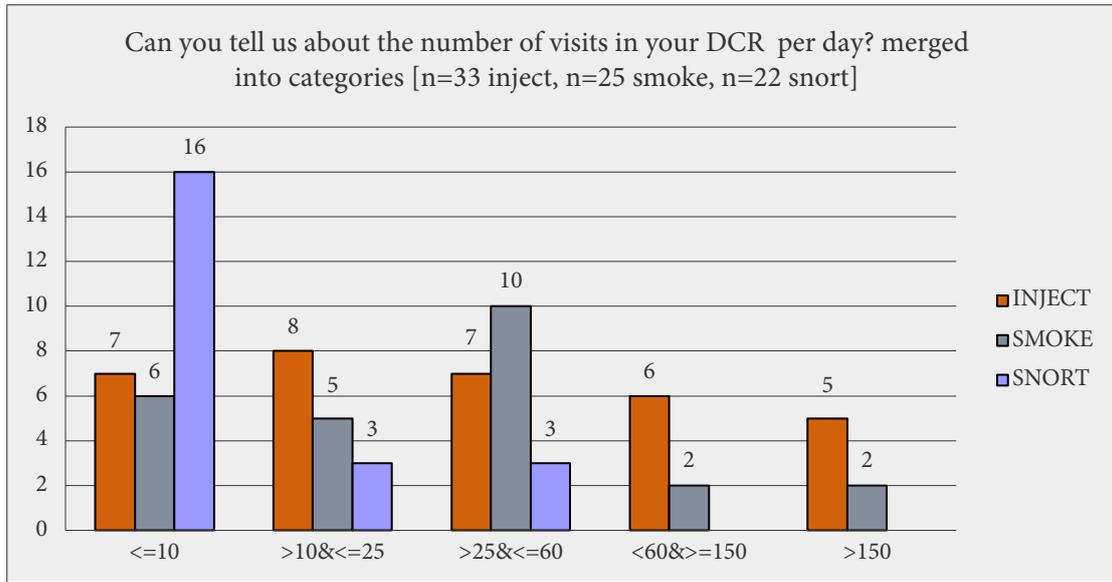
The rate of overdose was somehow related to the number of daily visits. Among the DCRs who stated that they didn't experience any overdose in the past year, more than half (56 %) had also a rather low number of visits per day ( $\leq 25$ ); majority (80%) of those where there was approximately one overdose per month ( $< 12$  per year) had  $> 25$  visits per day; also a great majority (86 %) of DCRs where approximately one overdose per week ( $\geq 52$  per year) occurred, had  $> 25$  visits per day. However, factors like main drug used or definition of an overdose could have contributed to the overdose rates reported by survey participants.

Figure 11: Number of overdoses per DCR.



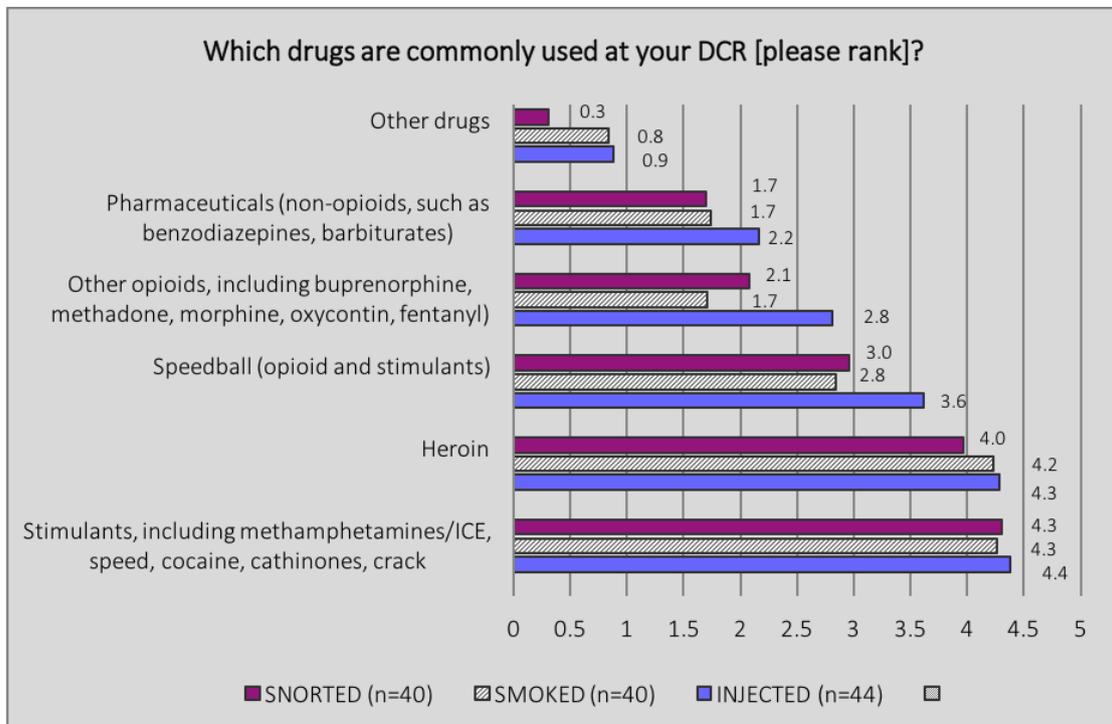
On average, about one hundred visits were made each day at a SIF/DCR (mean=108, median=78, min=3, max=550). Approximately 70 visits were made each day at a SIF/DCR to inject (mean=71, median=30, min=1, max=296), 51 visits to smoke (mean=51, median=40, min=3, max=260) and 12 visits to snort/inhale (mean=12, median=5, min=less than one per day, max=60). Figure 12 presents the distribution of the typical number of visits in the DCR per day.

Figure 12: Number of visits per DCR.



Finally, the survey respondents were asked to indicate which were the drugs used most commonly at their DCR/SIF via injecting, via smoking and via snorting. The responses were ranked from 6 – most common to 1 – least common; if e.g. only two types of drugs were commonly used in a DCR/SIF, than the rank values assigned to them were “6” and “5”). A weighted average was calculated based on the rank value and the no. of times the value was reported across the sample; the higher the rank the more common the drug was in the DCR/SIF. Figure 13 shows the findings - stimulants were most common and were closely followed by heroin; speedball (combination of stimulants and opioids) was next, followed by other opioids and then by other pharmaceuticals and lastly, by other drugs.

Figure 13: Drugs consumed most commonly.



## LIMITATIONS

The findings of this study pertain to a limited set of DCRs operating worldwide; each of the DCRs/SIFs that didn't participate in the survey (n=42) might be offering a slightly different set of services and be accessed by a specific group of clients in the locality. Also, each of the 49 DCRs participating in the survey answered a different set of questions (as none of them was obligatory). Beyond this survey, there is no official source of information that could be used to cross-validate whether the sample of DCRs was representative over the entire set or even what would compose this "representativeness". Within these limitations, the survey provides a snapshot of the services and client characteristics of the DCRs operating worldwide.

## CONCLUSIONS

DCRs/SIFs provide a broad range of social and health services in a safe environment for marginalised populations of drug users who experience a range of health and social harms and continue to use illicit drugs. There is a great variance in the services provided in DCRs and their operational characteristics, due to the different legal, social and local environments they are operating in. Overdose prevention and the prevention of blood borne infection diseases, however, can be identified as overall common priorities for these facilities.

In the light of the high infection rates for HCV among the DCR/SIF clients and the easy to apply new testing and treatment opportunities for HCV, these services could play a crucial role when it comes to prevent and treat the infection under this most vulnerable group of (potential) patients. As our survey shows, most DCRs/SIFs provide some HCV related services already or are interested to do so in the near future. I

Increased interventions in DCRs/SIFs should be considered in this context, including financial resources for capacity building and specialized staff. Certain operational challenges need to be addressed if HCV treatment was to be expanded at DCRs. This survey has offered a brief overview of what the main barriers and facilitators in this area might be and like that, sets up the grounds for further discussions about the DCR/SIF role in HCV treatment provision.

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