Drug Consumption Rooms in Europe

Operational Overview

Correlation
European Harm Reduction Network

Title
Drug Consumption Rooms in Europe – Operational Overview

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ENDCR European Network of Drug Consumption Rooms

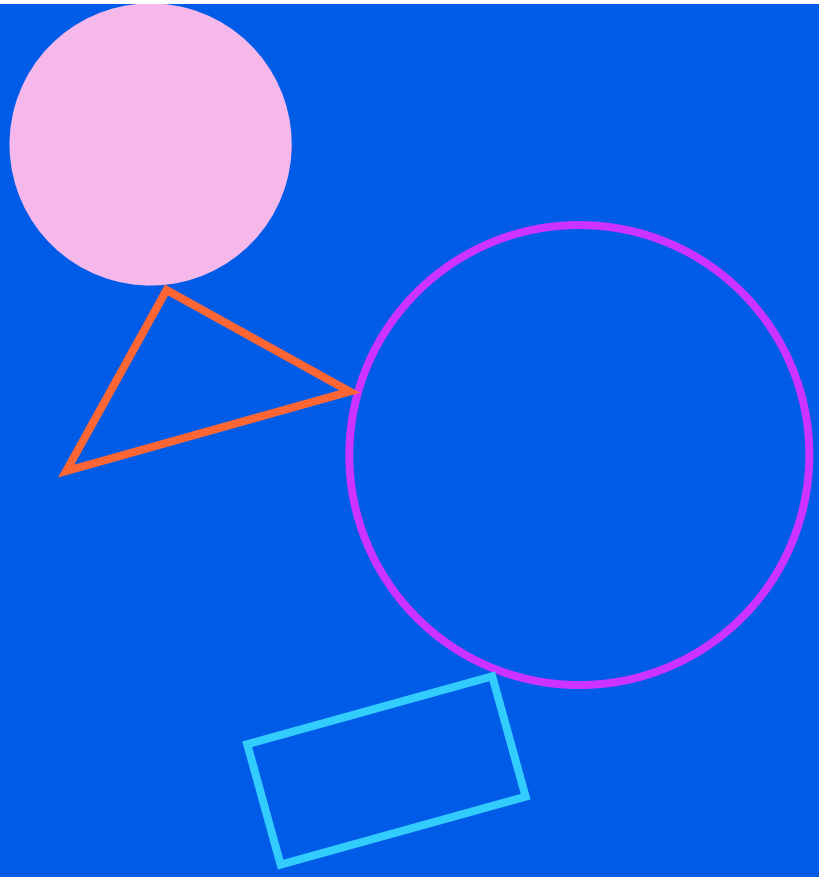
Correlation European Harm Reduction Network

DE REGENBOOG GROEP

Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
C-EHRN	Correlation - European Harm Reduction Network
COVID	Coronavirus Disease
DCR	Drug Consumption Room
DRG	De Regenboog Groep
EDA	European Drugs Agency
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENDCR	European Network of Drug Consumption Rooms
GHB	Gamma Hydroxybutyrate
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
INHSU	International Network on Health and Hepatitis in Substance Users
KPI	Key Performance Indicator
SENTINEL SURVEILLANCE/ MONITORING	A sentinel surveillance system selects, either randomly or intentionally, a small group of health workers from whom to gather data. These health workers then receive greater attention from health authorities than would be possible with universal surveillance (Source: London School of Hygiene and Tropical Medicine (2009). Types of Surveillance. London; London School of Hygiene and Tropical Medicine. **http://conflict.lshtm.ac.uk/page_75.htm**).
SOGIESC	Sexual Orientation, Gender Identity and Expression and Sex Characteristics
TVIP	Trauma and Violence Informed Practise



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Introduction

Correlation – European Harm Reduction Network

Correlation - European Harm Reduction Network (C-EHRN) is a European civil society network and centre of expertise in the field of drug use, harm reduction and social inclusion. C-EHRN is hosted and coordinated by Foundation De Regenboog Groep (FRG) – a low-threshold service provider based in Amsterdam.

C-EHRN envisions a future where Europe embodies a compassionate and equitable society where people who use drugs and other communities disproportionately affected by stigma, discrimination, and harmful (drug) policies have universal access to sustainable, high-quality health and social care. We imagine an inclusive and respectful environment where social justice principles guide policies and individuals and communities affected by harmful drug policies find empowerment and dignity.

Our mission is to create spaces for dialogue and action to reduce social and health inequalities and promote social justice in Europe. Bringing together the harm reduction movement in Europe, C-EHRN serves as an agent of change by promoting and supporting rights-based and evidence-informed policies, services and practices that improve the health and well-being of people who use drugs and other communities disproportionately affected by stigma, discrimination, health inequalities and harmful (drug) policies.

European Network of Drug Consumption Rooms (ENDCR)

The European Network of Drug Consumption Rooms (ENDCR) is a civil society platform uniting community-based and led organisations operating or planning to implement a Drug Consumption Room (DCR) in Europe. The ENDCR is hosted and coordinated by the C-EHRN and is governed by a Core Group that reflects the diversity of its members.

The overall goal of the Network is to enhance the availability, accessibility and quality of these services. To achieve it, the ENDCR supports and facilitates networking and cooperation among different stakeholders; contributes to and supports research, data and information collection; increases the effectiveness of DCRs through capacity-building activities, promotion of good practice and knowledge exchange; and promotes mutual support in advocacy activities in the field of human-rights and evidence-informed drug policies, including a broad range of DCR models and practices of care.

Methodology & Data Collection

Goal

The study aims to provide an overview of the range, scope and structure of care services for people who use drugs currently provided by DCRs in Europe. To this end, the study:

- describes the operational characteristics, capacities and services of DCRs in Europe, as well as their settings and client characteristics;
- identifies recent developments in the operational characteristics, capacities and services of DCRs in Europe.

Methodology

An online survey was conducted to assess the range and scope of care services for people who use drugs currently provided by DCRs operating in Europe at the time of this study (August - October 2023). Survey questions focused on the DCR's (1) environment and setting, (2) operational characteristics, (3) capacities and services, and (4) general client characteristics. Data on client characteristics were requested as an estimate in aggregated form. Additionally, specific questions focused on the DCRs organisational structure, barriers and facilitators to providing care services and recent operational developments and adaptations. The survey questions and the collected data or information were in English.

An invitation to participate was sent to DCRs in the ENDCR and C-EHRN mailing list, respectively. The initial email requested that a current employee of the DCR complete the survey on behalf of their organisation. To complete the survey, respondents had to confirm being a current employee of a DCR, having the knowledge and mandate to fill in the survey on behalf of their organisation, and agree to include in analysis reports and publications the information they provided. Should the respondents not meet or agree to one of these conditions, their responses were disqualified. Other reasons for survey response exclusion included empty responses and double responses.

Organisations operating more than one DCR were requested to complete an individual survey per service. To maximise the response rate, C-EHRN sent periodic follow-up emails. Additionally, key ENDCR organisation members promoted the survey among their networks.

Sample

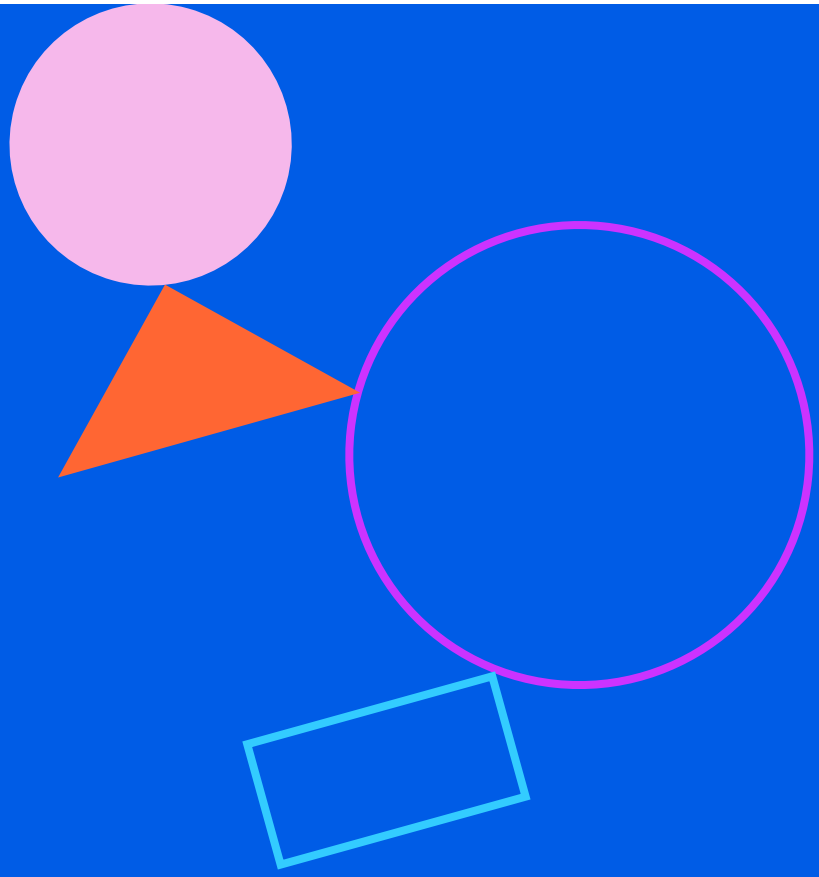
The project used an exhaustive sampling method (i.e. approached all DCRs operating in Europe at the time of the survey). A total of 102 European DCRs from eleven countries were invited to participate, namely Belgium (2); Denmark (4); France (2); Germany (38); Iceland (1); Greece (1); Luxembourg (1); Norway (1); the Netherlands (29); Portugal (5); and Spain (19) Switzerland.

In total, 56 responses were collected by the online survey tool. From these, duplicate entries and entries with >50% missing data were removed. The remaining valid responses (31) come from all the 11 countries where at least one DCR operated at the time of the survey: Spain (6); Portugal (3); the Netherlands (4); Germany (4); Luxembourg (2); Switzerland (6); Iceland (1); France (2); Greece (1); Belgium (1); and Norway (1).

Limitations

There were methodological challenges in reporting the age distribution of DCR visitors, as some DCRs used age ranges different from those requested in the survey. For instance, while asked about the percentage of users under 20, one DCR provided data for clients aged 18-24, another for 18-25, and one reported 0% of clients under 18. Similar discrepancies were noted across other age ranges, leading to exclusion of these responses from the analysis.

Regarding consumption episodes reported 12 months prior to the study, several methodological issues emerged. The ranges provided based on the EMCDDA's feasibility study were too broad for current participants, with most selecting options at the lower end ("between 1 - 50 per day"). This suggests that narrower ranges would better reflect the actual number of substance use episodes per route of administration per day for this cohort. Additionally, recording "consumption episodes" posed challenges, especially for non-injectable substances where dose recording methodologies are ambiguous. DCRs, constrained by staffing and capacity, often provided estimates rather than precise data, potentially leading to inaccuracies. Given the low-threshold approach of DCRs, expecting clients to report every substance use episode daily is impractical. A notable number of participants skipped parts of the question, possibly indicating zero episodes of use per day. These findings highlight the necessity to refine measurement methods and definitions for recording consumption episodes.



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Results

Overview of Operational Characteristics

Context & Motivation

The specific goals and objectives of Drug Consumption Rooms (DCRs) can vary significantly between cities and may evolve over time in response to local circumstances and motivations that led to their establishment. A notable proportion of respondents (13/31, 42%) cited the presence of open drug scenes in their cities as a primary reason for opening a DCR. These scenes were associated with concerns such as public nuisances (2/31, 6%), high rates of overdose (1/31, 3%), risks of blood-borne disease transmission (1/31, 3%), conflicts with residents (1/31, 3%), drug-related violence (1/31, 3%), visible heroin use (2/31, 6%), and drug user's vulnerability to violence, particulary among women and non-binary people (1/31, 3%).

For some respondents, addressing open drug scenes represented an acknowledgment of the limitations of responses solely based on law enforcement and repression. Motivations for introducing DCRs included the integration of harm reduction alongside other approaches (3/31, 10%), the provision of low-threshold social and sanitary support (1/31, 3%), and overdose prevention (1/31, 3%). One respondent illustrates it:

> *"The open drug scene made it necessary to change the approach. Pioneers thought that only repression, abstinence or therapy is not the answer in every case. That's why they started the approach of harm reduction."*

One respondent highlighted urban planning processes in response to open drug scenes and COVID-19:

> *"A new urban plan was carried out in the neighborhood where the largest open scene in the city was located. The local administration considered that the only way to contain the displaced people in a new area of the city was to offer specific services."*

These responses underscore how DCRs are shaped by local contexts and evolving local dynamics, emphasizing a multifaceted approach to addressing complex public health and social challenges associated with drug use.

Service Goal

The primary goal of most surveyed DCRs (24/31, 77%) is to function as a 'safety net' , meaning that the DCR cares for people who use drugs, offering them the opportunity to use drugs more safely, and provides the most urgent/basic medical and social care services. The primary goal of four (4/31, 13%) of the DCRs is to improve the living situation of its visitors and to refer individuals to other (care) facilities and cooperate with third parties to

strive for re-socialisation (a 'springboard'). Other include (3/31, 10%) two services goal that fall under the provided definitions of "*safety net*" and "*springboard*", and a third one aiming to "*build community break stigma, recognise knowledge of the participants, [and] advocate for social justice*".

Support to DCR Establishment

When setting up a DCR, advocacy activities within the Harm Reduction field demonstrate that the support of stakeholders is crucial. The vast majority of the DCRs that offered data to this report, were highly or moderately-highly supported by local governments (14/31, 45% and 11/31, 35%, respectively) and drug treatment services (12/31, 39% and 11/31, 35%, respectively). National government was also highly (10/31, 32%) and moderately (10/31, 32%) supportive in most cases.

Police and shelters were also rather more supportive than non-supportive for most DCRs, although only less than half of the DCRs (14/31, 45%) rated the support as moderately high or high in total. DCRs report having received high support from other stakeholders, such as the electorate, that supported the change in drug policy; unions of people who use drugs; regional health agencies; social movements; cooperatives; the media; local social services and medical facilities; and moderate support from hospitals and other harm reduction services.

The stakeholder that gave the lowest support to the larger portion of DCRs were neighbours, offering low support to 16 (16/31, 52%) of them and no support at all to 3 (3/31, 10%).

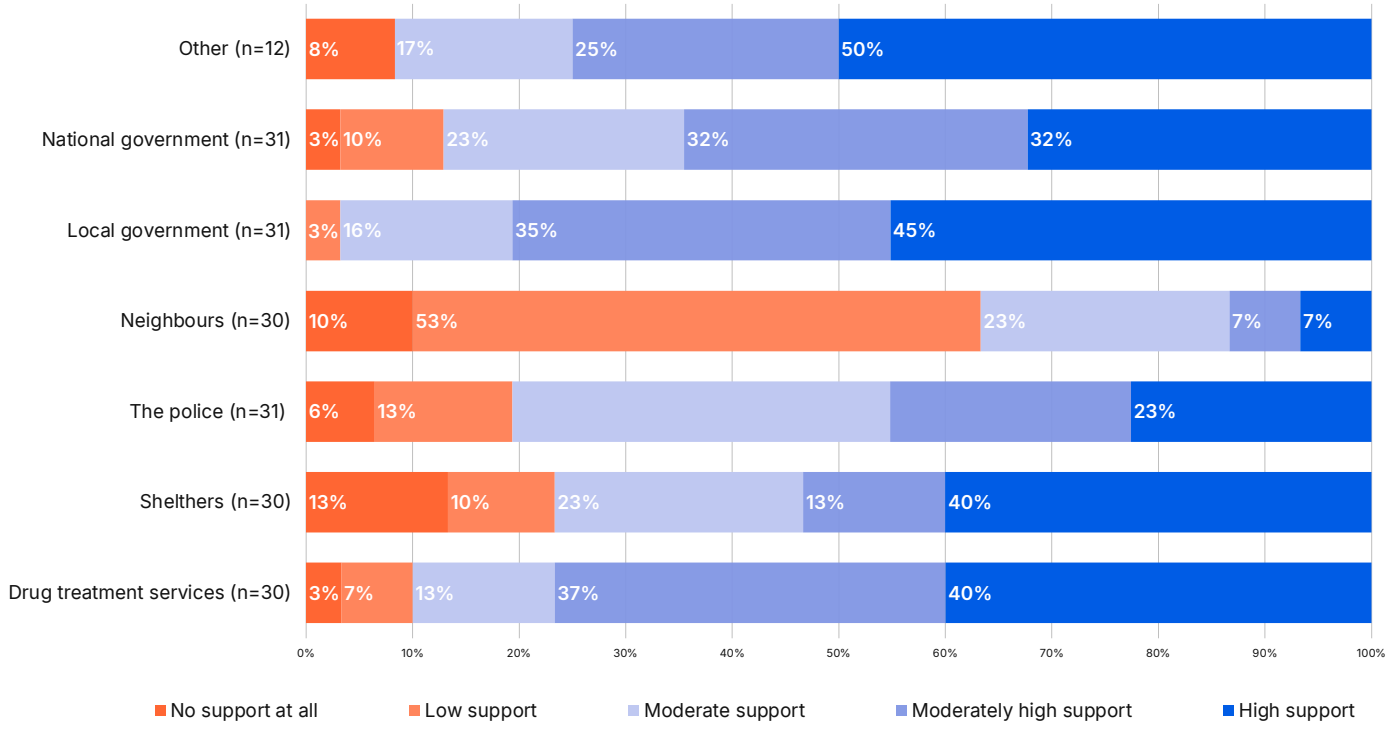


Figure 1. Degree of support from selected stakeholders for the opening of surveyed DCRs ***(N=31, skipped:0)***

Funding

Funding for most DCRs was primarily sourced from local (17/31, 55%), regional (12/31, 39%) or national (10/31, 32%) governments. Additional funding sources include charities and religious funds (3/31, 10%) was well as other sources (5/31, 16%), such as businesses, private health care insurance and individuals.

Setting

Most DCRs were operated by a not-for-profit organisation (19/31, 61%). Other DCR providers include local, regional or national governments (7/31, 23%) and one religious organisation. The operational models of most DCR services favour the co-location of supervised consumption services in existing facilities, such as low-threshold community-based care services (17/31, 52%), housing and accommodation services (2/31, 6.5%), or health services (3/31, 9.5%), such as treatment centres and hospitals. In six cases (6/31, 19%), DCRs are stand-alone facilities in a fixed location, and four are operated as a mobile service.

DCRs were most commonly located in an urban city centre (18/31, 55%) within the boundaries of a street-based drug scene (17/31, 52%) or near a major travel hub (13/31, 42%). Only a small number of DCRs (6/31, 20%) were located in the peripheries of a city in locations with facilities that support those who use drugs.

Governance

Social and health professionals from governmental and public institutions (26/31, 84%), community-based social and health professionals (22/31, 71%), law enforcement (19/31, 61%), and policymakers and elected officials (23/31, 74%) were frequently reported as stakeholders structurally involved in the formulation of various DCR goals and service models. People with lived or living experience (16/31, 52%) and the local community (15/31, 48%) were more often involved through informal feedback or ad hoc consultations.

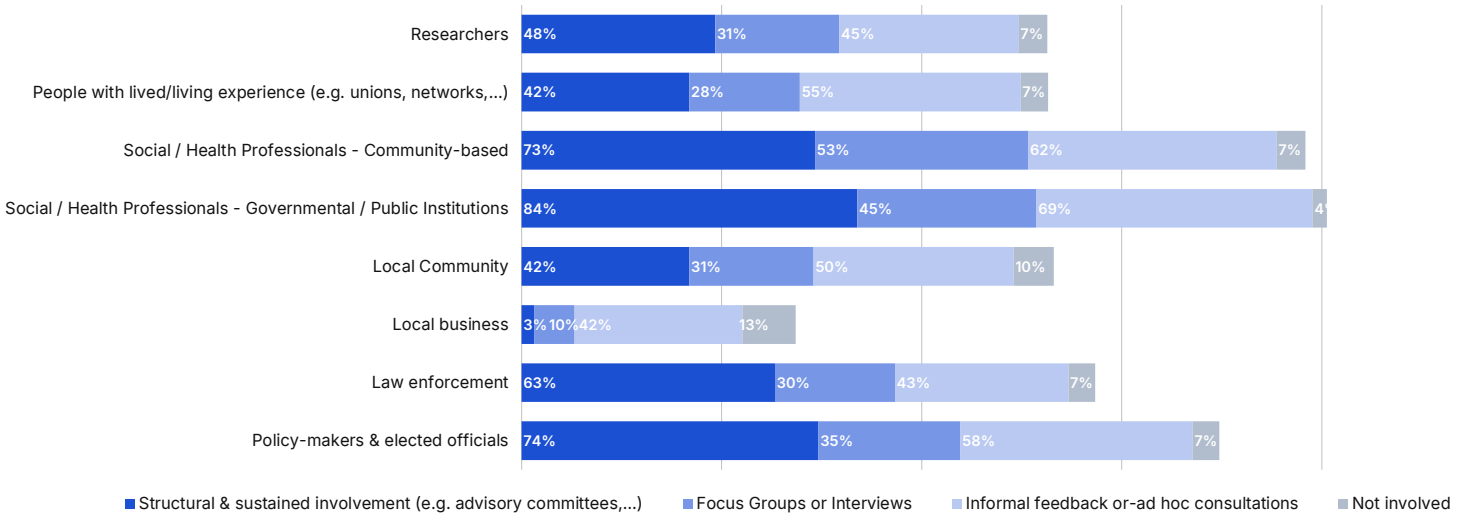


Figure 2. Modalities of cooperation from selected stakeholders in the formulation of surveyed DCR's goals and model of service ***(N=31, skipped:0)***

Overall, policymakers and elected officials, social and health professionals from governmental/ public institutions, and community-based social and health professionals are the most involved stakeholders at all levels, including structural and sustained involvement, focus groups, interviews, informal feedback, and ad-hoc consultations. While law enforcement was structurally involved by most of the DCRs, their involvement took place through informal feedback/ad-hoc consultations (13/31, 43%) and focus groups/interviews (9/31, 30%). Researchers, the local community, and people with lived or living experience were involved by in less than half of DCRs (12/31, 40%), especially through structural involvement and informal feedback/ad-hoc consultations. Notably, local businesses were the least involved stakeholders at all levels of involvement.

The design of DCR regulations and operations saw less influence from stakeholders who do not work at the DCR or are not part of the management team of the organization to which the DCR belongs. Specifically, the vast majority of DCRs indicated that the management staff of the organization was involved in defining target groups (27/27, 100%); setting DCR admission criteria (24/26, 92%); establishing DCR house rules and sanctions (25/27, 93%); determining the goals of the DCR (25/26, 96%); deciding DCR opening hours (25/26, 96%); shaping the operational model of the DCR (23/26, 88%); and determining the range/types of services provided (22/23, 96%).

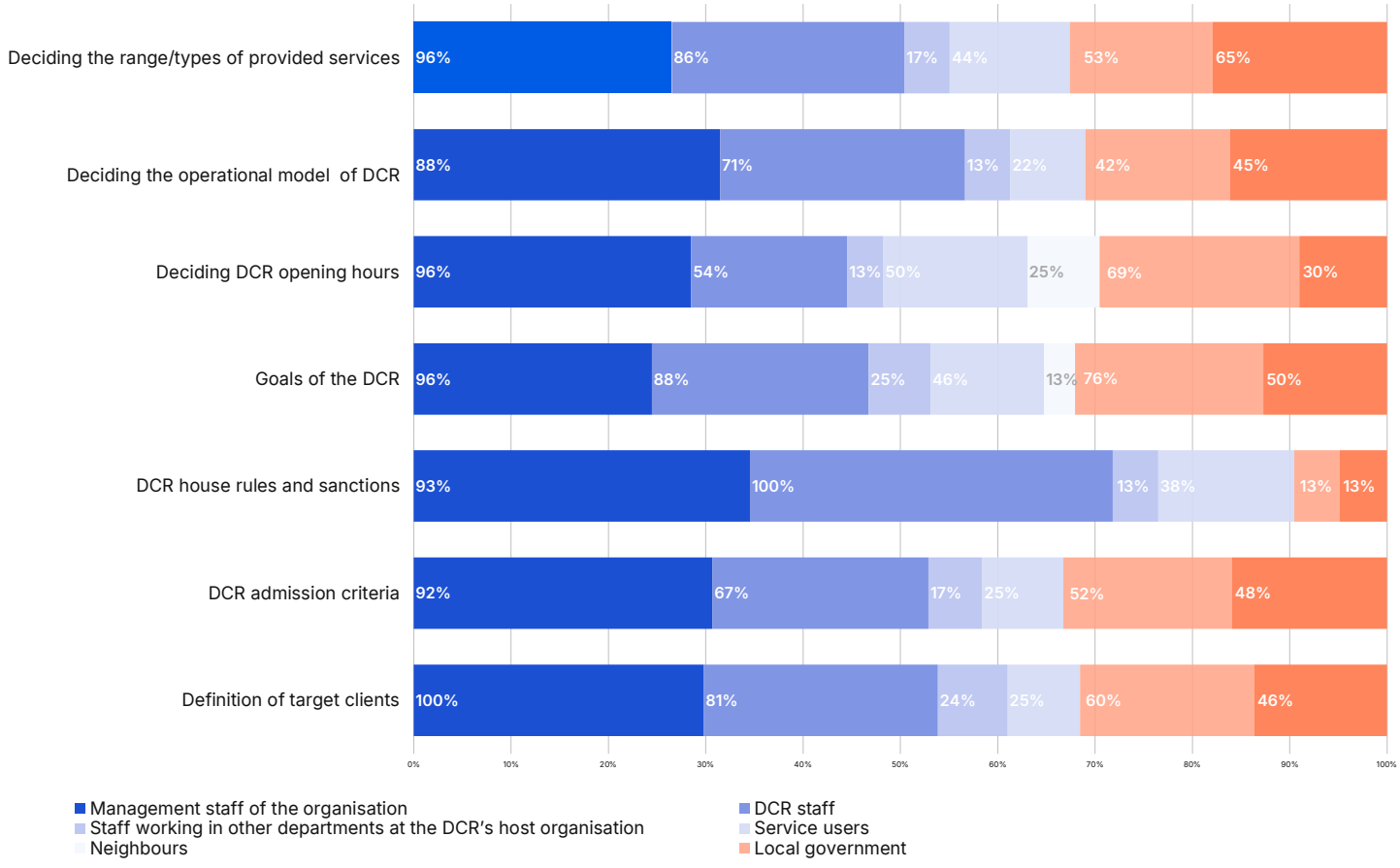


Figure 3. Extent of stakeholders' involvement in the design of surveyed DCR's regulations and operational procedures ***(N=27, skipped:4)***

DCR staff were also involved by the majority of DCRs in almost all these aspects, except for deciding the DCR opening hours, where their involvement was noted in about half of the DCRs (13/24, 54%). To a lesser extent, local governments were also involved by the majority of DCRs in defining clients (15/25, 60%); setting the goals of the DCR (19/25, 76%); and deciding DCR opening hours (18/26, 69%). Approximately half of the DCRs involved local governments in deciding admission criteria (13/25, 52%).

Service users had the greatest involvement in deciding DCR opening hours (12/24, 50%); setting the goals of the DCR (11/24, 46%); and determining the range/types of services provided (8/18, 44%). Neighbours were not involved by any of the DCRs in most aspects of the regulations and operational design. When neighbours were involved, it was only by 6 DCRs (6/24, 25%) in deciding their opening hours and by 3 DCRs (3/24, 12%) regarding the goals of the DCR.

Service users are involved in designing and developing services in all but five of the respondent DCRs. In most DCRs (20/30, 69%), this involvement occurs via informal feedback. To a lesser extent, involvement occurs through staff members with lived experience (10/30, 34%) and through regular consultations and focus group discussions (9/30, 31%). Some DCRs also hold service user councils within the organization to ensure this involvement (5/30, 17%), cooperate with service user unions or networks of people who use drugs (5/30, 17%), and involve staff with living experience (3/30, 7%). Other methods of involvement include surveys (4/30, 10%) to engage service users.

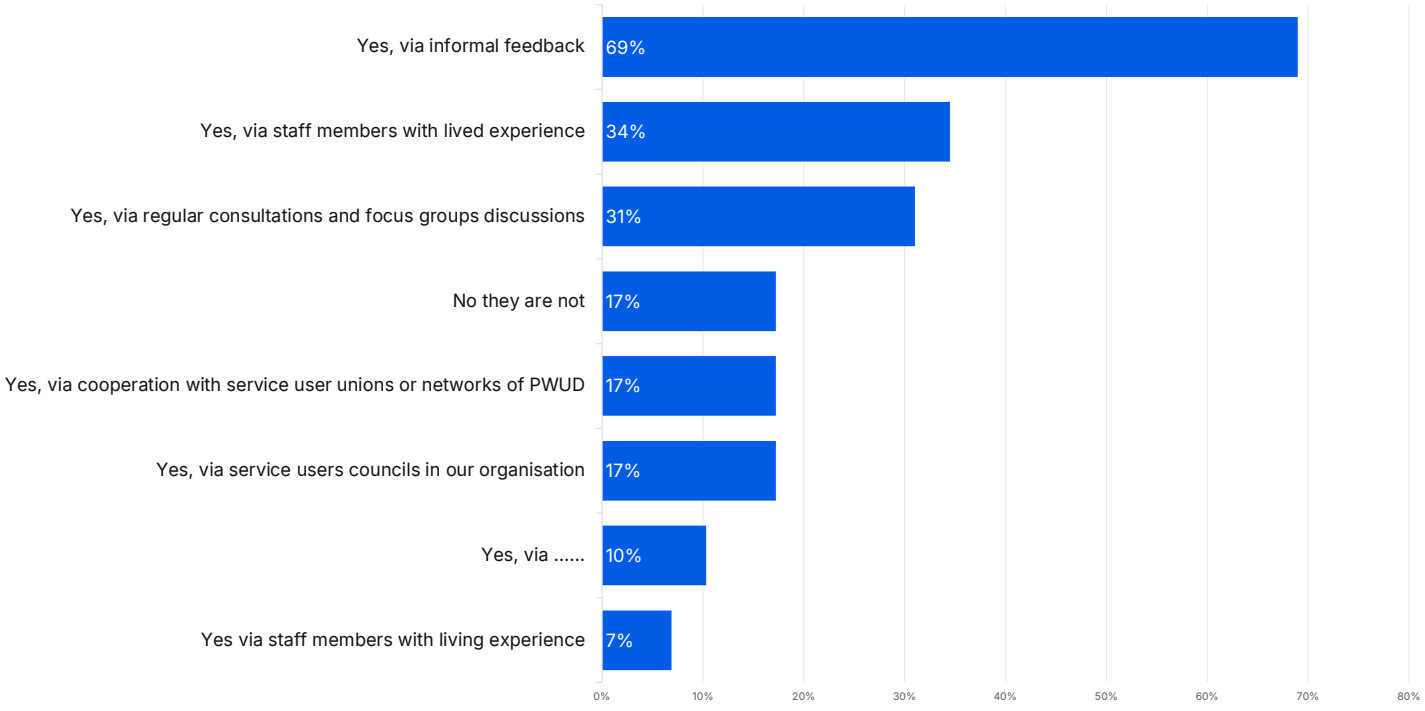


Figure 4. Extent of service users' involvement in the design surveyed DCR's services ***(N=30, skipped:1)***

— Operational Policies & Protocols

Admission Criteria

Several conditions on service use were reported. The majority pertained to age restrictions (29/30, 97%), commonly articulating 18 years old (25/30, 83%) or 23 years old (3/30, 10%) as the minimal age to access the services. Other criteria include having self-reported drug dependence or drug use (23/30, 77%); signing a term of use document/contract of conduct/house rules compliance statement (19/30, 63%); completing a registration survey or intake procedure (16/30, 53%); and possession of drugs before entering the consumption room (12/30, 40%).

Additionally, in 9 DCRs, the use of the service was limited to a specific drug. While most services are provided anonymously, 8 DCRs required visitors to present a national ID, registration at the DCR or its host organisation, or residency in a certain area/ registration with the municipality. In addition to those provided in the survey, two DCRs indicated that they had other criteria, namely, 'women and gender diverse people surviving situations of violence', or being a resident of the country.

To ensure a balance between the needs of the services and the needs of those who use the services, a third of DCRs (11/30, 37%) reported handling the admission criteria flexibly, particularly those related to age restrictions and formal linkage with a location and specific forms of drug administration, as long as they remain in compliance with the law.

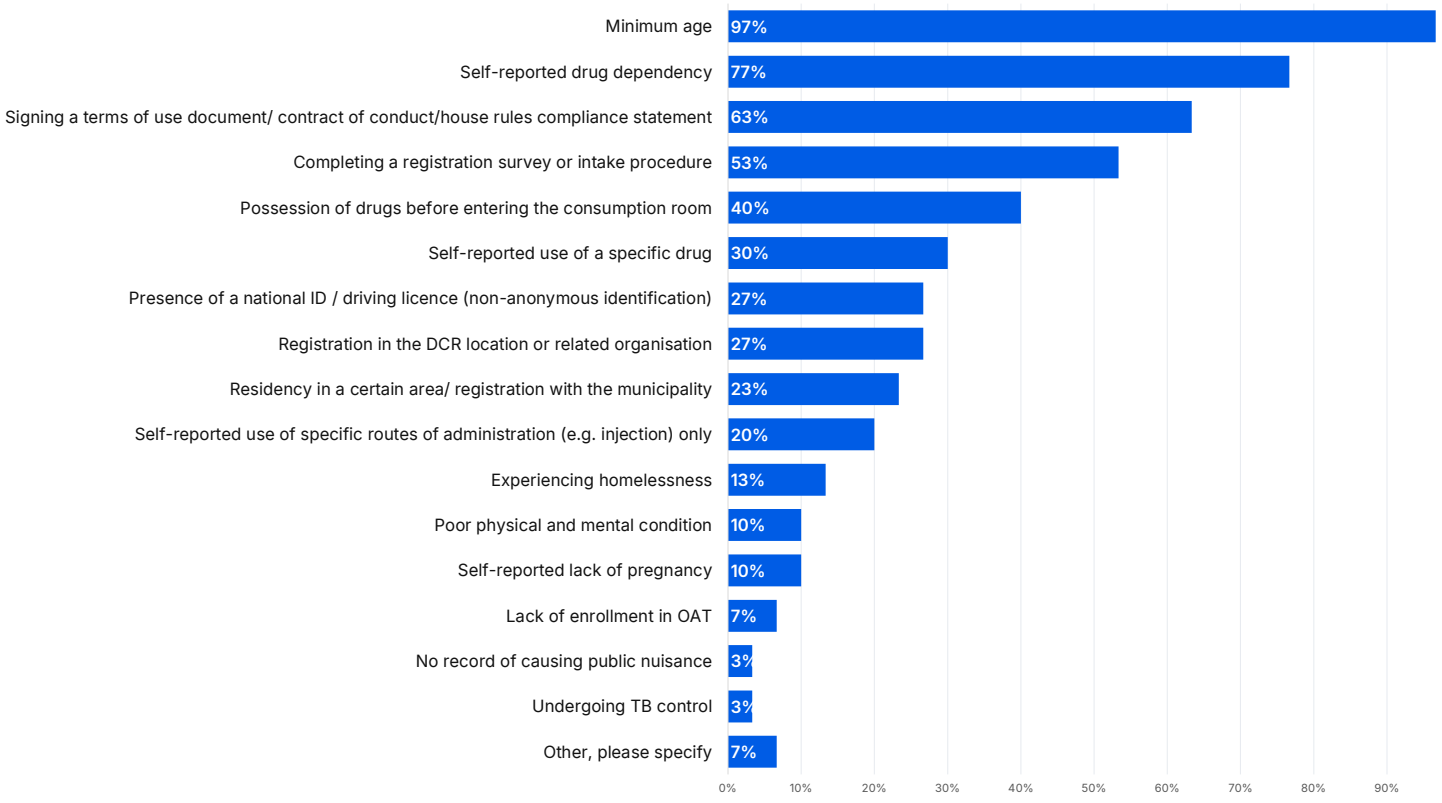


Figure 5. Eligibility criteria for service use of surveyed DCRs ***(N=30, skipped:1)***

General Rules & Regulations

Next to admission criteria, a range of diverse rules govern activities at DCRs. The most prominent ones include rules on the supply of drugs in the DCR, such as selling (25/29, 86%) or sharing (14/29, 48%) drugs onsite, and rules governing injection, such as the prohibition of assisted injections (13/29, 45%) or the prohibition of injection in specific body areas. (7/29, 24%).

Regulations related to use practices other than injecting are also standard, including the prohibition of particular routes of drug administration or the ban on consumption of specific substances, such as alcohol (23/29, 79%), tobacco (18/29, 62%), or cannabis. In contrast, a large number of DCRs allowed the use of Benzodiazepines (20/29, 69%), half of them the use of GHB (15/29, 52%) and a significant majority of them (24/31, 77%) allowed polydrug use. DCRs also indicated that they had rules to prevent violence, stigma, and discrimination.

The majority of DCRs reported communicating the service rules during an intake interview (25/29, 86%), through visual materials placed in the consumption areas (19/29, 65%) and other areas of the facility (16/29, 55%), oftentimes through a contract to be signed by the user/visitor.

In case of infringement of the service rules, or the safety of other users or staff members, the majority of DCRs (28/29, 96%) reported counting with sanction regulations. In those cases, temporary bans (20/29, 69%) or permanent bans (7/29, 24%) are the most common types of sanction, depending on the infringement and the availability of specific protocols during case management.

Two DCRs reported not using particular protocols. Instead, their teams have the possibility to custom-make a sanction based on the facts at hand, the specific service user and other contextual factors.

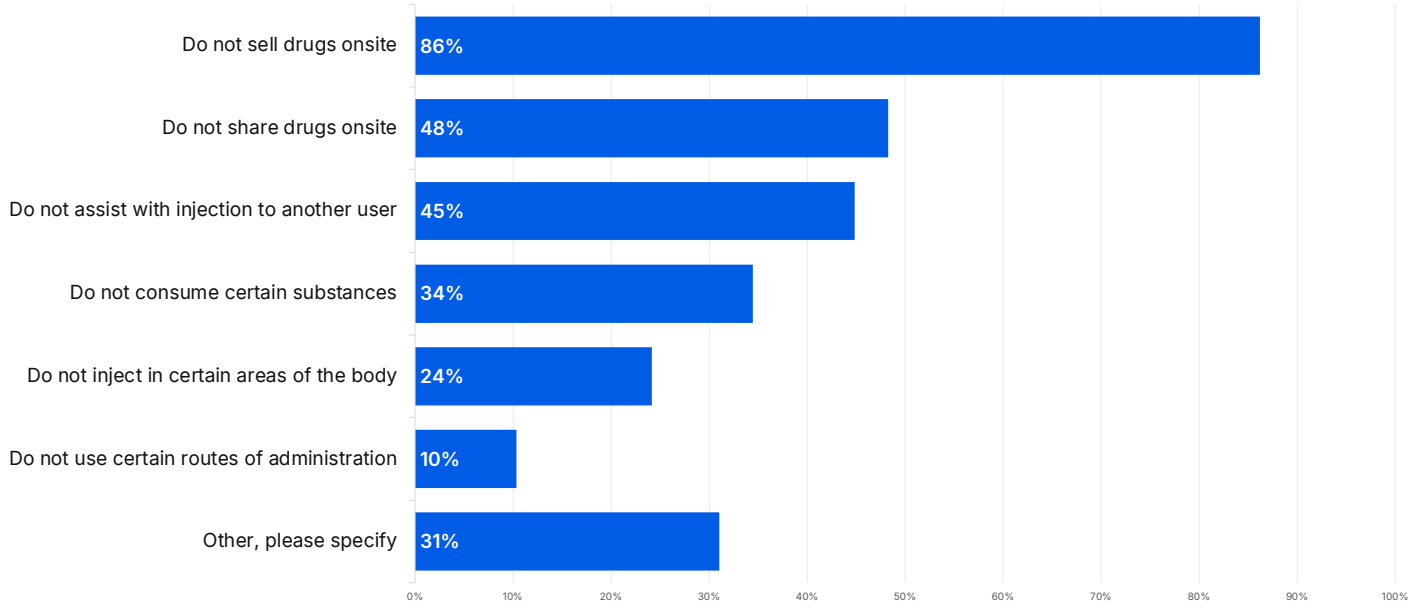


Figure 6. Rules and regulations applying to the service use of surveyed DCRs ***(N=30, skipped:1)***

Evaluation & Monitoring

Building evidence has been crucial for DCRs to sustain their operations and adapt to the evolving needs of the communities they serve. The majority of DCRs reported collecting comprehensive data on their visitor intake. This included demographic characteristics such as age (29/31, 93%) and gender (26/31, 83%); medical history including years of drug use (18/22, 81%), history of injecting (22/31, 71%), and engagement in opioid agonist treatment (OAT) or abstinence-based treatment (18/31, 58% and 9/31, 29% respectively); blood-borne disease history (17/31, 55%); and social history encompassing housing status, residence, and social/family networks.

In addition to intake data, DCRs reported collected information on each client visit. This included the frequency of service use (18/31, 58%); number of drug use episodes per visit (15/31, 48%); occurrences (27/31, 87%) and management of overdoses (25/31, 81%); substances used (22/31, 71%) or amounts of safer use materials distributed (21/31, 68%); utilization of other on-site services (19/31, 61%); and referrals or engagement with external organizations/institutions, alongside other relevant daily affairs data.

While most DCRs implemented service evaluation procedures (18/31, 58%), a significant number did not (12/31, 39%). Data sources for evaluation included internal and external statistics, activity reports, user surveys, and focus groups, as well as internal procedures. Often, evaluations involved internal and external audits that incorporated feedback from key stakeholders, internal meetings, predefined key performance indicators (KPIs), established quality systems, and monthly indicators.

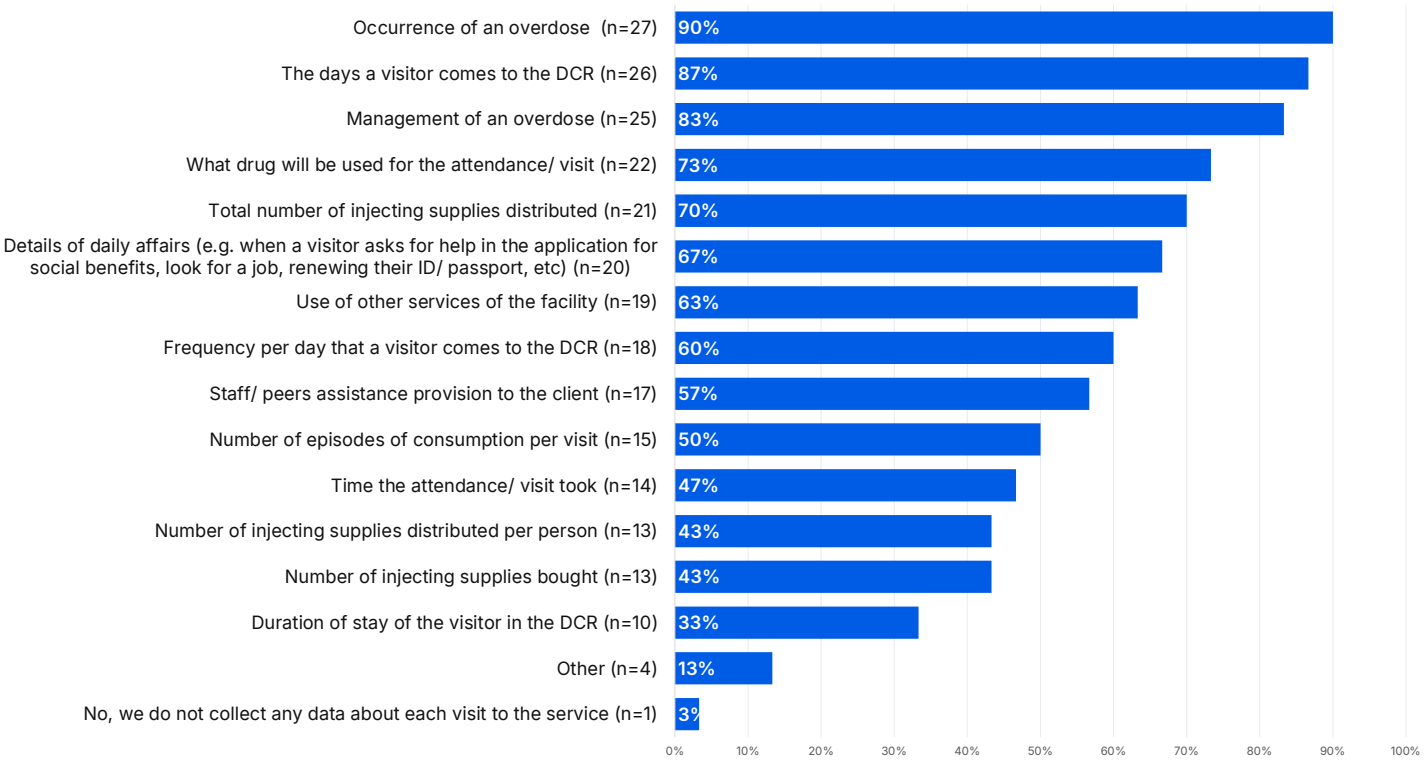


Figure 7. Data collected by surveyed DCRs per visit ***(N=30, skipped:1)***

Overview of Operational Capacities

Client Characteristics

Regarding client characteristics reported by DCRs, most clients were reported to be men (81.42% mean, 83.50% median, min=45%, max=92%). Fifty-six percent of the clients were reported to be aged between 41 and 50 years old, and 56% were currently experiencing homelessness (mean 55.9%, median 55.9%, min=9.9%, max=100%).

All of the DCRs reported having provided services to people experiencing homelessness. It is important to highlight the high variance between the minimum and maximum percentages of people experiencing homelessness using DCRs. This variance is likely due to the operational model of the DCR, as those who reported an average of around 100% were integrated with a housing service or drop-in center, while the DCR that reported less than 10% was a mobile service.

Furthermore, 42% of service clients had ever been in abstinence-oriented drug treatment, and 29% had been on OAT (mean 29.83%, median 40%, min=0%, max=65%). On average, 24% reported being HCV-positive (mean 24.80%, median 21.23%, min=0%, max=75.3%) and 8% reported living with HIV (mean 8.07%, median 3.42%, min=0%, max=45.1%).

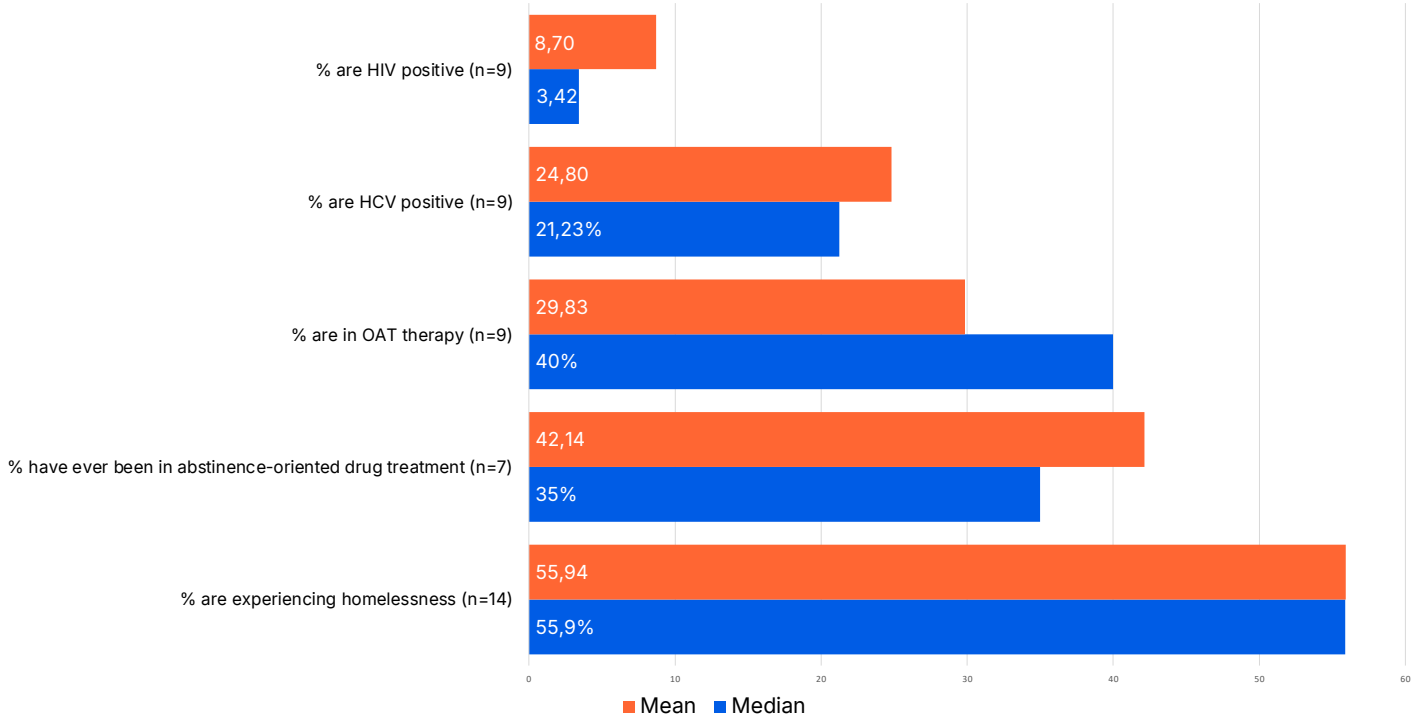


Figure 8. Specific characteristics of DCR visitors 12 months prior to the study ***(N=27, skipped:4)***

Number of visitors

The number of visitors varies considerably among respondents to this question (22), with an average of 81 individuals accessing a DCR per day in the 12 months prior to data collection (min=3, max=202, mean=81, median=73). The lower number of daily visitors corresponds to data provided by mobile DCRs with 6, 10 and 12 visitors per day respectively.

Repeated visits on the same day were possible in almost all facilities (26/29, 90%). However, almost half of the DCRs (12/29, 41%) operate a maximum duration policy that regulates the duration of visits. In these cases, the range varies between 15 and 60 minutes, depending on the route of drug administration (a greater time allowed in injection rooms), number of visitors, and the number of available spaces for consumption. Also, it is important to mention that maximum duration policies may be restricted to consumption areas, allowing visitors to remain in other areas of the facility, such as the courtyard or cafeteria.

Intending to allow as many users as possible into the DCR, one respondent highlights the implementation of flexible policies that allow their staff to modify the duration of visits as frequently as needed based on service demand at a given moment or day. To support the achievement of public order and safety in the vicinity of the facility, two DCRs operate with policies that set a minimal amount of time a visitor needs to be outside of the service before being allowed inside again; the shorter period of 30 minutes, and the longer being 60 minutes.

Operating Time

On average, in the 12 months prior to the survey, the mean number of opening days was 6 days per week. However, the majority of DCRs were open every day (17/31, 55%) and, exceptionally, just one DCR opened for one day peer week. From all respondents, 10 DCRs (10/31, 32%) indicated having provided evening/night services, 6 (6/31, 19%) of them every evening, 1 (1/31, 3%) of them six days per week and 2 (2/31, 6%) for five days per week.

The number of hours that they were open per week averaged 51 hours (min=8, max=105, mean=51, median=51), 12 hours on Saturdays and Sundays per week (min=0, max=48, mean=12, median=12) and about 3 hours per week on evenings/nights per week (between 8pm and 8am) (min=0, max=19, mean=3, median=0).

Number of Consumption Spaces

In general, most DCRs offered places for intravenous drug use (23/24, 96%) as well as for smoking/inhaling substances (23/24, 96%) and snorting (21/24, 88%). More than half of the DCRs (16/24, 66%) offered space for the three routes of administration, while only four provided specialist services for only one route of administration.

The mean number of spaces for safer consumption in the DCRs was 6 spots for injection (min=0,

max=18, mean=6, median=6), 7 spots for smoking (min=0, max=18, mean=7, median=6) and 3 spots for snorting (min=0, max=14, mean=3, median=4).

Workforce

Staffing Models

The staff at DCRs included management staff (16/24, 67%), nurses (16/24, 67%) and social workers (14/24, 58%) and, to a lesser degree, medical doctors, social/health educators, security staff and psychologists. In addition to the categories provided by the survey, DCRs reported counting as professionals such positions as chef, cleaning professional, student, health auxiliary and translator.

The number and professional specialised staff is insufficient to meet the goals of the service in the past 12 months in half of the DCRs (12/23, 52%). More specifically, staffing was insufficient in general in 7 of the DCRs (7/23, 30%), and in 5 (5/23, 22%), the number of staff was insufficient in the following professions/specialisations: health professionals, such as nurses (5/5) and medicine (2/5); peer workers (1/5); and harm reduction professionals (1/5). The remaining DCRs (11/23, 48%) expressed having had sufficient staff to meet the goals of their respective services.

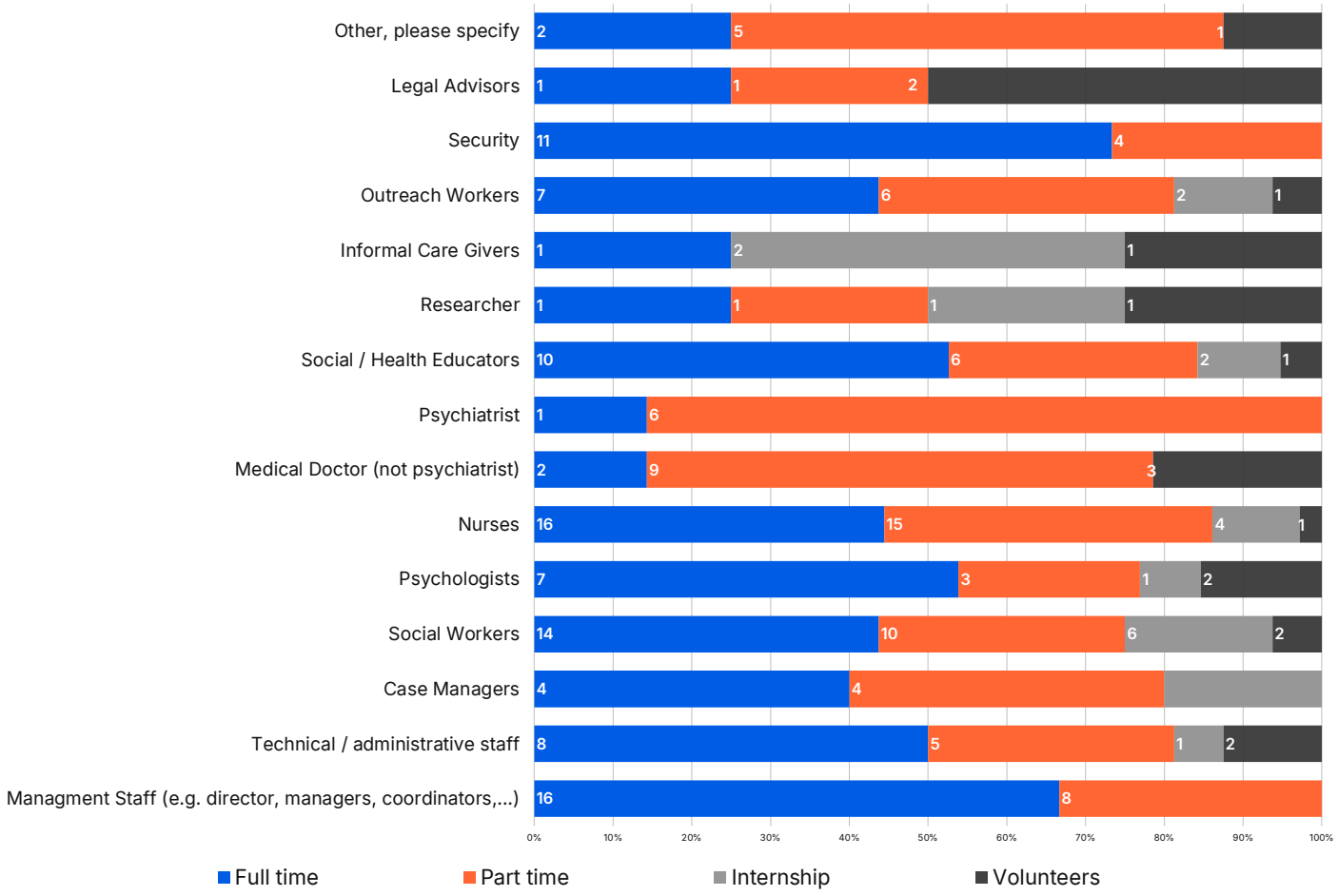


Figure 9. Service staffing at surveyed DCRs 12 months prior to sutdy ***(N=23, skipped:8)***

However, only 9 out of 23 DCRs (39%) expressed having insufficient staff to meet the needs of its users in the past 12 months. Most of the remaining expressed that the number of staff was insufficient in general (7/23, 30%), while one of the DCRs expressed that the number of staff was insufficient in nursing and medicine services, and one explained that they started only with two employees and, upon perceiving that the number was insufficient, a third staff member was hired 6 months later. More than half of the DCRs (14/23, 61%) do have sufficient staff to meet the needs of its users.

Peer Involvement

Data provided by respondents highlight a low inclusion of individuals with (self)identified living or lived experience in their teams. Only 9 DCRs (9/31, 29%) employ at least one staff member with living or lived experience in any professional category or employment modality. In those DCRs, the range varies between 1-and-6 professionals with lived or living experience, including management (1/9, 11%); technical/administrative professionals (2/9, 22%); social workers (2/9, 22%); social/health educators (3/9, 33%); informal caregivers (1/9, 11%); outreach workers (2/9, 22%); case managers (1/9, 11%); students (1/9, 11%); and peers (1/9, 11%).

Organisational constraints, negative previous experiences of peer engagement, a lack of technical information, a lack of trust, legitimacy and stigma are identified as ongoing issues in terms of achieving opportunities for equitable peer employment. Staff might, in fact, have lived or living experience, but the DCRs either do not ask (1/13, 8%) or do not hire the person in question because of this experience (1/13, 8%) and, therefore, do not consider it when responding to the question.

None DCRs that do employ people with (self-) identified lived or living experience (e.g. of drug use, homelessness, etc.) in the last 12 months require complete abstinence (including legal substances, e.g. alcohol or non-medical use of prescription medicines). Instead, 4 of the DCRs require abstinence during working hours only and 3 require abstinence of illicit drug abstinence (or in OAT). The other two did not provide an answer to this question.

Professional Competences

The staff of DCRs are required to know Harm Reduction principles and approaches in all of the 23 DCRs that provided information on this topic. Most of the DCRs also require professional skills or training, such as overdose prevention, recognition and management (20/23, 87%); basic health care and first aid (19/23, 82%); how to deal with acute intoxication and agitation (18/23, 78%); safer injection practises (16/23, 69%); and safety and conflict management (16/23, 69%).

Additionally, about half (12/23, 52%) require mental health first aid professional skills or training, but other aspects of mental health practise, such as trauma and violence informed practise (TVIP) (5/23, 22%), cultural safety and diversity (5/23, 22%) and burnout prevention (6/23, 26%) are only required by a small number of the respondent DCRs.
A smaller number of DCRs also require other professional skills or training, such as legal rights (6/23, 26%) and supervision (1/23, 4%). Nevertheless, most of the DCRs (18/23, 78%) do

not demand certification of these skills or training certified by an official entity. Only one (1/23, 4%) of the DCRs does not offer training for the continuous development of staff. Of the DCRs that do, most do so in-house (15/23, 65%), while seven (7/23, 30%) do so externally.

Professional Support

Staff support and care services were continuously available in most of the DCRs in the past 12 months in the form of individual (such as onsite counselling, assistance programmes, etc.) (18/22, 82%) and group (including debriefing sessions, support groups, team meetings) (17/22, 77%) support. Leadership programmes (4/22, 18%), and community support (4/22, 18%) were offered to a lesser extent. Three DCRs reported 'other' support (3/22, 14%), including the presence of a psychologist over a period of time, external support where necessary, and supervision.

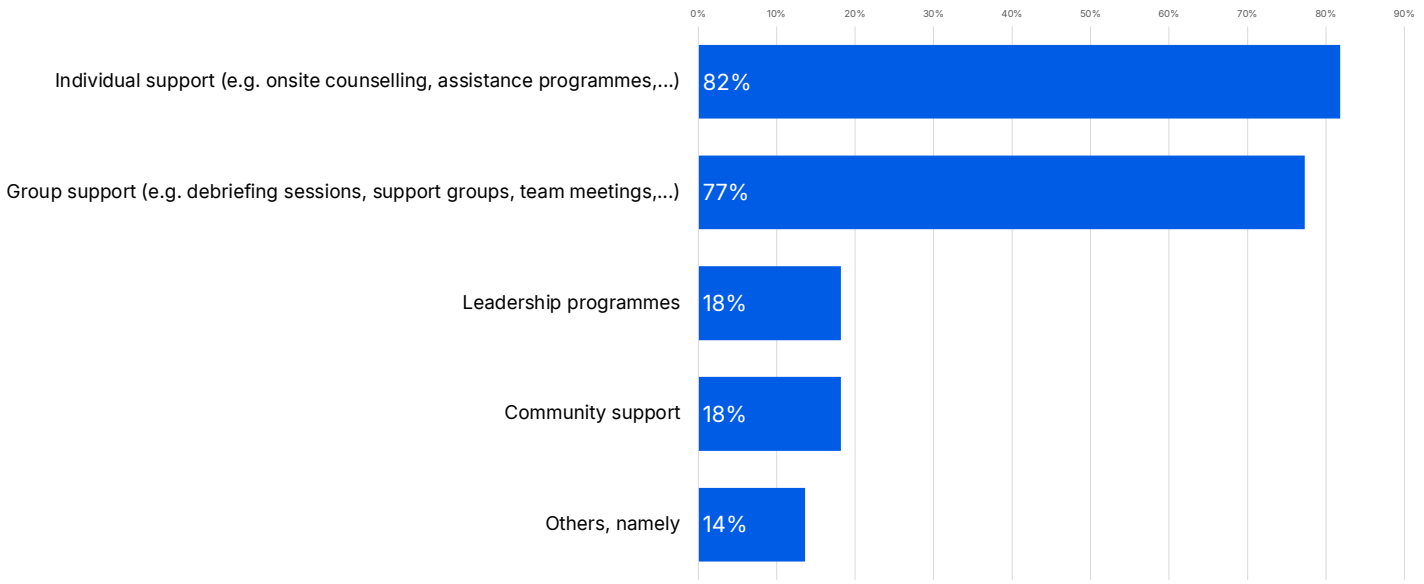


Figure 10. Number of DCRs providing specific support services to workforce 12 months prior to the study ***(N= 22, skipped:9)***

When it comes to supporting employees with self-identified or identified lived or living experience, information was provided by only 8 DCRs. Among these, four (4/8, 50%) reported having an organizational code of conduct with principles and values of peer work, along with sensitization training for staff without lived or living experience, and established strategies or structures for such training. Additionally, three DCRs (3/8, 37%) indicated offering peer supervision and mentorship, counseling and management strategies related to relapse, changes in substance consumption patterns, or initiation to substance use, as well as support for burnout, triggers, and prevention of other harmful circumstances, alongside peer supervision and mentorship.

Two DCRs (2/8, 25%) mentioned having strategies or protocols for the prevention and resolution of conflict with service users and/or professionals with or without lived or living experience, and another two (2/8, 25%) support for managing chronic health conditions. One DCR (1/8, 12.5%) mentioned conducting peer risk assessments, while another (1/8, 12.5%) selected 'other' without specifying the reason.

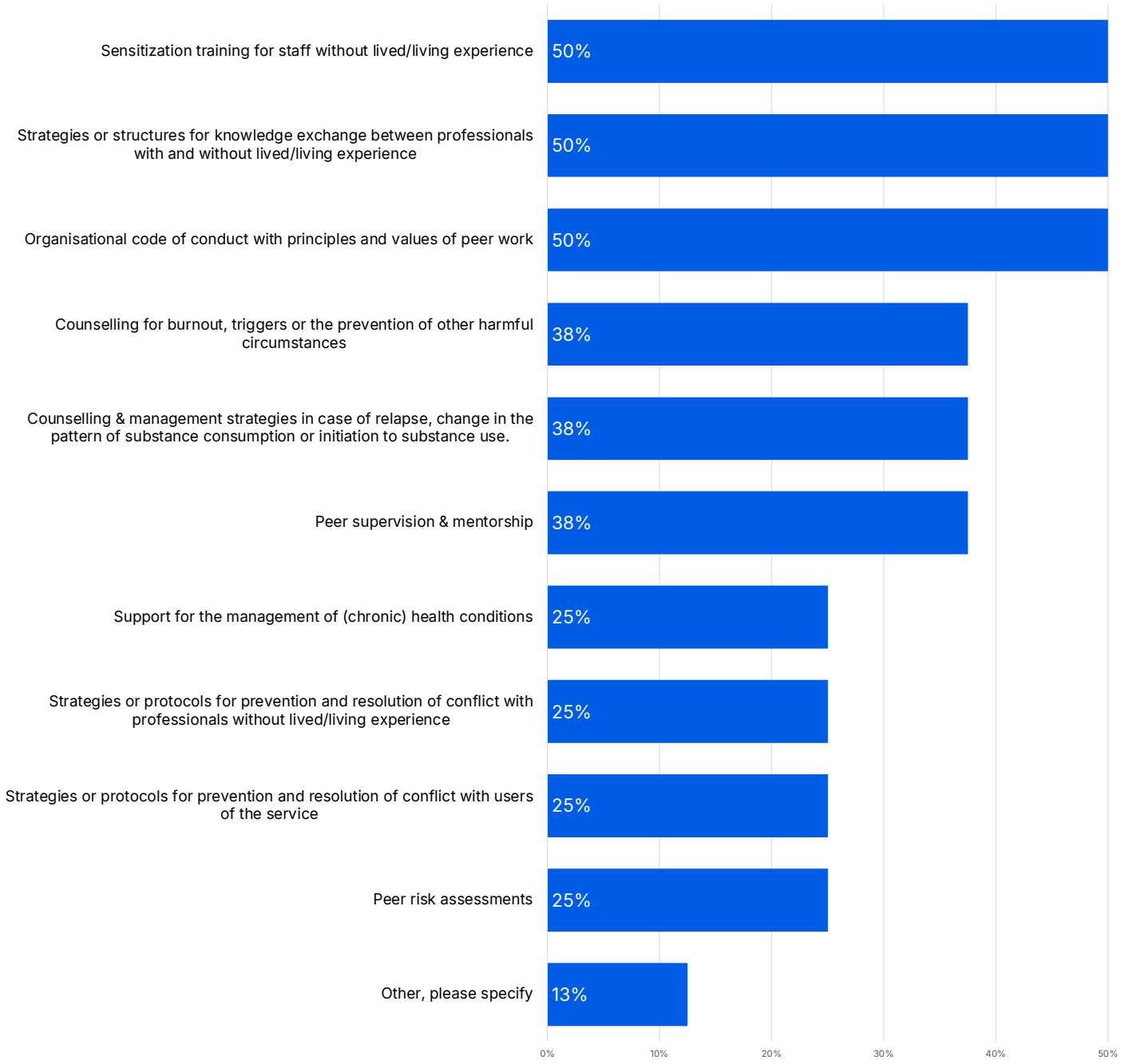


Figure 11. Provision of specific support services to workforce with lived and/or lived experience of drug use 12 months prior to the study ***(N=8, skipped:23)***

Care & Support Services

In addition to providing a safer and hygienic space for drug use, DCRs offer a range of essential harm reduction services. These services include access to health education (24/24, 100%); safer drug use materials such as inhalation supplies (22/24, 92%) and intranasal supplies (17/24, 71%); counseling (21/24, 87%); provision of basic needs (20/24, 83%); basic medical health care (19/24, 80%); and case management (16/24, 67%).

When health education was provided, the primary focus of interventions was safer drug use (15/24, 62%). All respondents who chose "other, namely" (9/24, 37%) indicated that they address all the mentioned areas: safer sex, infectious diseases, and safer drug use.

All respondent DCRs (24/31, 77%) indicated providing health education interventions on request, including at flexible times and on-demand, rather than at fixed times in a structured approach, such as once a month. Additionally, half of the DCRs (14/24, 50%) provide health education both in groups and one-on-one, while 11 DCRs (11/24, 46%) only provide one-on-one health education interventions. HCV testing was similarly offered by DCRs onsite (15/24, 62%), through integrated low-threshold centers within the organization (15/24, 62%), and by referral (17/24, 71%).

Most DCRs provided a range of additional services through referral to other entities. These included the provision of accommodation, such as permanent housing (19/24, 79%) and night shelters/temporary protected living, and legal support (20/23, 87%). Health and mental health-related services were also commonly referred, including opioid agonist treatment (OAT) (20/24, 83%); basic medical care with a nurse (18/24, 75%) and with a doctor (19/24, 79%); testing and treatment of blood-borne diseases and abstinence-oriented drug treatment (19/24, 79%); counseling (19/24, 79%); and mental health care provided by a psychologist (18/24, 75%) and a psychiatrist (17/24, 71%). Additionally, drug checking was offered by a significant number of DCRs through referral (14/24, 58%).

Naloxone kits were distributed by staff in about half of the DCRs, onsite (13/24, 54%) and through outreach within the same organization (11/24, 46%). Approximately half of the DCRs offered take-home naloxone programs with training at the DCR (11/24, 46%), through an integrated low-threshold center (10/24, 42%), outreach within the same organization (9/24, 37%), and by referral (3/24, 12%).

Fentanyl strips were the least offered service. The highest percentage of DCRs providing fentanyl strips corresponded to about 30% (7/23), offered both at the DCRs and by referral.
Few organizations offered services online, with drug counseling (8/23, 35%) and health education (9/22, 41%) being offered most frequently through this modality.

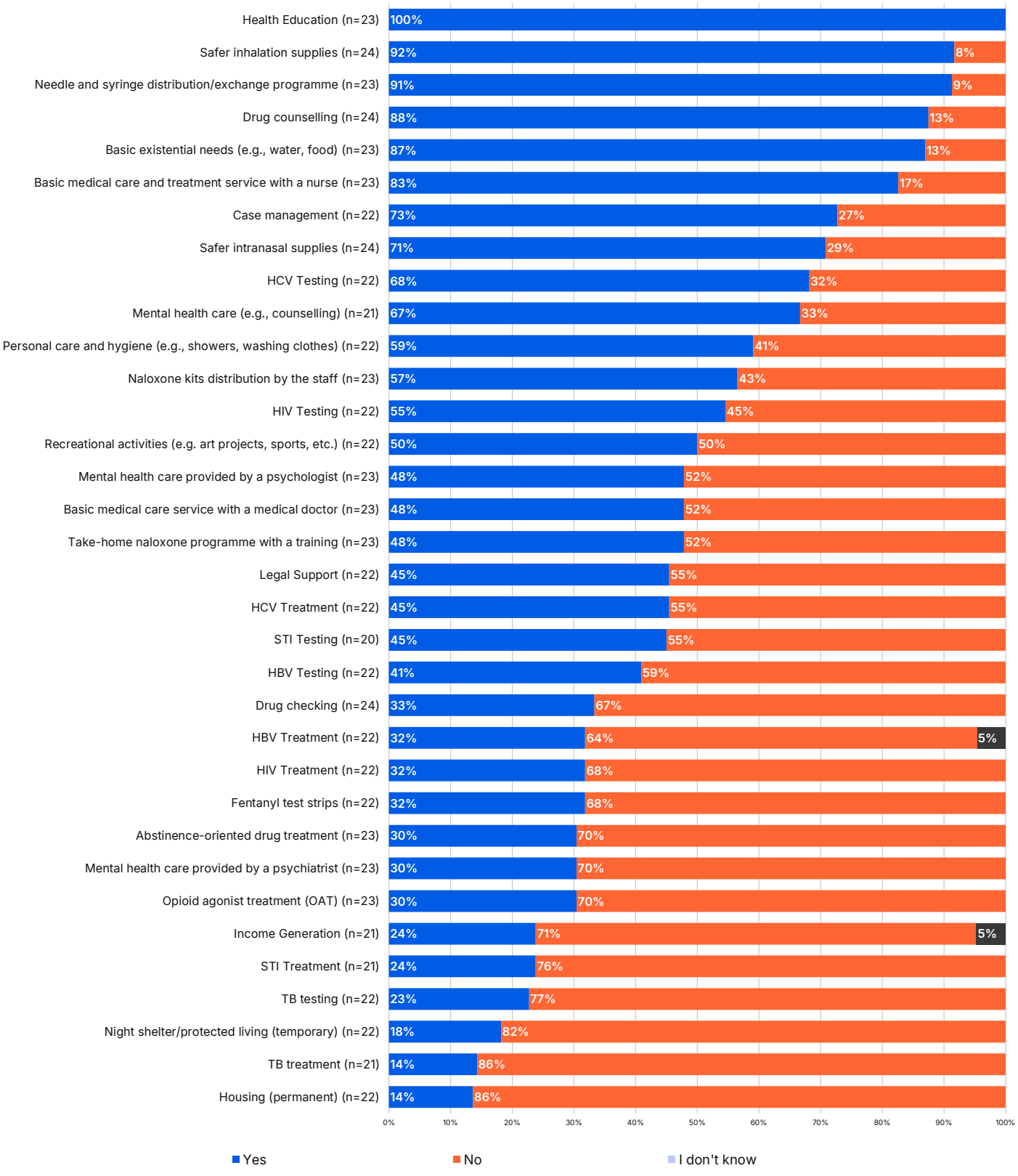


Figure 12. Provision of specific onsite support services by surveyed DCRs ***(N=24, skipped:7)***

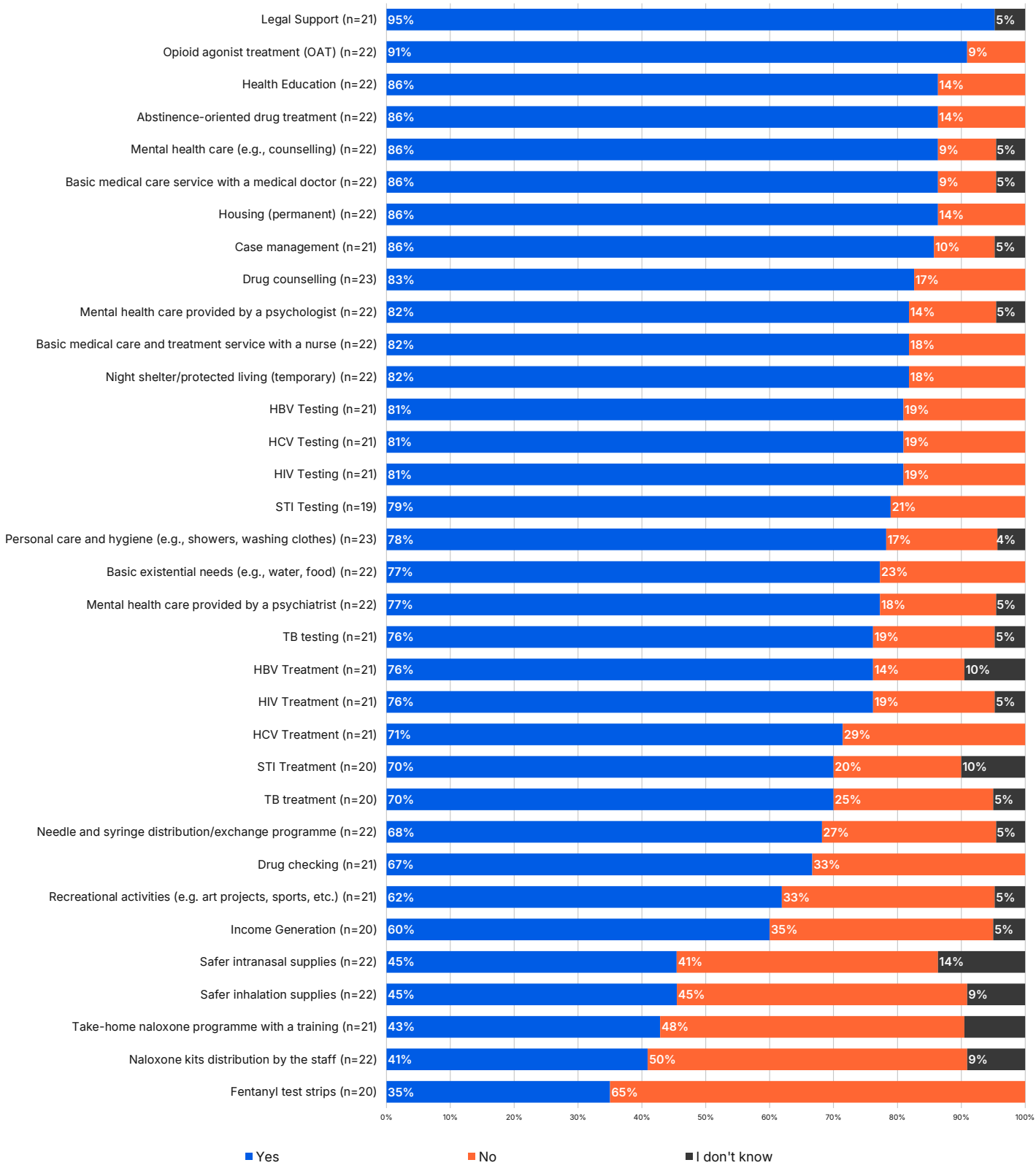


Figure 13. Linkage to specific support services by surveyed DCRs ***(N=24, skipped:7)***

Operational, Capacity and Services Trends

The operation of DCRs requires innovation and flexibility to adapt to the changes in profiles and needs of their target groups, new patterns of use, new types of drugs emerging on the market, and other contextual factors. This entails addressing a broad range of practices and harms. This has included, in some countries, providing spaces for non-injecting routes of administration, most commonly smoking, and allowing the consumption of a wider range of substances.

Client Profiles

A significant number of DCRs (19/30, 63%) reported challenges in reaching specific communities experiencing barriers to accessing health, drug, and social services. Information provided by DCRs highlighted an increasing need for new approaches and adapted services to support migrants, women, and individuals of diverse sexual orientation, gender identity, and expression, as well as variations in sex characteristics (SOGIESC) who use drugs and access harm reduction services.

Additionally, responder highlight a growing need to expand DCR services to accommodate other routes of administration and new substances, such as the inhalation of crack cocaine, GHB, and methamphetamine.

Operating Hours

In the 12 months preceding the survey distribution, most DCRs adhered to their regular operating hours (25/31, 80%). However, a notable proportion of services (8/31, 26%) experienced significant changes, with some reporting more than a 20% increase (5/20, 25%) or reduction (3/31, 10%) in operating hours. These examples underscored the complex interplay of various factors influencing operational adaptations. Three DCRs cited increased service demand as the reason for changing their operating hours, with two expanding their hours in response, and one reducing services due to staffing and facility constraints. Staffing shortages, attributed to funding cuts, also led to reduced operating hours in another case. Political shifts affecting funding and staffing priorities, along with the lifting of COVID-19 restrictions, also drove operational changes.

Changes in service demand impacted not only structural elements like operating hours but also influenced day-to-day activities and program implementations. Almost half of the DCRs (13/31, 42%) reported fluctuations in daily visitor numbers, with policing strategies and actions cited by six DCRs as a primary cause, including police presence near facilities and interventions in known drug dealing areas. Other factors affecting DCR operational capacities included changes in the drug market and availability, seasonal/weather-related phenomena, and financial resources available to service users.

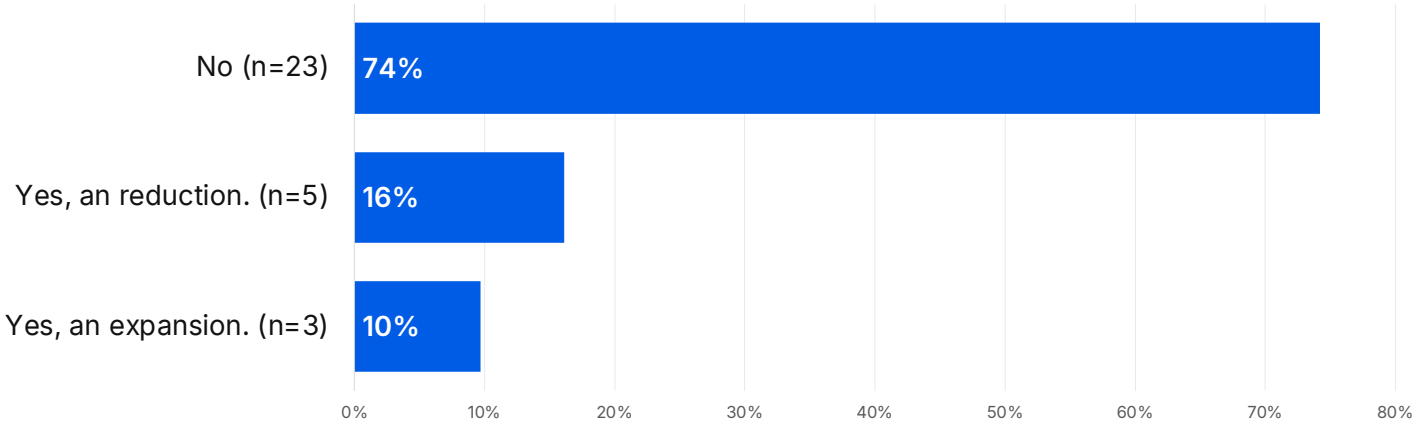


Figure 14. Changes in operating hours in surveyed DCRs 12 months prior to study ***(N=31, skipped:0)***

Changes in Setting

Half of the DCRs (17/31, 54%) have consistently operated in the same location since their establishment. However, 15 DCRs (15/31, 48%) have experienced changes in their service setting. Reasons for these changes include the need to secure larger premises to accommodate a growing number of visitors, or to adapt to shifts in consumption patterns. Examples include the relocation of a DCR to a more suitable space in response to an increase in inhalation among service users. Furthermore, two DCRs were relocated from temporary to permanent locations. Lastly, a change in the public institution responsible for the administration of the DCR, and developments in local urban planning and zoning, were also cited as reasons for relocation.

The remaining respondents referred to changes in the operational capacity of the DCR, the target group, in the type of services provided, or the staffing model of the DCR. For example, two explained that their rooms were enlarged to meet the needs of people who smoke drugs. One of them because it had observed the increase of smoking substances between the clients and adapted the service to meet their needs, while the other only offered a room for intravenous consumption and decided to adapt the room to other means of consumption. On the other hand, one DCR had a room intended for intravenous use and does not have that facility anymore.

Changes in Service Provision

While most DCRs (22/31, 71%) maintained the same operational model since establishment, 10 DCRs (10/31, 32%) reported changes. Only two (2/10, 20%) provided explanations aligning with defined operational model changes. For instance, one DCR integrated into a drop-in center from a temporary standalone fixed location with limited health services, while another transitioned from a mobile DCR to seek housing services. One DCR modified visitor access from "all people who use drugs" to "people from a certain area," reflecting

an operational model change. Other changes included expanding services from night shelters to include medical and social care and adjusting staff involvement in decision-making processes based on lived experience.

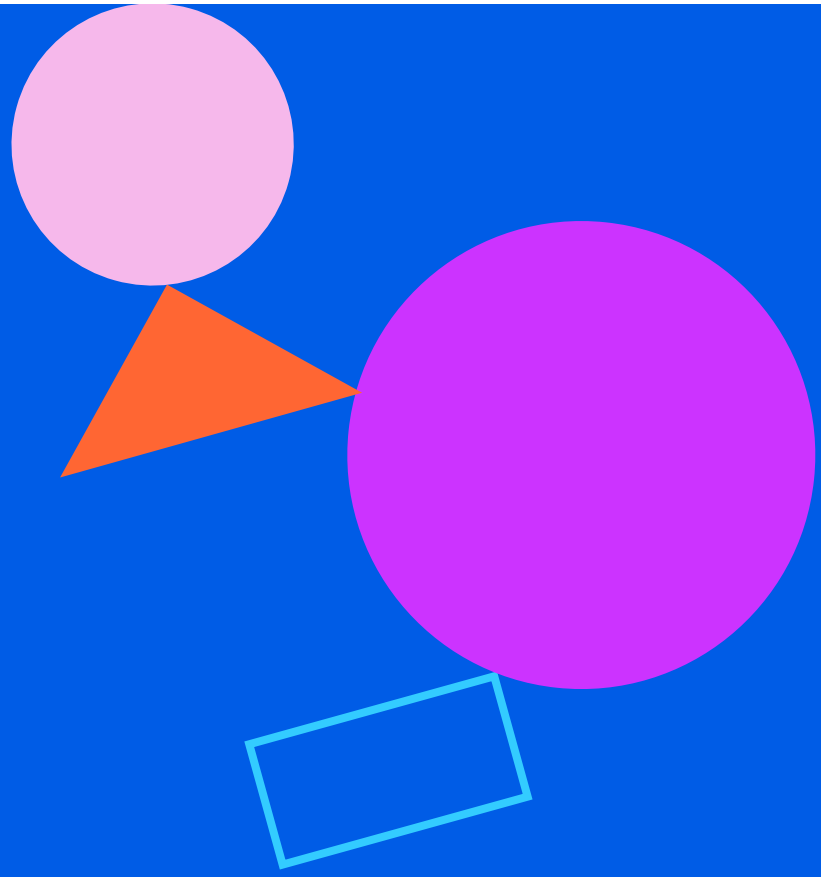
Trends in Governance & Partnerships

Half of the DCRs (16/31, 52%) reported experiencing increased support from key stakeholders in their local context since their establishment. Law enforcement (7/31, 22%) and local and national governments (9/31, 29%) were most frequently cited as providing incremental support. In some cases, this increased support led to enhanced funding or changes in legislation to incorporate harm reduction in drug responses, along with resources to improve relations between DCRs and their neighbors.

However, relations with neighbors and local communities did not uniformly improve. Some DCRs saw increased support from local communities through sensitization and dialogue strategies. Conversely, in other cases, support remained stagnant or declined due to the 'not-in-my-backyard' phenomenon exacerbated by the social impacts of COVID-19 and the transition to normalcy. In areas where DCRs have operated for an extended period, support diminished as local communities perceived them as unnecessary, influenced by perceived improvements in public health and urban amenities. This trend also affected support for services addressing HCV, with fewer observed cases.

Service Continuity

The majority of respondents (20/31, 64%) expressed confidence that their DCRs were 'very likely' to continue operating over the next five years, with an additional seven considering it 'rather likely.' None found it 'rather unlikely' or 'very unlikely,' while a few (4/31, 13%) found it 'difficult to tell,' noting ongoing pilot phases. Many DCRs expressed optimism about future service continuation, citing government support and perceived community needs. Some suggested the need to expand services to include additional substances or administration routes.



Appendix

Country	City	Organization	CR Name	Contact
Belgium	Brussel	Transit ASBL	GATE	Nicolas de Troyer
France	Strasbourg	Ithaque	Argos	Nicolas Ducournau
France	Paris	GAIA Paris	Espace Jean Pierre l'homme	Elisabeth Avril
Germany	Bielefeld	Drogenberatung e.V. Bielefeld	Drogenhilfezentrum (DHZ)	Jan-Gert Hein
Germany	Berlin	Fixpunkt e.V.	Mobil Drugconsumption Room Project (3 Mobiles)	Sebastian Bayer
Germany	Düsseldorf	Düsseldorfer Drogenhilfe e.V.	Drogenkonsumraum	Patrick Pincus
Germany	Frankfurt am Main	Jugendberatung und Jugendhilfe e.V.	Drogennotdienst	Wolfgang Barth
Greece	Athens	OKANA	STEKI 46	Litsa Lagakou
Iceland	Reykjavík	Redcross	Ylja	Hafrún Elísa Sigurðardóttir
Luxembourg	Esch-sur-Alzette	Jugend an Drogenhëllef	Contact Esch	Martina Kap
Luxembourg	Luxembourg	Abrigado, C.N.D.S.	Abrigado	Claudia Allar
Netherlands	Amsterdam	De Regenboog Groep	AMOC	Cedric Charvet
Netherlands	Amsterdam	De Regenboog	Blaka Watra	Daphne van Zetten
Netherlands	Amsterdam	De Regenboog Groep	Princehof	Wendy Broekhof-Runhaar
Netherlands	Zaandam	De Regenboog Groep	Villa Westerwiede	Maciej Szplitt
Norway	Oslo	Municipality of Oslo, Agency of Welfare	Brukerrommet i Oslo/ DCR Oslo	Christina Livgard
Portugal	Lisbon	Ares Do Pinhal	SAI - Serviço de Apoio Integrado	Paulo Calderia
Portugl	Lisbon	GAT - Grupo de Ativistas em Tratamentos	GAT IN-Mouraria (unofficial DCR)	Maria Luísa Salazar
Portugal	Lisbon	Médicos do Mundo	Programa de Consumo Vigiado Móvel	Adriana Cordeiro de Almeida
Spain	Barcelona	ABD	CAS BALUARD	Ester Aranda
Spain	Barcelona	ABD	CRI LOTUS	Ester Aranda
Spain	Barcelona	Creu Roja	CAS/ARD LLUIS COMPANYS	Patricia Colomera Aguilar
Spain	Barcelona	Metzineres	Metzineres	Aura Roig
Spain	Santa Coloma de Gramenet (Barcelona)	Asaupam	Avda Sanatori, 13	Alicia Molina Hernández
Spain	Sant Adrià del Besòs (Barcelona, Spain)	Hospital del Mar	REDAN La Mina	Francina Fonseca
Switzerland	Basel	Suchthilfe Region Basel	Kontakt- und Anlaufstelle Dreispitz	Horst Bühlmann
Switzerland	Bern	CONTACT	CONTACT	Heidi Chalupny
Switzerland	Biel	CONTACT	CONTACT Anlaufstelle Biel	Simone Schär
Switzerland	Schaffhausen	Tasch Schaffhausen	Tasch Schaffhausen	Nathalie Sander
Switzerland	Solothurn	PERSPEKTIVE Region Solothurn-Grenchen	Kontakt- und Anlaufstelle	Sibylla Motschi
Switzerland	Zurich	City of Zurich	Kontakt- und Anlaufstellen Zürich	Franziska Schicker

Table 1. Contributing Drug Consumption Rooms

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Correlation

European Harm Reduction Network

correlation-net.org

Correlation

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