

Drug consumption rooms in Europe

Models, best practice and challenges



Colophon

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Drug consumption rooms in Europe: models, best practices and challenges

BACKGROUND OF DRUG CONSUMPTION ROOMS

The earliest examples of drug use being allowed in drug service centres, either unofficially or on a semi-official basis, date back to the 1970s in the Netherlands (the Prinsenhof and the HUK Amsterdam) and from the early 1980s in Switzerland ('Fixerraum-Experiment' at the AJZ in Zurich). These initiatives were fundamentally different from today's drug consumption rooms, as the supervision of drug use or distribution of hygienic equipment was not their primary objective. They primarily focussed on protected places for the consumption of drugs and further on to get in contact with people who use drugs. These facilities attracted large numbers of people who use drugs (PWUD) and also suppliers, which created problems both in terms of the dynamics between service users and also in maintaining a safe environment. These experimental initiatives were stopped after a relatively short period of time either by the agencies themselves or after police intervention.

The first drug consumption room (DCR), in a modern sense, was established in Berne, Switzerland in 1986. This was at a time of increasing concern about the spread of HIV/AIDS, the significant increase of drug related deaths, and the growth of public drug scenes in a number of European cities. At that time, it became evident that drug policy focusing exclusively on abstinence (e.g. via detoxification treatment, drug free rehabilitation or imprisonment) was ineffective. It was during this period that 'harm reduction' approaches began to emerge, including needle and syringe exchanges (NSP) and opiate substitution treatment (OST).

88 DCRs have been set up in Europe (2014):

Country	No. of DCRs
Switzerland	13
Netherlands	30
Germany	24
Spain	13
Luxembourg	1
Norway	1
Denmark	5
Greece	1

There are approximately 90 DCRs worldwide, including DCRs outside Europe in Canada (Vancouver) and Australia (Sydney).

In Europe, DCRs are well established in countries like Spain, Germany, the Netherlands and Switzerland. These success stories have stimulated debates about DCRs in a number of countries and, in European countries like Portugal, France, Great Britain and Austria, campaigning groups have been established to champion the cause of DCRs in their countries.

DIFFERENT MODELS OF DRUG CONSUMPTION ROOMS

In the literature (e.g. Hunt and Hedrich) three different types of DCRs are being described:

- **integrated DCR**
- **specialised DCR**
- **mobile DCR**

The integrated model

Integrated facilities are the most common type. These DCRs are typically a part of a broader and interlinked network of services. Today DCRs are mostly based in drug service centres alongside a range of other services, such as counselling and testing for blood borne viruses, drop in centre (DIC) with needle and syringe programmes (NSP), psychosocial care, care for homeless people, medical services (e.g. wound care), and access to employment programmes. Usually the DCR is provided in a dedicated area of the service and the access is normally controlled by staff. This allows staff to limit the number of PWUD using the DCR at any one time and also to manage entry restrictions, most commonly to enforce a minimum age limit of 18 years and also to prevent those in opiate substitution treatment from entering the service (e.g. Germany).



DCR Bonn, the integrated Model

In Bonn (Germany) we find a “prototype” of an “integrated drug consumption room” that includes many services for PWUD. The care and support centre is based directly behind the main train station in Bonn Germany. This integrated model of care provides different services on different floors of the building:

- Ground floor - cafe area with a lounge/sitting area and a kitchen. In addition, there is an area where clients can take a shower and also wash and dry their clothes.
- First floor - a drug counselling centre providing psychosocial support for people in opioid substitution treatment (OST).
- Second floor - Medical Outpatient Clinic provides help with general health care needs and also on this floor OST (methadone and buprenorphine) is provided to more than 220 PWUD.
- 3rd floor - short term inpatient crisis intervention for a maximum of 6 clients using on top of their prescription can stay 3 weeks for detoxification.
- Backyard - drug consumption room with five seats for intravenous use and three for inhalative use and in addition clients can access wound care and syringe and needle exchange services.

Integrated service models are often seen as best practice because clients can access a range of services in one location. However, the Bonn model attracts criticism from PWUD and professional experts and this is addressed in the discussion below.

The specialised model

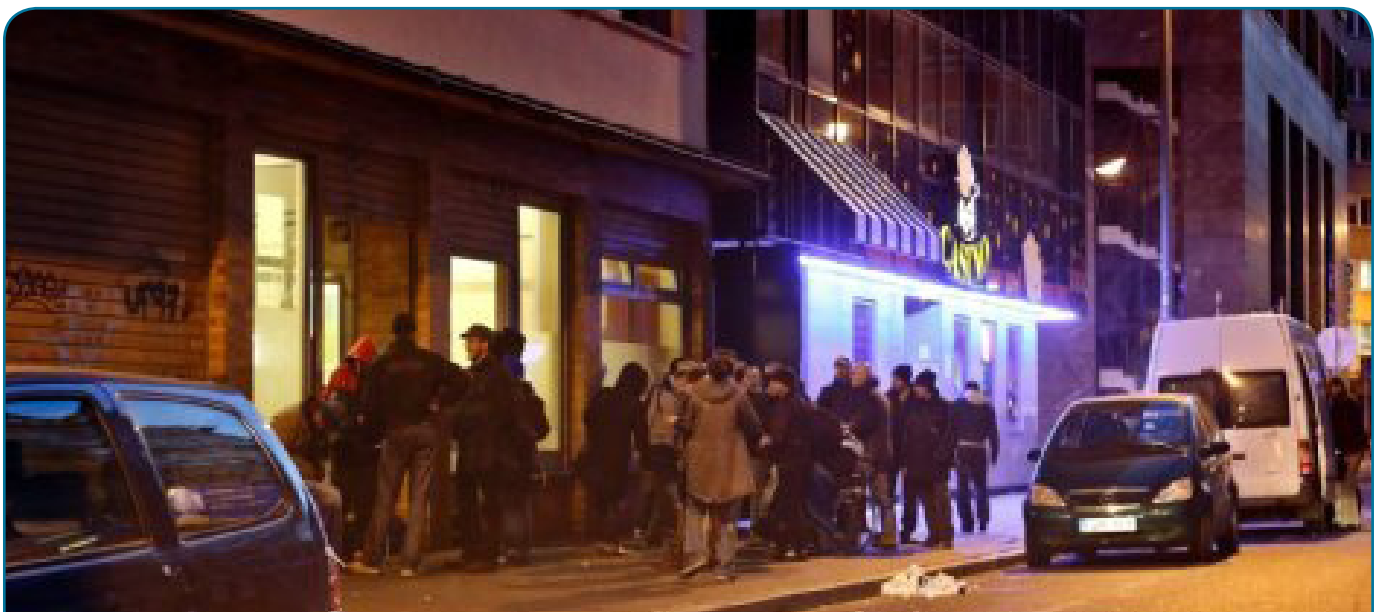
The drug consumption room in Frankfurt/Germany (Niddastr. 49) is an example of a specialised model. More than 100,000 drug consumption events have been supervised in 2012. The facility is located near the main railway station, in close vicinity to a range of other drugs services. It is part of a major non-governmental organisation that runs a range of other programmes, including a night shelter, counselling services, access to employment services, and a methadone maintenance treatment programme. The service follows a three-step admission procedure:



DCR Nidda 49 , Frankfurt

- * Front-desk staff determines whether potential clients meet the general admission criteria,
- * The clients then have to read and sign a declaration that they are 18 years old or older age and that they are not in an OST programme,
- * They are made familiar with the house rules.

When a place is vacant, the client receives sterile equipment and enters the consumption room, usually for about 30 minutes. After consumption, clients clean up after themselves and leave the consumption area. Staff is available to provide information and referrals; medical services are provided in a separate area of the facility at specific times.



In front of the DCR NIDDA49 in Frankfurt, Pic: P.Jülich

Mobile DCRs

DCRs are typically described in the literature as a fixed site service in close proximity to established stable drug markets and the link with such a drug scene seen as a precondition for establishing a DCR. However, mobile drug markets, such as found in underground stations or in large scale cities as Berlin, may require mobile services to meet the needs of clients.

Mobile drug consumption rooms exist in only three European countries - Spain (Barcelona), Germany (Berlin) and Denmark (Copenhagen). Barcelona (population: 1.5 million) and Berlin (population: 3.5 million) are major European cities with established drug markets that have been running since the 1970s. Recent estimates suggest that there are around 7,000 people who inject drugs (PWID) in Barcelona and between 8,000 and 10,000 in Berlin.

Neither city has one large public drug scene and instead, smaller scenes have become established in a number of locations in the cities where dealing and, in some cases, public consumption take place.

The mobile DCRs in Barcelona (Pics. 1 and 2) and Berlin are comprised of especially fitted-out vans that have three injection booths. While the van in Berlin does provide services in different locations, the Barcelona van is currently based in only one location, an industrial area that is a well-known location for the dealing, and use of illegal drugs.



Pic 1 Mobile DCR in Barcelona



Pic. 2 Mobile DCR Barcelona



Pic 3 A look inside the mobile DCR Berlin

Clients of the mobile DCRs are registered after an initial assessment, which provides an opportunity for onward referral. Following registration there are no restrictions on access to the mobile DCR in Barcelona. However, in Berlin, PWID who are in opiate substitution treatment are not allowed to enter the mobile DCR. The general operating principles of the mobile DCR are consistent with fixed site DCRs. The major difference is throughput. With only 3 booths, mobile DCRs inevitably see less people per day than larger fixed-site services.

For example, the typical throughput on a busy day in the Berlin facilities is around 20– 30 injections per day (a total of 4,082 in 2010, and average of 11 per day), which is far less than the average in larger fixed-site DCRs.

A second but related issue concerns the cost of the mobile facilities. Mobile DCR have lower throughput but still require similar levels of staffing to the fixed-site DCRs in the same cities. As such the cost per client is inevitably higher.

Thirdly, normally mobile DCR operate as an adjunct to fixed-site services operating in the cities. The local context is indeed crucial. Barcelona's first DCR was a mobile bus established in 2000. This option was chosen because it provided a more socially acceptable option to a fixed-site service. Importantly, the mobile DCR in Barcelona was an important stepping-stone to the three other fixed site services that currently operate in the city, which have been further complemented by four smaller fixed-site services. Therefore, mobile DCRs can complement, connect and add value to fixed site DCRs.

Discussion – which model would you prefer?

The integrated model of DCR for active drug users provides an important 'one-stop shop' for a range of different harm reduction and healthcare services. Being able to take a shower, wash ones clothes, eat breakfast, receive treatment of abscesses, exchange injecting equipment and consume drugs in hygienic conditions has obvious advantages and attractions. However, while this integration may work well for active drug users, the impact on people being dispensed OST from these centres may be less helpful. Each day they have to manage picking up their OST in the immediate vicinity of the drug consumption room where drugs are bought and sold. This situation may be even more challenging for those in the detoxification centre, as they have to undertake their detoxification while they can hear, smell and must always be aware drugs are being brought, sold and used only a few floors below.

The integration of services for active drug users and those on OST inevitably triggers clients who are trying to stay away from illicit drug use and this provides a risk of relapse. For those people on OST, they face these risks without the benefits of accessing the DCR. People on OST are not allowed to enter DCRs in Germany and attempting to use the service results in the risk of exposure and the impact this may have on their engagement in OST. Sometimes people describe this model as a "hamster in a wheel", as people start in the low threshold cafe before entering OST services. If they need to reduce using on top of their prescription then they can enter the inpatient detoxification centre, however, the close proximity of the DCR means that some discontinue their detoxification and instead start using drugs again in the DCR. The normal checks and balances that would highlight this unhealthy interaction are lost because the costs of treatment and care are all held within one organisation.

The services in the specialised model are much more restricted, however, the advantage is that those PWUD who come into these facilities (e.g. Nidda49 in Frankfurt/Germany) come to use drugs and all PWUD using or waiting around the location of the service all have the same goal. The range of other services is still available but PWUD know that services like counselling or detoxification are provided by another organisation.

Integrated DCRs are part of a wider network of services for people who use drugs. The drug consumption room provides an important additional component of services alongside services like opiate substitution treatment, drop in centres and counselling.

Specialist DCRs focus on protected places for the hygienic consumption of drugs in a non-judgemental environment. They are usually set up close to other drugs services and located near open drug scenes. Specialist DCR focus on the referral to other services like substitution treatment, counselling, housing or access to employment services.

Mobile DCRs are specially fitted out vans with 1-3 injections booths inside. They are able to operate in a variety of settings across a city. Also, they offer a range of harm reduction services, such as syringe exchange, blood borne virus testing, and referral to other services. Mobile DCRs avoid the risk of making one building the focus of all the activity and they can reach people who want to hide or not being seen in the different areas of a city.

BARRIERS FOR ACCESS TO DCRS:

DCRs can only realise their full potential if all those in need have access to the service. Access restrictions still limit the number of people who can benefit from a DCR's services. As such, the aim should be to reduce or remove access restrictions.

All over Europe, we see different admission criteria that exclude PWUD from using DCRs. Germany currently has the strictest criteria for DCRs in the world. Most significantly, the exclusion of people in opioid substitution treatment limits access for more than 70,000 clients of OST services in Germany. Other than Germany, only Luxembourg excludes people in opioid substitution treatment from using DCRs.

Additional admission criteria DCRs in Europe:

- Clients are regular or dependent users and must be 18 years of age or older.
- Some German DCRs accept PWUD if they are at least 16 years old and if they have written consent from their parents.
- The substances the clients carry with them are subject to visual control. There are two staff members present in the DCR at all times, and all staff are trained to resuscitate PWUD if they overdose.
- Occasional or first-time users are excluded.
- Drunken or otherwise intoxicated persons are excluded.
- Some DCRs in Germany, Switzerland and the Netherlands only allow access if clients residing in the vicinity of the DCR.

The negative effects of the admission criteria are well illustrated by research in an unnamed DCR in Germany. On 544 occasions potential clients of the DCR were denied access for the following reasons:

- 150 times because clients were drunk or intoxicated
- 109 times because people were in opioid substitution treatment
- 4 times because people were first-time or occasional users
- 2 times because PWUD were under 18 years of age without a permission from their parents
- 250 times because they do not reside in the vicinity of the DCR

This shows how different admission criteria limit the number of PWUD significantly who should be able to use the DCR. The impact of this is highlighted by reviewing the 98 drug-related emergencies that happened in the vicinity of the DCR during 2013. These people were treated by staff of the DCR who reported that many of these emergencies were directly related to the admission criteria. The PWUD who were affected by these drug-related emergencies did not reside in the vicinity of the DCR, and others were in opioid substitution treatment. As such, there was a direct relationship between the reasons for excluding these potential clients and their risk exposure when they decided to use drugs but without the safety net provided by the DCR. A key lesson from this briefing is that staff in DCRs must be given room for maneuvermanoeuvre, so they can use their discretion and respond to individual needs of clients and their assessed risk exposure.

DRUG CONSUMPTION ROOMS FOR WOMEN WHO USE DRUGS

In the European context and also worldwide there is only one drug consumption room, which focuses exclusively on women who use drugs. The DCR was initiated and operated by RAGAZZA, a facility that specifically addresses the core needs and care of women who use drugs who also work as sex workers in Hamburg, Germany. The team - including social workers, nurses, doctors, lawyers and cultural mediators – is comprised exclusively of women.

In a survey, 80% of RAGAZZA's clients reported that they feel more comfortable and safe among women. In addition, the atmosphere in a woman-only space is more relaxed than is a mixed-gender service. 90% of respondents said that they could speak more openly about their problems and they trusted staff more readily, which made it easier to accept offers of help.

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Other than the Project "RAGAZZA", only the DCR in Biel/Switzerland hosts a weekly two-hour service for women who use drugs. During this time, the DCR is exclusively reserved for women who

use drugs. Various studies have shown that the proportion of women in DCRs varies between 10% and 25%. The particular barriers faced by women trying to enter mainstream DCRs are not well known. However, the experience of those DCRs that offer women-only services is that they can reach out more effectively to women who use drugs. Mixed gender DCRs are not as attractive for women who use drugs given the limited range of specialist services.



DCR with iv and smoking room for female drug user in Hamburg



DCR Biel, Switzerland

DRUG CONSUMPTION ROOMS SAVE LIVES

Illicit drug-related overdose has been recognised as a common cause of morbidity and mortality among PWID. In many countries, fatal overdose is the leading cause of death among PWID, and in response a variety of overdose interventions have been implemented.

Between 1995 and 2013, 6,500 – 8,500 PWUD died each year as a result of a drug related deaths in Europe. In light of the ongoing harms associated with overdose, several studies into the determinants of overdose have been undertaken, with most of these studies focusing on heroin-related overdoses. Opiates play a significant role in relation to drug-related deaths - 32% in Belgium to 96% in Ireland. Despite millions of injections occurring at DCRs over the past 20 years, there has been only one reported death. In December 2002 a PWUD died from anaphylaxis (a severe, whole-body allergic reaction) in a German consumption room (Hedrich, 2004)

Deutsche AIDS-Hilfe undertook a review of 75% of the existing 24 DCRs in Germany in 2013. This study highlighted the high impact of DCRs in terms of preventing drug related deaths.

The study reviewed 584 drug-related emergencies that were documented in 2013. 77% (450) of these drug-related emergencies concerned men and 23% (134) related to women. Information on severity was provided for a total of 503 emergencies and this showed that while 309 drug-related emergencies were classified as minor or moderate, 194 (38.5%) involved severe and life-threatening symptoms. These severe emergencies affected the vital functions (consciousness, respiration, circulation etc.) and as such were life-threatening.

According to the assessment of the workers in the DCRs, these severe drug-related emergencies could have had a fatal outcome if the client had been alone at home or at a public place.

This study highlighted the high-risk combination of poor physical/mental condition at the time of the emergency and the consumption of alcohol and/or benzodiazepines as being the main risk factors. Furthermore, when drug use followed a period of self-imposed or externally imposed abstinence (e.g. imprisonment, detoxification, or rehabilitation) this was another risk factor for drug-related emergencies.

Bringing these high risks into DCRs has been shown to substantially contribute to reducing the prevalence of drug-related deaths, as a result of intoxication, and this reaffirms the message that DCRs save

Discussion

It is welcome news that the number of reported overdose deaths per year in Europe decreased from around 7,100 in 2009 to 6,100 in 2012. However, more than 70,000 PWUD died in Europe in the preceding decade.

Most overdose deaths are linked to the use of opioids, primarily the injection of heroin. Reducing drug-related deaths remains a major challenge for public health policy in Europe. Drug overdose deaths are preventable, and there is evidence to show that DCRs reduce the occurrence of overdose events and prevent fatal outcomes when overdoses occur. Millions of injections have been supervised but only one fatality has occurred in a DCR. Based on the data collected and evaluated in 2013, it becomes evident that prompt and competent interventions by medical and non-medical skilled staff in DCRs prevent an increase in the mortality rate of PWUD.

The type of substances used, the route of administration and the health of the user all have an impact on the risk of overdose. Injecting is also the most hazardous way of using heroin and injecting heroin has resulted in an increase in the numbers of overdose deaths among people using opioid drugs in Europe. Intravenous drug use has been well established as part of the heroin epidemics that spread across Europe in the 1980s. Since 1995, there have been almost 100,000 drug-related deaths reported.

PWID are among those at highest risk of experiencing health problems from their drug use, such as blood-borne infections (e.g. HIV/AIDS, Hepatitis), mainly due to sharing injecting equipment, or drug overdoses and vein damages. In most European countries, injection is commonly associated with opioid use, although in a few countries, it is associated with use of amphetamines. Levels of injecting among people using opioids vary between countries, from 7 % in the Netherlands to 94 % in Latvia.

The available data suggests that the risk of accidental overdose when smoking heroin is substantially reduced compared to injecting. Moreover, the exposure to HIV and Hepatitis B or C infections is also considerably reduced when heroin is smoked.

Many European countries have seen a decrease in injection drug use and an increase of inhalative drug use in the last 10 years. The decrease in heroin injection is observed in all countries, although the decline is more marked in western European countries. In 2009, while the western countries reported that heroin smoking had become the main route of drug administration for more than half of the heroin clients (53 %), in eastern countries, 70 % of heroin clients reported injection to be their main route of administration.

Given that smoking is associated with decreased overdose risks and reduced exposure to blood borne viruses, DCRs should be supportive of the trends towards smoking heroin and other drugs. This is particularly important as having space and time to smoke was seen as a key factor in the switch to smoking heroin in the Netherlands. It is notable that all Dutch and 21 of 24 drug consumption rooms in Germany have separate areas for those who want to smoke their drugs.

Most DCRs in Switzerland reported more seats for smoking than for injecting drugs. By contrast only 3 of the 13 DCR in Spain offer smoking rooms to inhale heroin or cocaine. The increase of smoking drugs was also considered when setting up the new DCR in Copenhagen called "Skyen". This is the first DCR in Denmark with smoking booths for seven users.

Despite the fact that smoking drugs has become more and more common in many European countries, DCRs offer more places for injection use than for inhalative use of drugs with the exception of Switzerland and the Netherlands. Dutch facilities offered an average of 14 smoking places and 5 places for injection. This difference can be explained by the fact that the prevalence of injecting drug use in the Netherlands is among the lowest in Europe.

In light of the growth of smoking drugs increases in many European countries, DCRs which have so far exclusively focused on injecting drug use, should expand their range of services to include a smoking room where PWUD can inhale their drugs. This does not downplay the risks associated with smoking drugs and particularly the significant pressure placed on the lungs and the respiratory tract by smoking.

However, these risks are better managed when engaging people in services, and when comparing overdose or blood borne virus rates, inhalative use is considerably less dangerous than injecting drug use.

Best practise – SMOKE IT! From injecting to inhaling –

The survey “SMOKE IT” in cooperation with 6 DCR in Germany in 2012 demonstrate that the patterns of heroin users can be influenced by a mixture of new prevention tools (pre-cut foils that are uncoated, thicker and thus more resistant to tearing, tubes) and personal interventions, videos and literature. Slightly more than half of the respondents indicated that they had smoked off foil instead of injecting. When the survey participants were asked to indicate why they smoke heroin with the new foil temporarily instead of injecting:

- Almost six in ten (58.9%) said that this method of administration was healthier than injecting.
- Half of the respondents (49.1%) cited curiosity as the reason for smoking off foil.
- One-third (35.7%) identified the reduced risk of infections such as Hepatitis and/or HIV/AIDS was a particularly significant factor.
- One-third of the respondents use smoking foils to avoid the danger of an overdose.
- 30.4% gave the need to give their veins a break as a reason for using foil to smoke heroin.



Inhaling drug allowed, SKYEN, Denmark



Inhaling drug allowed, SKYEN, Denmark

Best practise - the handling of hazardous substances

Some European countries have seen an increase in the amount of cocaine used over recent years. It is estimated that around 2 million Europeans (0.6 % on average) have used cocaine in the last month and it is possible that this figure is an underestimate.

In spite of the fact that more than 80% of cocaine users reported the use of powder cocaine, there are indications that the use of crack cocaine has become more and more common in some European countries. Crack is produced through a process that separates the cocaine base from the hydrochloride, using a process called freebasing, and this produces small rocks of crack cocaine. Unless they buy their crack cocaine pre-prepared, people who use crack cocaine normally use ammonia or bicarbonate of soda to freebase cocaine.

In some drug consumption rooms (e.g. in Copenhagen/Denmark) clients are allowed to use ammonia to produce crack.

Bottles of ammonia can be purchased in Copenhagen in shops in the area surrounding the DCR. As such, people who use crack cocaine carry these litre or half litre bottles of ammonia with them so they can freebase cocaine when required. Many of them use the smoking room inside the DCR to make crack with ammonia, as it is a well-protected and safe environment. After using crack cocaine people will have heightened levels of adrenalin in their system, which can lead to aggression. In addition, cocaine causes disinhibition, which can make people's behaviour unpredictable.

If staff tried to intervene, people using crack throw the ammonia into the faces of the staff, with the risk of serious eye and tissue damage. Initially the option of prohibiting the use of ammonia in the DCR was considered, however, this would mean that many PWUD could no longer use the DCR. Instead DCR staff creates an "ammonia station" which can be used in the 'Smoker Room' to freebase powder cocaine into crack. Rather than to prohibit the freebasing of crack, it is now possible to get 1ml of ammonia in the DCR, which is sufficient ammonia to produce enough smokable cocaine for a few pipes.

The ammonia station: First user must push the button to top one time and then 1 ml of ammonia will come out of the hole in the front.



The employees know that inhaling ammonia is much more harmful and dangerous than using bicarbonate of soda for the production of crack. As a result, alongside the introduction of the “ammonia stations”, staff informs people who use crack cocaine that bicarbonate of soda is the healthier alternative to ammonia. To motivate a change in behaviour, smokers get a glass crack pipe, to prevent TB, HCV, Herpes and other infections, and a small package of bicarbonate of soda. Offering options and harm reduction advice is the right way to change PWUD’s behaviour.

The ammonia station: First user must push the button to top one time and then 1 ml of ammonia will come out of the hole in the front.

CONCLUSIONS

Illicit drug-related overdose has been recognised as a common cause of morbidity and mortality among PWID. In many countries, fatal overdose is the leading cause of death among PWID, and this has led to the implementation of a variety of overdose interventions. The reduction of drug-related deaths in cities, which implemented DCRs is a milestone in the development of drug services.

DCRs address the risks that PWUD encounter each day by providing a clean and supervised consumption facility. The low threshold nature of DCRs, helps them provide a bridging function into other services, which are aiming to further support and stabilise PWUD through access to counselling, entry into treatment, housing support, access to employment, or undertaking social activities.

Three different models of DCRs are described in this briefing:

- ➔ Integrated into a comprehensive drug service,
- ➔ Specialized to only provide hygienic and supervised consumptions
- ➔ Mobile DCRs reaching out in different quarters of a city.

Each of these models have their advantages and disadvantages and the choice of models needs to reflect with the nature of the area, the needs of PWUD and the interests of the wider community. There is no one model that fits all needs. Instead those interested in implementing a DCR have to decide which of these models might fit best with their drug service system.

DCRs are an ideal setting to develop services targeted at specific populations. Only one DCR exclusively focuses on the needs of women who use drugs with only female staff. By responding to the specific needs of women using drugs, the DCR ensured that their female clients felt more comfortable and protected in a women only setting.

DCRs also have an important role in supporting and encouraging the trends away from injecting towards inhaling opioids, which has been promoted by several services in Europe. There is a general trend towards smoking in many European countries and, given the associated reduction in risk of overdose and blood borne virus transmission, these trends should be accommodated and supported by DCRs who should expand their range of services to include a smoking room where PWUD can inhale their drugs. Another growing trend is the increase in the use of crack cocaine use in some European countries. PWUD freebase cocaine to release it from its hydrochloride base but the use of ammonia in particular can create risk for both PWUD and the staff in DCRs. These risks can be reduced by promoting the use of bicarbonate of soda or by giving out small amounts of ammonia in a controlled manner in DCRs. DCRs are an appropriate setting to motivate change among crack cocaine users whether by providing smokers with a glass crack pipe to prevent TB, HCV, Herpes and other infections or by promoting onward referral into services. This reflects a pragmatic and sensible approach to the promotion of behaviour change among people who use crack cocaine.

It can also be concluded that DCRs present a win-win-situation, between the needs of PWUD and the needs of the police and general public who want to avoid public nuisance in cities and especially around parks, train stations and other public spaces.

However, despite the advantages of DCRs to different stakeholders, there remains opposition from politicians and policy makers who do not want DCRs introduced into their country/city. This denial often is the result of traditional public opposition to all harm reduction measures, feeding the myth that these services attract open drug scenes and create public nuisance. For some talking about DCRs may be seen as an acknowledgement that risky drug use exists and is widespread in the city and this acknowledgement may be politically risky. Interestingly, when looking at the countries currently discussing the implementation of DCRs there is no one political party that is in favour of implementing these services. For example in Germany DCRs have been supported in a region ('Länder') by conservative, social-democratic, green or left parties, however, the same parties have opposed DCRs in other regions/Länder. This highlights how DCRs are still politically controversial and professional arguments and evidence-based research can be lost in the midst of these political debates.

However, even once the political barriers are overcome to DCRs, PWUD face ongoing barriers to accessing DCRs and this limits the number of clients using these important services. All over Europe, DCRs operate with admission criteria that exclude PWUD. Germany has the strictest entry criteria for DCRs in the world and in particular this impacts on the 75,000 opioid users in Germany who cannot enter DCRs (except in Hamburg). Therefore, a key recommendation from this briefing is that barriers to accessing DCRs should be removed as much as possible.

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