SAFER CONSUMPTION SPACES

GUIDANCE & RESOURCES FOR THE IMPLEMENTATION, OPERATION & IMPROVEMENT OF DRUG CONSUMPTION ROOMS

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Safer Consumption Spaces. Guidance and resources for the implementation, operation and improvement of Drug Consumption Rooms

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Almost forty years after establishing the first Drug Consumption Room and ninety-two cities with sanctioned facilities, substantial evidence has accumulated to support its effectiveness and role within a continuum of care and support services for people who use drugs. However, implementation remains controversial, particularly at the level of political and public debates.

While other harm reduction services, such as needle and syringe programmes and opioid agonist therapy, have been widely adopted since the 1990s, DCRs did not spread at the same pace. In many cities, the introduction of these services can last for years. In Portugal, the legal basis for DCRs was created in 2001, but the first facility opened its doors eighteen years later. In Ireland, disagreements on the intended location have delayed its opening since 2016. In Scotland, where drug-related deaths are particularly high, these facilities remain illegal under current UK legislation.

These cases exemplify some of the controversies that DCRs spark and the multiple barriers encountered during their establishment. Consequentially, a substantial effort of those involved in its implementation is dedicated to the politics of drugs and drug use, as well as the processes of power (re)negotiation aiming to transform legislation, institutional structures and particular principles for the governance of social life.

However, the politics of DCR implementation extends beyond cultural, ideological or political change processes. It also includes a broad spectrum of direct, transformative and collective practices that aim to transform the immediate, everyday relational and material conditions that allow people who use drugs to sustain themselves.

Still and all, experiences in implementation evidence how situated, practical considerations and negotiations tend to receive less attention despite an equal complexity. Such considerations include, among others, strategies and practices with which to design supervised consumption care support services, the environments they create, and their day-to-day operation, from articulating and improving procedural protocols to responding adequately to the context, needs, preferences and values of the communities they serve. Such questions become even more pressing if a DCR is established in a specific country or region for the first time, particularly in areas with high drug-related deaths or limited access to resources.

Far from being a process with a definite endpoint, establishing a DCR is an ongoing process in which contentious practices are periodically enacted to (re)establish their efficacy and legitimacy. For example, many of these services operate under exceptional and/or experimental legislative frameworks or, as in Liege, Belgium, without political consensus at the national level or an appropriate legal framework. Such frameworks have considerable implications for the sustainability of DCRs, as well as for the services they may provide or the budgets they receive, influencing their long-term impact and effectiveness.

Next to this, to ensure that services can continue working in the best conditions and be understood or accepted, DCRs are required to continuously improve coordination across local, regional and national levels of governance, fostering and maintaining multi-agency partnerships or ensuring that (newly) elected officials have adequate first-hand
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Recognizes the importance of harm reduction strategies, highlights the need for evidence-informed policies, programmes and practices, by the meaningful participation of communities. Specifically, this manual:

Maps and provides orientation on the main areas of consideration when designing and operationalising a DCR in Europe.

Disseminates existing experiences, resources, frameworks and models of practice in the field of DCRs.

Identifies and provides an introduction to current discussions and approaches in the field of DCRs.

Audience

This manual is intended for service providers, including community-based and community-led organisations, policymakers, programme managers and other related health and social professionals, considering establishing a DCR or improving an existing one.

Structure

This manual is organised into distinct sections, each focusing on crucial areas in designing, implementing and operationalising a drug consumption room. Each section builds upon a selection and a synthesis of current

Manual Goals

This manual has been developed with the aim of fostering safe and supportive environments for people who use drugs while simultaneously addressing broader public health concerns associated with drug use. It recognizes the importance of harm reduction strategies, highlights the need for evidence-informed policies, programmes and practices, by the meaningful participation of communities. Specifically, this manual:

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Last but not least, as it also occurs in many other harm reduction services, the operation of DCRs requires continuous improvement to adapt to new patterns of use and types of drugs emerging on the market or to respond to the multiple barriers that people who use drugs experiencing to access the support they need. Broadening the accessibility of DCRs requires the development of new multifaceted models of practice and service typologies to address the patterns of exclusion, criminalisation, stigma, and violence experienced by people who use drugs that contribute to their adverse health outcomes.

Successful DCR implementation cannot exist without changes in both social-institutional politics and its immediate spaces of existence. However, whereas literature on policy mobilisation, analysis or guidelines for commissioning processes exist, practice-oriented resources on DCR design and operationalisation remain scarce and often fragmentary. For this reason, this manual aims to fill this gap and presents recent literature, tools and models of practice to support establishing new and improving already existing DCRs.
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scientific research, guidelines, methods & tools, and field experiences with which to promote curiosity and critical thinking and foster dialogue.

It is important to note that this manual is not meant to be prescriptive or exhaustive. Rather, it should be seen as a starting point – a foundation upon which to build knowledge – and as a set of reference points with the capacity to provide orientation across a diverse range of cultural, political, and legislative environments, as well as community needs, values, preferences or access to resources.

Equally, we invite you to consider this manual as a living document continually evolving alongside developments in research, best practices, and the ever-changing landscape of drug consumption rooms. The current work on Monitoring & Evaluation done by the ENDCR in cooperation with the EMCDDA is an example. Future versions of this manual will include and reference this work.

ABOUT THE ENDCR

The European Network of Drug Consumption Rooms (ENDCR) is a civil society initiative bringing together a variety of DCRs in Europe, representing different geographical areas and service models.

The ENDCR aims to increase the availability, access and quality of DCRs. To achieve its goals, the Network supports and facilitates networking and cooperation among different stakeholders; contributes to and supports research and data and information collection; increases the effectiveness of DCRs through capacity-building activities, promotion of good practice and knowledge exchange; and supports advocacy and dissemination activities at local, national and European level.
WHAT IS A DRUG CONSUMPTION ROOM
Drug Consumption Rooms are commonly defined as services where people who use drugs can use pre-obtained drugs under hygienic conditions, with professional support, and in a safe environment without fear of violence, arrest or legal repercussions. As part of these services, trained staff intervene in the event of a drug-related overdose or other medical complications and provide education on safer use practices. DCRs also supply equipment for drug use and a wide range of other services, including social, medical and mental health care and support, either onsite or through a referral system.

**LOCAL RESPONSES**

Initially established in Swiss, Dutch, and German cities, the first sanctioned DCRs emerged as vital components of local efforts towards reducing the harms associated with heroin epidemics and HIV/AIDS prevention efforts.

These early DCRs aimed to bring individuals who inject street-based heroin closer to healthcare services. Fast forward to the present day, DCRs in North America play a crucial role in addressing the synthetic opioid crisis by striving to reduce the alarming levels of morbidity and mortality associated with opioid use in the region.

Equally as when they were introduced in the late 80's and early 90's, DCRs represent a 'local' response implemented at the community level to address specific challenges within a particular locality.

As a component in a continuum of care for people who use drugs, the localized approach of DCRs allows for responsive strategies to promoted the health and well-being of people who use drugs.

**TAILORED TO LOCAL NEEDS**

DCRs are developed based on a comprehensive understanding of the unique needs and dynamics of a specific community. Successful responses take into consideration, among others, the prevalence and patterns of drug use, local health indicators or the social and environmental factors that increase risk of drug-related harm.

**COMMUNITY ENGAGEMENT**

As with other drug services, active involvement and collaboration with local communities and relevant stakeholders has been identified and an essential component of DCRs design and implementation. By fostering meaningful participation and dialogue, DCRs can ensure that the perspectives of the community are taken into account, ultimately leading to more effective and accepted interventions.

**PROXIMITY & ACCESSIBILITY**

DCRs are typically located within or near the communities they serve. This proximity ensures that the services are easily accessible to individuals who use drugs, reducing barriers such as travel time and transportation costs.
2. WHAT IS A DCR?

FLEXIBILITY & ADAPTABILITY

DCRs have the flexibility to adapt and evolve based on the changing needs of the community. They can incorporate feedback, evaluate outcomes, and make adjustments to ensure services remain relevant and responsive to emerging trends and challenges.

FEASIBILITY STUDIES

There are different ways to plan, design and implement a DCR according to the communities it will serve, existing social and health care networks for people who use drugs and resources available, including funding, space or stuff. For this reason, organisations or partnerships considering establishing a DCR are advised to conduct comprehensive local needs assessments. Organisations are frequently required to complete a feasibility study to assess such a service's needs, effectiveness, appropriateness and sustainability.

The goals of a feasibility study may vary, including, among others, evidencing the need for a DCR through empirical data, measuring stakeholders' perceptions and their acceptability, understanding the willingness to use, examining design and operational preferences, evaluating existing network of drugs services or identifying potential risks.

To ensure the effectiveness, acceptability and integration of a DCR into the local context, organisations or partnerships should engage the local community of people who use drugs, as well as key stakeholders and the broader community, in the planning and execution of such feasibility work.

It is also important to remember that the goals and aims of a DCR may change over time, in accordance with funding and staffing, as well as changes in the needs of its users, local service networks or the local drug scene.

While the specific goals may differ from one DCR to another, certain common features are

DCR GOALS

As a local response, the overall goals of a DCRs are diverse. As such, its goals and outcomes should be aligned with the results of the local assessments as well as achievable with the available resources.
shared among most existing services, highlighting health and safety objectives, both on and individual and collective level.

Firstly, DCRs aim to reduce risks and harms resulting from the ‘risk environments’ that people who use drugs experience as a consequence of multiple interactive physical, social, economic and policy factors¹.

Equally, DCRs aim to enabling access to social, material and affective resources to support the maintenance health and well-being of people who use drugs. By making sterile equipment, advice and emergency intervention available, DCRs contribute to prevent diseases transmission or mortality, contributing to the achievement of public health objectives.

Lastly, by providing spaces for safer and more hygienic drug use, DCRs contribute to reduce drug use in public and improve public amenity.

OVERVIEW OF EFFECTIVENESS

Prevent death by the oversight of drug administration and immediate response to an individual experiencing a drug overdose.

Reduce drug use and related nuisance, including crime, in public spaces.

Reduce transmission of HIV, hepatitis C virus (HCV) and other blood-borne diseases through the provision of sterile drug use equipment and related paraphernalia.

Enable testing for communicable diseases, such as HIV, HCV, sexually transmitted infections (STIs), and tuberculosis (TB).

Reach the most marginalised people who use drugs and do not have access to other services.

Provide primary physical and mental health care.

Promote voluntary access to other types of support such as health, housing, social, economic, and legal services, and evidence-based drug detoxification and treatment.

Provide specialised support to women who use drugs.

Provide ‘real-time’ drug market monitoring data to alert people who use drugs, harm reduction service providers, public health professionals, academic researchers, and law enforcement of highly potent or adulterated batches of drugs circulating in the community that have unintended effects when taken.

Support voluntary behaviour change, including safer approaches to drug use.

MORE INFORMATION | C-EHRN Factsheet: Drug Consumption Rooms. Amsterdam; C-HERN, 2020.

¹ (Rhodes, 2002).
2. WHAT IS A DCR?

TYPES OF DCR

Broadly speaking, three different models have been identified across the literature: integrated, specialised and mobile DCRs.

INTEGRATED DCRs

In this model, the DRC is most commonly set up as a co-located service, integrated within a healthcare facility, such as a hospital or community-based harm reduction agency, and functioning as part of its broader service portfolio.

Here the supervision of drug consumption is one of several harm reduction and social/health services offered, which may include drop-in services with the provision of food, showers and clothing to those experiencing homelessness; shelter; psychosocial care; medical care and voluntary testing for infections; advice, counselling and referral to treatment (of substance use or others); and, in some cases, access to employment programmes.

SPECIALISED DCRs

Where a large capacity is required – such as an important open drug scene –, supervised drug consumption may operate in the form of specialised stand-alone facilities. Whilst they still operate as part of a local network through which their clients can access other health and social services, they are physically separated.

They typically offer a narrower range of services directly related to supervised consumption, including the provision of hygienic drug use equipment and materials, advice on health and safer drug use, intervention in emergencies and a space where drug users can remain under observation after the consumption of a drug.

MOBILE DCRs

In some locations, supervised consumption spaces are provided by outreach vehicles, in particular where several small, dispersed local drug scenes exist in neighbourhoods where there is strong resistance from local residents that has stopped fixed sites from being established; or when funding is limited.

Such mobile DCRs are specially fitted vans or buses with typically one-to-three injection booths. They have the advantage of being less costly (at least to set up) and more flexible, i.e. services can be provided to clients in more than one location.

Limitations exist, such as with regards to the type of drug consumption that can be supervised - usually restricted to injecting as supervision of drug smoking requires a separate compartment within the mobile unit equipped with a robust exhaust system; also, their operations can be severely affected by the weather (heat, wind, rain). Mobile DCRs usually have a capacity for fewer clients due to their small size and limited capacity to offer showers or use of toilets.

Similar to specialised DCRs at fixed locations, mobile facilities work as part of a more comprehensive local network of services. Staff refer (and sometimes accompany) clients to other service providers, as required, to ensure follow-up.
UK’S FIRST UNSANCTIONED OVERDOSE PREVENTION SITE

The United Kingdom, especially Scotland, is experiencing record levels of drug-related deaths. Glasgow is currently witnessing a large outbreak of HIV among people who inject drugs, with particularly high levels of cocaine and public injecting associated with increased risks of HIV and viral hepatitis, overdose, and skin and soft tissue infections. As the impact of drug-related deaths mounts, several expert and political bodies have recommended Overdose Prevention Centres (OPS) to be opened in the UK. However, the UK Government has repeatedly stated this is not possible on legal grounds.

Local agencies in Glasgow were planning to open an OPS with a co-located heroin-assisted treatment (HAT) service. In 2018, this plan was paused as legal barriers to service provision were raised. Two years later, between September 2020 and May 2021, an unsanctioned OPS was implemented by Peter Krykant with no financial or other support from local or national governmental agencies. He acquired a second-hand minibus and equipped it with basic first aid equipment, needles and sterile equipment, and naloxone.

A recent report documents the feasibility to run such a service in the UK without being closed down by the police. Importantly, it evidences a demand for low threshold and peer-informed services among people who are highly marginalised, with complex health, psychological and practical needs.

Safer Consumption Spaces

COMMUNITIES
In the realm of DCRs, it is paramount to recognise the significance of a nuanced understanding the communities they serve. A drug consumption room is not a one-size-fits-all solution but rather a comprehensive service that recognises how health outcomes are produced in relation to various social, economic and cultural factors, particular social positions, and in connection to specific patterns of substance use.

In this section, we echo current debates and presents and range of experiences and insights examining how an individual's different social positions can impact access to and utilisation of DCRS.

Adopting an intersectional lens, these resources highlight the importance of comprehensively analysing the unique challenges and needs of the communities you work with. Additionally, it opens up an opportunity to explore the implementation of models of care that respond to the complex layers of oppression and discrimination experienced by the communities you work with. Lastly, it highlights the importance of undertaking this work with meaningful community participation as strategies that promote holistic well-being.

**PEOPLE WHO USE DRUGS**

**GENRE**

Despite the fact that there are marked differences among men, women and people of diverse SOGIESC in terms of their drug use and health outcomes, less attention has been offered to their access to DCRs, including the need for gender-competent, culturally safe and trauma-informed care. This is especially the case for people of diverse SOGIESC who use drugs, for whom there is a noticeable lack of data or inclusion in policies. Both in international and national frameworks, gender generally remains understood to stand for women and girls. Guidance that recognises greater gender diversity is hard to come by.

As researchers have noted, women – especially racialised and transgender women -, are differentially affected by drug-related risks and harms compared to men who use drugs. Recent works have also evidenced how violence differentially impacts women and people of diverse SOGIESC within street-based drug scenes in relation to determinants of health, such as housing insecurity and homelessness, homophobia, transphobia, poverty, racism or mental health challenges.

Notably, their ability to access and navigate health services is shaped by the same legislative, cultural and individual factors that

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increase their vulnerability in other contexts. Issues of concern include criminalising policies and harsh policing practices that diminish the agency of women and people of diverse SOGIESC who use drugs and their right to access services. Additionally, it is important to highlight the barriers that stigma and discrimination among healthcare workers generate, including the denial of care, provision of substandard care, longer waiting periods, disclosure of confidentiality, or even specific forms of violence.

Within these conditions, DCRs may act as an environmental intervention that can reduce the risks of violence for women and people of diverse SOGIESC who use drugs, disrupting the various forms of violence experienced on the streets. However, their access remains limited, highlighting a need for adaptation through gender-sensitive frameworks that question the inequities that a DCR may be (re)producing, the extent to which it takes into consideration the needs, values and preferences of these communities or its approach to the integration of sexual and reproductive health services.

Next to considerations of accessibility of existing DCRs, gender-sensitive approaches have opened up possibilities for developing new models of service in the very settings and contexts in which women and people of diverse SOGIC use drugs, alongside the expansion of gender specialist models.

Studies provide evidence for a preference among women who use drugs for women-only spaces and how such spaces alleviate the stigma, discrimination and gendered-power relations that women may experience in the ‘masculine spaces’ of mixed-gender DCRs. Also, their capacity to amplify service users’ voices and their empowerment through active participation and sharing of experiences with one another in such spaces. Additionally, the involvement of women and people of diverse SOGIESC in the operation of DCRs as both peer workers and site operators is essential in ensuring positive health outcomes and promoting autonomy, self-esteem and safety.

SEXUALITY

Harm reduction spaces and the services and approaches they contextualise have historically been established through a heteronormative lens that does not adequately consider other identities.

Studies have documented the effect of such roles in generating barriers to the engagement of particular individuals and communities. Issues of concern include the stigma, discrimination and violence experienced by individuals who are perceived as non-heteronormative. Additionally, still currently, frameworks that render LGBTQ+ communities as “at risk” contribute to

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removing their agency and differentially problematising their substance use.⁹

Including relational and intersectional frameworks in the design and operation of DCRs opens space to overcome conflations of sexuality in dichotomous categories and supports establishing services that build upon existing nuances negotiations of sexuality and practices of care among these individuals and communities. Specifically, it provides a basis for considering the productive role in transforming and enacting queer identities.

A DCR FOR WOMEN WHO USE DRUGS

Ragazza is a low-threshold contact point and shelter for women in Hamburg’s St Georg district. It offers the services of a contact and counselling centre and is a meeting place and day-shelter for women who use drugs and engaging in sex work. A cafeteria arranged like a small living room is the first point of contact and a place where women can meet, rest and provide themselves with essentials, or just talk. During its opening hours, Ragazza offers up to four emergency beds in safe surroundings for women who need to rest and recover from street life.

The all-women staff working at Ragazza provide confidential advice, including information on various issues surrounding drug use, harm reduction, safer sex, social benefits and insurance, housing and planning of further life perspectives or medication and medical advice. In the supervised drug use facilities, it is possible to smoke or inject drugs under hygienic and safe conditions in the presence of a professionally qualified member of staff, access sterile syringes and other supplies for safer drug use and safer sex.

MORE INFORMATION | Ragazza e.V.

RACE & ETHNICITY

Amongst people who use drugs, communities of colour remain acutely underserved and underrepresented. In many European countries, there is still a lack of recognition that enduring racial disparities are related to criminalising drug policies and unequal enforcement of these laws, grounded in discrimination and negative racial stereotypes.

A large body of evidence of how race and its intersection with other socioeconomic determinants across generations negatively shapes social and health outcomes, including

imprisonment and restricted access to the health, harm reduction, treatment and social services they may need. The war on drugs, manifested through racial discrimination and equal enforcement of drug law, remains a source of profound racial injustice.

MIGRATION

Europe has been witnessing growing migratory patterns, including migrants who use drugs. Currently, many migrants are entering the EU from Ukraine, a country with high levels of injecting drug use. In addition, a global survey conducted by the World Health Organization (WHO) among migrants and refugees reported that as a result of the COVID-19 pandemic, the use of drugs and alcohol increased by 20%. However, little information is available on the actual drug use among, and characteristics of, first-generation migrants, as well as on the use of and access to drug dependence services.

The availability and accessibility of drug-dependence services for migrants in the EU are limited. The latest data from 2013 revealed that among 180 dependence treatment service centres in European capitals, only 18 (10%) offered services for refugees/asylum seekers and 8 (4%) for undocumented migrants. The main reasons provided for not accessing drug dependence services are poor knowledge about treatment services, language barriers and a lack of social protection, including health insurance and other social security benefits. In addition, fear of experiencing stigma and discrimination, including deportation, and previous negative experiences with drug dependence services in the country of origin prevent migrants from accessing these services upon arrival in the EU.

Concerning best practices, the EMCDDA report on drug-related problems among migrants, refugees and ethnic minorities in Europe identified 121 practices focusing directly or indirectly on drug-related responses for migrants and ethnic minorities.

Finally, in addition to being available, services need to be accessible for migrants who use drugs. Recommendations include actions to improve accessibility, such as focusing on reducing language and cultural barriers as well as stigma and discrimination and increasing knowledge and awareness of available services.

ABILITY

There is a growing appreciation of how ability influences harm for people who use drugs. Clinical and ethnographic studies have demonstrated how physical and mental health

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conditions, such as poor venous access, paralysis, Parkinson’s disease, and depression, resulting from ageing, long-term drug use, and traumatic experiences can create drug-related outcomes impacting the morbidity and mortality of people who use drugs\textsuperscript{17}.

In addition, people who use drugs who have disabilities may require assistance injecting, which is often prohibited at DCRs to minimise the potential for civil or criminal liabilities\textsuperscript{18}.

Substance use and complex mental health experiences are intimately intertwined. However, emotional and psychological support for people who use drugs with an experience of grief, loss, trauma, and other adverse psychological experiences, as well as psychopharmalogical or psychotherapeutic treatment for neurodivergent individuals, is found to be lacking in DCRs.\textsuperscript{19, 20}

Addressing both mental and physical health among people who use drugs is especially important, including anxiety, stress, and feelings of isolation. At the same time, it is critical to recognise that many people who use drugs experience incessant structural forms of violence that shape their access to services like DCRs.

\section*{CLASS}

Structural factors associated with class and income inequality, such as neighbourhood underdevelopment, welfare policies, or insurance schemes, influence drug and health outcomes. Income inequality is inherently racialised and gendered and overlaps with criminal justice practices, including mass incarceration and drug-related arrests, in ways that can increase, among others, health risks for people who use drugs\textsuperscript{21}.

For people experiencing, or at risk of, homelessness and living in poverty, concurrent substance use is disproportionately high\textsuperscript{22}. As such, it may arise as a strategy to cope with the stress of unsafe living situations. Yet, people experiencing homelessness or vulnerably housed encounter unique barriers to accessing harm reduction and treatment.

\begin{flushleft}
\textsuperscript{22} Magwood, O., Salvalaggio, G., Beder, M., et al. (2020). The effectiveness of substance use interventions for homeless and vulnerably housed persons: A systematic review of systematic reviews on supervised consumption facilities, managed alcohol programs, and pharmacological agents for opioid use disorder. PloS one, 15(1), e0227298. \url{https://doi.org/10.1371/journal.pone.0227298}
\end{flushleft}
ESTABLISHING A COMMUNITY-INFORMED MODEL

Efforts to establish a community-informed model began between March and May 2022 in the form of a consortium led by Cranstoun with the participation of EuroNPUD. Its goals are to build a local, sustainable peer-to-peer programme and to engage a peer group of people who inject drugs to review the Cranstoun provision of harm reduction services and to guide the research and development for an Overdose Prevention Centre.

The project team conducted a combination of focus groups, photo-ethnographic and traditional ethnographic fieldwork sessions with people who use drugs in street-based settings. Data generated with people who use drugs was balanced with interviews conducted with local community stakeholders affected by street-based drug use in Sandwell. These methods were used to capture the varied views towards street-based drug use held by different community members in Sandwell.

This project represents a successful example of participative development, building on community networking and mapping, and systematically engaging local community associations and partnership organisations around street-based drug use. This provided important intelligence that informed the selection of the four priority areas identified by the study.


PEOPLE WHO SELL DRUGS

Both experience and research evidence how drug selling or ‘drug dealing’ may arise as an income generation strategy among people who use drugs. In fact, the categories of ‘drug dealer’ and ‘drug user’ are somewhat fluid, with many people who use drugs moving into or out of low-level drug selling depending on circumstances and economic necessity.

When examining the relationship between people who use drugs and people who sell drugs, those who use often describe high levels of trust when buying from their ‘regular’ drug seller and consider a long and

24 Carroll JJ, Rich JD, Green TC. The protective effect of trusted dealers against opioid overdose in the U.S. Int J Drug Policy. 2020 Mar 3;78:102695
trusted relationship with the person selling them drugs as a harm reduction strategy or a source protection against overdose or a harm reduction strategy.  

Despite these circumstances, with few exceptions, harm reduction programmes remain slow to engage with people who sell drugs. In general terms, DCRs tend to focus on their visitors as consumers of drugs and little attention has been paid to developing specific services or strategies through which people who engage in drug selling – often the same people –, could be integrated into its harm reduction efforts.

Due to criminalisation, drug selling represents a particularly contentious issue to be managed through prohibitive approaches implemented by law enforcement agents or the same harm organisations that provide services to people who use drugs. Examples of common institutional practices in DCRs include rules prohibiting sharing or selling drugs – inside or within the vicinity of the facility-, specifying particular methods of drug administration or regulating whether people may receive assistance with injections.

However, validating these acts opens possibilities for developing more effective services that acknowledge the wide variety of drug use experiences and practices of care for the self and others within larger social economic context that remain hostile to drug use.

Focusing on drug selling and buying as key dynamics in the lives of people who use drugs is not a new idea. There exist multiple examples of harm reduction services integrating other practices that are frequently overlooked as “care” because they are associated with criminal acts. However, they rarely are documented. The Peer2Peer Project is an exception, echoing the positive effects of engagement of small-scale drug dealers in opening spaces for outreach teams facilitating their work or supporting the dissemination of information, among others.

However, for this to happen, an in-depth examination of the local norms within the spaces where drugs are used and sold in the community, in partnership with the communities of people who use drugs, is necessary before the development of any programming that aims to integrate people who sell drugs into harm reduction service delivery.

For many harm reduction programmes, meeting people “where they are at” highlights the need to bring focus to the harms caused to people who use drugs by drug prohibition, particularly the harms stemming from an unregulated drug market with no quality control or method of verifying the potency and composition of drugs, and where the risk of arrest and incarceration is ever-present.

A current example of such an approach can be found in the establishment of ‘tolerance areas’ for micro-dealing in places where it does not disturb the general population.

In Switzerland, a 2018 study on street dealing in Bern and Zurich identified how allowing micro-dealing in areas near/in DCRs or some housing services arises as a pragmatic new form of cooperation between DCRS and law enforcement that contributes to reducing the

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amount of dealing around the facilities and preventing public drug use in all other areas.27

### SUBSTANCES

When DCRs were first sanctioned in Europe, many facilities initially catered only for people who injected drugs. In the following years, supervised consumption was expanded to non-injection consumption routes. Admitting those who smoke or inhale heated drugs meant that specific areas of a facility had to be separated and equipped with smoke extraction devices and by creating adequate architectural conditions. However, mirroring general developments in the field of harm reduction, responses to stimulant use remain underdeveloped compared to those for opioid use28.

One specificity of stimulants is a higher injection frequency. Also, the anaesthetising effect of some stimulants on the injection site can lead to a greater risk of injury during subsequent injections. This has implications for the organisational procedures of DCRs and requires adaptation of the provided materials. For needle gauge and syringe/barrel size preference can vary between substances (and injection site), as does the need for specific filters. Also, the stimulant effect of such substances may generate agitation among DCR users. This can create a different dynamic for DCRs to manage, and staff should be trained accordingly. In these cases, it is important to identify strategies to reduce harm and to incorporate how people define and experience the effects and what they do (or will be willing to do) to mitigate unwanted effects29.

There are several harm reduction strategies while using stimulants. One of them is to prevent ‘overamping’, a term used instead of ‘overdose’ because it captures the unpredictability and complexity that goes beyond ‘taking too much’. Overamping describes psychological effects like anxiety, and paranoia, or physical effects like overheating, increased blood pressure, or rapid heartbeat. This happens when people take more stimulants than they intend or can tolerate and it is more likely to occur when the person has not slept, eaten enough food, or is dehydrated. To avoid overamping, it is necessary to drink plenty of water, get enough sleep, and eat sufficient food; and start with a small dose and wait to feel the effects before using again. This is especially important for those who inject, swallow, or use rectally since taking more than planned is easier.

Many cities around the world have experienced substantial increases in crack cocaine use. People who smoke crack experience disproportionately high levels of morbidity, such as chronic and infectious

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diseases, physical health problems, and mental health challenges\textsuperscript{30, 31} even in comparison to other drug-using populations\textsuperscript{32}. Crack smoking is independently associated with HIV and HCV infection\textsuperscript{33} and the incidence of HIV and HCV among crack-smoking populations has been documented to be as high as 7.5\% and 35.3\%, respectively\textsuperscript{34, 35}. Crack-smoking populations are also severely socially marginalised and disproportionately impacted by intersecting social inequities that function to increase their exposure to violence and compromise their health\textsuperscript{36, 37}.

The public health response to crack smoking has been impedied by emphasising drug law enforcement. This has reinforced the barriers that crack-smoking populations encounter in accessing health services and further undermined their health, safety and opportunities to enact risk reduction, such as by discouraging pipe-sharing through distributing safer crack use kits.

However, public health programmes have begun to address crack smoking, primarily through distributing safer crack-use equipment, but their impacts have been limited. The limitations of these programmes point to the need to scale up safer environmental interventions for crack-smoking populations – that is, interventions that reshape the settings in which drug use occurs to promote risk reduction and safety, broadly considered to encompass exposure to social violence. More comprehensive interventions, specifically safer smoking rooms, have been implemented in specific European cities.

In addition, DCRs have experienced the need to adapt to new types of drugs emerging in the market or new patterns of use among the communities they work with. In the Netherlands, for example, an increase in the use of GHB (Gamma Hydroxybutyrate) among existing and new services users has been reported in a recent overview of harm reduction in the country\textsuperscript{38}.

GHB is a central nervous system depressant that is commonly referred to as a ‘club drug’. GHB use is associated with a high risk of overdose and its use is not allowed in almost all DCRs in the Netherlands. However, some facilities permit it to prevent riskier consumption when used alone or in public spaces. A need for discussion has been identified on whether GHB should remain


\textsuperscript{37} Fischer, B., et al. (2007). Ibid.

forbidden in DCRs, or how services can be extended to care for this user group, as well as a need for training of staff in how to respond to GHB.

Furthermore, the same overview identified an increase in the number of those using, or being dependent upon, pain medication among those using DCRs. This is not limited to the ‘traditional’ group of people with opioid use disorders but includes an increasing number of people who became dependent on prescription opioids that they received from their health care professional.

MANAGED ALCOHOL PROGRAMMES

As seen before, the concept of DCRs has expanded to other areas. Managed alcohol programmes (MAPs) focus on individuals experiencing homelessness who depend on alcohol. This strategy continues to gain acceptance, especially providing care to those not interested in, or experiencing challenges accessing, traditional abstinence-based services.

There is promising evidence that MAPs reduce acute and social harms associated with alcohol dependence, particularly in the context of Housing First programmes. Except in Canada, where MAPs have been developed, MAPs are still rare but reported to exist in Australia and a few European countries, including the Netherlands, Ireland, Germany and the UK.

During the COVID-19 pandemic, the need to provide shelters and other services for vulnerable populations scaled-up the implementation of such services, namely shelters with both drug and alcohol consumption rooms. Some DCRs in the Netherlands have been relocated to now function as MAPs.


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In a DCR, staffing levels and composition depend upon the identified needs, operational model - such as delivery platform, typology and amount of care and support services, and opening hours - service capacity, including the number of people making use of the service at the same time, availability of funding and the scope of practice regulations outlined by the authorities.

Equally, decisions on the staffing model balance such considerations with ensuring safety - particularly in relation to possible emergencies - and the quality of the care and support provided. It is also necessary to identify training needs adapted to specific contexts and legislation and consider the medium-to-long-term needs of staff, considering the pressure on carers and frontline staff working in contexts of deprivation and suffering.

STAFFING MODELS

The most common staffing model is a team of health and care workers, such as nurses, social workers or psychologists. In an online census conducted in 2018, most DCRs participating reporting employing nurses (80%) and/or social workers (78%)\(^{40}\). Other typology of staff in DCRs include health educators, employed peer workers, case managers and outreach workers. Less frequently, medical doctors, informal caregivers, and unpaid peers or researchers are involved.

As with other health and social services, DCR teams include professionals that are not part of the clinical team. This includes, among others, administrative, security, and cleaning personnel. However, DCR guidelines or studies often do not document or articulate their contributions or professional needs in this context, although they may be in permanent contact with the users of the services.

Besides variations in functions, there is also great diversity in the number of staff members, ranging between 8 and 71 across European DCRs, and the amount of hours worked [full-time/part-time].

INVISIBLE WORKERS

Many DCRs employ the so-called invisible workforce: cleaners, healthcare aides, assistants, and security officers, although the literature rarely includes their experiences or particular needs. Their work is critical to quality care, maintaining efficient flow, promoting engagement, and ensuring safe and hygienic environments.

Some of these workers have links themselves with wider social marginalisation processes. Individuals performing cleaning roles or security tasks are often linked to disadvantaged socio-economic groups. Often, they experience a lack of training and support, lower pay and worse work conditions, which contribute to less status and attention in the services and teams.

DCRs can consider including non-clinical professionals as supporting staff, as part of

the team, providing opportunities to receive training or supervision, better interact with clients, and deal with and process situations of vulnerability to which they are exposed.

For example, in the DCR Baluard in Barcelona (Spain), cleaners learn about the philosophy of the intervention, they receive naloxone training and information about Post Exposure Prophylaxis (PEP), and they can use the psychologist as any other member of staff because sometimes they are also experiencing violence/conflicts.

PEER INVOLVEMENT

Research has illustrated how task shifting, the systematic redistribution of healthcare tasks from specialised health professionals, helps to reduce health inequities by improving access to care to underserved individuals and communities. Equally, task shifting to peer workers is a successful approach for facilitating the rapid implementation and delivery of low-threshold DCRs in the context of an overdose epidemic, thereby strengthening emergency response capacity in a timely manner. Also, the task shifting approach functions to enhance the effectiveness of DCRs, including by improving service engagement, reducing potential for overdose-related harms, and promoting uptake of other health services among people who use drugs.

Peer Bursary | Bolsa de Pares
The Lisbon Mobile DCR opened in 2019 as the first sanctioned safer space in Portugal. From the beginning, peers were involved as full-time staff. Additionally, a peer programme, called 'Peer Bursary', was developed to promote self-organisation. The programme included flexible payment (by hours or by task) and could define working methodologies and activities. They could also participate in outreach work of the DCR. The most regular activity became the intervention in informal consumption spaces. Another peer group of women started later and became autonomous.

MORE INFORMATION | Peer involvement in low-threshold supervised consumption facilities | Drug consumption rooms and peer involvement: experiences from Lisbon |
STAFF PREPARATION & TRAINING

Across DCRs in Europe, there are no standard minimal levels or set skills, competencies or training requirements for the professionals working there. However, what is common practice is the articulation of roles and responsibilities for all staff and all the mandatory and recommended specific training to implement the care policies, protocols and activities. Training usually takes place both externally and internally. In the latter case, DCR often develop their own training curricula and toolkits.

COMMON TRAINING MODULES

Harm Reduction
This training aims to prepare care workers to support people who use drugs from a rights-based and equity-oriented approach. Commonly, it provides an overview of the principles, ethics, history and foundations of harm reduction and strategies for its implementation. It also includes the role of personal choice in harm reduction, provision of care using non-directive approaches, an overview of the different safer drug use supplies available, and best practices when using and distributing the supplies.

Overdose prevention, recognition & response
This training provides in-depth discussion of overdose response strategies, including overdose prevention, overdose identification (such as differentiating between a heavy sleep and an overdose), naloxone administration, rescue breathing and airway management, and overdose aftercare. Commonly, it also includes information about communication and engagement with first aid and emergency services.

Safer Injection Practices
Safer injection training aims at building the skills of individuals already experienced in drug use and harm reduction who wish to address the specific needs of counselling to improve injection techniques and other health outcomes, such as the prevention of communicable diseases. Commonly, it discusses the differences and preferences for needle length and gauge, as well as needle safety, vein care, the management of common soft tissue infections and supportive tips for finding veins.

Basic Health Care & First Aid
Universal precautions for blood borne pathogens, needle stick injuries, HIV and viral hepatitis (covering prevention, testing and treatment), and sexual health. This includes Cardio Pulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) practice.

Safety & Conflict Management
Usually, this typology of training presents a combination of frameworks, strategies and techniques to reduce the risk of harm in crisis and conflict situations. Topics range from conflict prevention, de-escalation, management and resolution to self-care strategies. Strategies may include violence and aggression prevention, communication
techniques, emotional awareness, persuasion and cooperation, mediation approaches or redirection of negative behaviour.

OTHER TRAINING MODULES

Cultural Safety
In general terms, cultural safety training aims at building personal awareness and emphasising person-centred care for marginalised individuals and communities. Cultural safety involves understanding histories, needs, power imbalances and the influence of care workers' beliefs and values on service delivery. As such, it requires that the care provider prioritises the individual narrative, builds partnerships with the individual to reflect upon and transforms existing power imbalances involved in caregiving.

Trauma & violence informed practice (TVIP)
The focus of TVIP is to minimise the potential for harm and re-traumatisation and to enhance safety, agency and resilience for individuals involved with care systems or programmes. It usually provides frameworks and tools to transform how care systems operate. Also, it discusses trauma and violence and their impact on people's lives. Care workers are supported in creating emotionally and physically safe environments based on personal choice, collaboration and connection and providing a strengths-based and capacity building approach to care and support.

Withdrawal Management
This capacity building activity provides information on withdrawal management for those who, by choice or necessity, are seeking to reduce or stop using particular substances. Particular emphasis is made on reducing risks when weaning off substances like alcohol, benzos, or GHB.

Legal Rights
This workshop provides an overview of legal rights and responsibilities with a focus on how specific law and regulations may be used against people who use drugs. Among others, topics may include drug use and drug possession, homelessness, access to social health and support, or sex work. Also, they may include strategies and communication skills when engaging with police and other law enforcement agents.

Preventing Burnout
This workshop provides an opportunity to discuss stressors and conditions related to harm reduction work and strategies for managing it. As such, it generally provides an overview of strategies that support self-reflection, identification and management of boundaries, identification of burnout and fatigue signs and strategies for emotional resilience.

SUPPORTIVE ENVIRONMENTS

It has long been identified that there is a need for better training and employment conditions for those working in harm reduction. Even before the COVID-19 pandemic began, the demands placed on harm reduction workers
were stressful. In Europe and elsewhere, these care workers frequently feel unsupported, are under-funded, under-resourced and their well-being is affected by ongoing structural factors, such as high employment insecurity, low wages or minimal employee benefits⁴¹, ⁴².

Although they experience the positive effects of its work, harm reduction care workers carry even greater levels of burnout and trauma than other colleagues in hospital and primary healthcare settings⁴³.

The consequences of public health measures introduced in response to COVID-19 led to fewer face-to-face connections. At the same time, the increased toxicity of the illicit market further compounded the overdose emergency taking place in several parts of the world. Additionally, harm reduction staff may experience stigma by association, also known as ‘courtesy stigma’. In addition, many direct care givers have lived or living experience of substance use and have close relationships with the people they support.

In the context of the preparation of this manual, DCR professionals also highlighted the need to guarantee supervision, and develop self-care and motivational strategies. As some activities can be highly stressful, it was also mentioned the need to include strategies that address the provision of care to caregivers and the need to have diversity at work and task rotation.

Equally, it is also advised to create specific communication moments between staff in order to prevent and manage conflicts inside the teams, as well as specific physical spaces to go back to in moments of stress.

DCR professionals also highlighted the need for access to timely care and support, including counselling resources that are gender-, trauma-, and grief-informed and well-integrated approaches to mental health and substance use. The evaluation of equitable staffing models and policies were identified by participant DCRs as priorities to ensure the well-being of harm reduction care workers.

**Employee-specific support**

This includes onsite counselling, employee assistance programmes, support groups, team meetings and debriefings.

**Professional and service support**

Exploration of alternative models of staffing; inclusion of staffing support such as nurses, outreach teams, good practice exchange, monetary compensation, employment recognition, and holidays/leave/absences.

**Supportive leadership**

Hesitation to report emotional impact to their supervisors, fearing it may negatively affect their employment. Adequate training & education programmes Inclusion of staffing support such as for nurses and outreach teams.

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Community & peer support
Equally, important forms of support are activated through family, friends, colleagues or other supportive communities.


Safer Consumption Spaces

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STRATEGIC POLICY FRAMEWORKS

The legality of DCRs and other SEIs has been a matter of debate since their inception, raising various legal questions and concerns. It is, therefore, key to carefully consider the compatibility of DCRs with the existing international and national legal frameworks, as well as to define the conditions and criteria to be taken into account to provide a sufficient level of legal protection for the involved actions.

INTERNATIONAL CONVENTIONS

UN Conventions
The UN Conventions constitute the core international legal framework concerning drug-related issues. The Single Convention on Narcotic Drugs, as amended by the 1972 Protocol, the 1971 Convention on Psychotropic Substances and the 1988 United Nations Convention Against Illegal Traffic in Narcotic Drugs and Psychotropic Substances provide the basis for the debates around the acceptability and operation of DCRs. However, as these services have been largely developed since 1988, the Conventions do not directly discuss them.

The so-called ‘executory’ character of the Conventions imposes obligations on States, but they are not directly or immediately enforceable. In practice, signatory countries interpret them within domestic legislation and it is this domestic legislation that determines questions of legality. Therefore, countries that have already introduced DCRs considered their operation both Convention-compliant and worthwhile.


NATIONAL LEGISLATION

In Europe, each country establishes the main instruments by which the UN Conventions are incorporated within national law. Next to their national legal measure relating to drug use, possession for personal use or supply, States may count with other areas of legislation that have potential relevance to the operation of DCRs. Below we present some legal risks or areas where a prosecution may arise.

It is important to notice that criminal charges are not necessarily brought if a decision to prosecute is judged not to be in the public interest; for example, where a DCR is expected to reduce public nuisance and improve public health. Judgments of this sort can sometimes be formalised in an ‘accord’ between local stakeholders. Such agreement does not alter or overturn the law or remove the powers of the police but defines the expectations regarding the implementation of the law. Such agreements often underpin services elsewhere.

Facilitation or inciting drug use
Many countries have legislation that makes it a punishable offence to make available a room in order to facilitate the use of illegal
drugs. Managers or occupiers could face prosecution.

**Unlawful Possessions**
People using a DCR are in possession of substances they bring to the facility and would, therefore, be punishable since the possession of any illegal (controlled) drug is considered a criminal offence.

**Supply of illegal drugs**
Any user who would share drugs with another commit an offence and are liable to criminal prosecution. Managers are committing an offence if they knowingly permit or tolerate the supply, or attempt to supply, a controlled drug.

**Paraphernalia**
Without specific legislation or regulation, workers are liable to criminal prosecution by providing certain paraphernalia to users, seen as facilitating drug use “by other means”.

**Unlawful practice of medicine or nursing**
DCRs may involve a certain amount of supervision of the injection of drugs by users, including advice on safe injection conditions or observations regarding the (un)lawful practice of medicine or nursing or violations that can lead to criminal prosecution.

**Occupational Health & Safety**
Although the European Union has a solid, binding legislative framework covering health and safety regulations at work, national legislation and how it is enforced varies between European countries. Health and safety legislation requires all employers to implement workplace programmes committed to establishing a healthy and safe workplace, including clearly defined and assigned responsibilities.

**Public safety and order.**
Discretionary competencies can exist to close a DCR on the grounds of public safety and order. Without specific regulations or agreements between the actors involved, this could prove an obstacle for the implementation in certain communities.

**More information**
- Fortson, R. (2019) Setting up a drug consumption room. Legal Issues
- Vader Laenan, F. et al. (2018) Feasibility study on drug consumption rooms in Belgium
- EMCDDA Penalties for drug law offences in Europe at a glance

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**PROCEDURAL POLICIES & PROTOCOLS**

Whether authorised or not, permanent or temporary, DCRs have a set of policies, procedures or service rules that support and articulate their daily operations. Such policies shape, for example, who may use the space, how the service can be used or what services staff can and cannot provide. In the case of authorised DCRs, some operational rules may be determined by formal external constraints such as those described in enabling legislation. Others may be established to meet the needs of external stakeholders.

Operational guidelines have been rarely

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available, especially for unauthorised services and other service models that diverge from the most common ones, such as integrated or stand alone. Recently, some organisations have published their guidance documents to their newly established services. Below we include some examples of existing policies and protocols and references to a selection of examples.

**Admission Criteria**
The 2017 online census among DCRs documents eligibility criteria based on data from 45 DCRs\(^\text{45}\). Access to DCRs is typically restricted to registered individuals, and entry regulations exclude people under 18 years of age and those who have never previously injected drugs. Some of the DCRs offer their services only to local residents. Before using the services, some facilities require individual interviews or registration surveys to be completed. Additionally, some DCRs require signing a ‘terms of use’ document.

**House Rules**
Internal rules forbid violence and drug selling. Moreover, many DCRs prohibit drug sharing or helping other users with drug injections. Some DCRs have a rule limiting the areas of the body a person is allowed to inject. Additionally, some DCRs stipulate a maximum duration per consumption. However, repeated visits on the same day are possible in most facilities.

**Overdose Protocol**
DCRs should count on an overdose prevention and response protocol, addressing onsite and offsite overdoses and ensuring that care workers know their content. This includes identifying areas and spaces where individuals might use substances and be at risk of overdose, such as washrooms and stairwells, and a system for checking these spaces. Also, DCRs should examine their policies and practices to ensure they support a culture of open communication in relation to substance use and overdose.

Policies that penalise specific substances or routes of administration may lead individuals to hide their substance use and diminish the capacity to prevent, recognise and respond to overdose. Additionally, care workers are encouraged to engage the people they work with in overdose prevention conversations and explore together strategies for preventing them and other drug-related harms.

**Health & Hygiene Protocol**
DCRs count with clearly guidelines for all care workers, administrators and authorities that articulate practices for infection prevention and control.

**Emergency Protocols**
DCRs should be prepared as much as possible in emergencies by developing a site-specific emergency plan and ensuring that care workers are familiar with their content and roles. All fire exists must be identified with signs and there should be a designated off-site meeting area where staff and users of the service meet in the event of an evacuation.

**More information**

Blythe, S. et al (2017) This Tent Saves Lives. How to Open an Overdose Prevention Site

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The establishment of procedural policies and protocols is a process that requires particular attention as it requires balancing functionality in relation to external requirements, optimal access to and quality of a DCR and to ensure safety while not excluding those who might need the service the most. As such, one aspect that illustrates common underlying tensions and multiple agendas in the operation of DCRs is revealed in some specific injecting rules that some DCRs articulate, including: prohibition of user-to-user injection or assistance; splitting and sharing of drugs; or the requirement of close supervision while injecting.

Other aspects include the approach of some DCRs to establishing ‘order’ within the service via their design (such as stalls, mirrors, type of spaces), rules (including individual use, opening times, waiting time, amount of time for use), or punishment systems or other daily practices governing conduct.

When existing, such approaches are likely to be implemented to prevent disputes between service users, facilitate access to greater numbers of users, or to limit any legal liability that may exist in relation to criminal charges of drug supply or manslaughter in cases of death-related overdose. However, such regulations may be inadvertently, or by design, at odds with the needs of users and ignore or undermine many of the sociocultural dynamics and existing practices of care among local communities of people who use drugs.

Despite a generally positive perception that users may have about the implementation of DCRs, studies provide evidence to how specific procedural policies and protocols in particular contexts may create barriers to their access, contributing to an increased risk of criminalisation or exacerbating health disparities, particularly in contexts where only one service exists. These studies also illustrate the difficulties that the institutional

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Vancouver Coastal Health (2022) Overdose Prevention Site Manual

The First Seven Minutes. Designing an Overdose Protocol

Engaging in Overdose Prevention Conversations

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regulations that surround DCRs are low-threshold and the power imbalances that may exist between service providers, other stakeholders and those accessing the services.

Given the dynamic complexities of the interplay between macro, meso and micro ‘contexts’, to ensure equity, acceptability and relevance of DCR services, user involvement in all its forms is essential.

Literature on peer-run services remains scarce. However, existing studies provide evidence on how DCRs with fewer rules (or behavioural guidelines that emerge organically from communities of people who use drugs) contribute to an increased engagement with its users, particularly among highly marginalized people who are excluded from accessing other services or those who choose not to due to the protocols and conditions they establish\(^{50, 51}\).

Research on unsanctioned and peer-run services also documents mutual aid and support practices contributing to public health goals that frequently are overlooked as “care” as they do not align with traditional framings of “care work”, standardized biomedical procedures or constitute an offence under specific drug laws\(^{52}\).

The practices of mutual aid and support that drug users cultivate in contexts of social and economic disadvantage remind us that care is a contested concept and practices of care are not neutral. Instead, the concept of care is constrained by asymmetrical power relationships that dictate which practices of care are worthy of attention and to “count” as care\(^{53}\). Recognizing and building upon existing practices of care among local communities offer DCRs the potential to expand the relevance and reach of harm reduction services and contribute to achieve public health goals.

SPLIT & SHARING

Many people who use drugs buy together and split it amongst themselves, colloquially referred to as ‘splitting and sharing’. While this is a common practice, restrictions in DCRs are frequently enacted. Individuals are often requested to go outside to split their substances, exposing them to the risk of criminalisation, including harassment and a higher risk of arrest. Such restrictions also disproportionally exclude specific individuals such as women or people with disabilities.

In Canada, members of the Urgent Public Health Need Site (UPHNS) Community of Practice and the Canadian Association of People Who Use Drugs (CAPUD) have formed a national working group to explore this topic. Its goal is to highlight the impact of current regulations and suggest pathways towards policy change on the issue. The first initiative this group undertook was the development and distribution of a survey for individuals who work at, or are users of, a DCR in Canada.


ASSISTED INJECTION

Peer-assisted injection, sometimes called ‘doctoring’, is a common practice among people who inject drugs. Some individuals require assistance because they lack experience injecting or on account of physical or psychological limitations. Additionally, user-to-user injection may be regular between partners and other close and intimate relationships among people who use drugs, and women are likely to need help injecting, having smaller veins. As such, peer-assisted injection manifest values of empathy, compassion, trust, protectiveness and solidarity.

Only recently has peer assistance been introduced at some DCRs, often through a pilot project. Recent studies brought evidence about how incorporating these practices is a valuable service for more frequent injecting drug users or those more willing to access DCRs.

MORE INFORMATION
Kolla, G., et al (2020) Help me fix: the provision of injection assistance at an unsanctioned overdose prevention site in Toronto, Canada

An approach that has been used effectively in other harm reduction services is to set up Community Advisory Committees (CAC). Ideally, the involvement of key stakeholders should already be established from the planning phases and maintained once the DCR is operating. Overall, CACs or similar platforms can help to:

Plan services that meet the needs of clients whilst also addressing community concerns.
Support public communication activities about the workings of a DCR and inform about public health, public safety, as well as

COALITION BUILDING &PARTNERSHIPS

Although the implementation of a DCR might be initiated by one agency, given the controversy surrounding the implementation of such services, it is advisable to develop community engagement strategies to help ensure its effectiveness and sustainability.


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the social and human rights goals of the programme.

Provide a mechanism where community members can bring their concerns and discuss solutions.

Participate in the development and implementation of service evaluation and monitoring.

The following section are intended to assist in identifying partners and establishing their respective roles.

**LOCAL BUSINESSES**

Drug-related issues can affect a community, including local businesses. Such impact is variable and subjective because it depends on social and individual perceptions about people who use drugs, drug use and related activities (such as drug-related litter, dealing, exposure of children)\(^5^7\).

It is important to take into account specific concerns of businesses when considering implementing or running a DCR. This approach can be similar or even combined with the strategies developed for residents (as described above), such as including business owners and workers in local committees, providing information and organising visits.

Specific strategies can also be used, such as integrating materials, products and services from local businesses or supporting the development of necessary services they may require.

**ELECTED OFFICIALS**

Financing and supporting DCRs is usually a challenge for elected officials, especially when it is understood that public opinion will not be in favour of them. Perceived effects, outcomes and overall sense of cost-efficiency may vary across decision makers\(^5^8\), but showing a sympathetic attitude towards the needs, rights and voices of people who use drugs is usually not prioritised in the political process of setting up DCRs\(^5^9\).

Nevertheless, some factors may favour supportive positions for DCRs in society: when a drug problem is seen as a public rather than individual issue, when health outcomes are perceived, if DCRs are shown to be an effective tool to reduce public nuisance, or a way to reduce visible open drug scenes\(^6^0, 6^1, 6^2\).

Public debate and the involvement of drug user groups, community organisations, service providers, academic institutions and religious leaders may facilitate changes.

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regarding attitudes on drug policy, harm reduction interventions and DCRs\textsuperscript{63,64}.

Taking this in consideration, many strategies can be utilised, such as documenting the needs and outcomes of DCRs, organising visits to existing DCRs and informing public opinion or gathering support from politicians and parties across the political spectrum.

Furthermore, in some cases, civil disobedience (creating DCRs, even if not allowed) has been used to force the removal of legal barriers. In Denmark, the use of an unsanctioned mobile DCR by local activists and organisations was used as a form of grassroots engagement to highlight how the barriers experienced resulted not from laws, but from politics.

\textbf{LAW ENFORCEMENT}

Cooperation with law enforcement is crucial to ensure the adequate functioning of a DCR. To ensure that police actions are consistent with the aims and objectives of a DCR and congruent with both government and community concerns, implementing the following strategies is advised.

\textbf{Local Roundtables}

Local roundtables should be established that bring together representatives from DCRs and other harm reduction services, the police and public prosecutors, and representatives from local health and security departments. These roundtables should meet regularly to discuss questions relating to security, public order, nuisance and feelings of security around DCRs, as well as how to react and intervene in the event of problems.

\textbf{Standard Operating Procedures}

Clear protocols and Standard Operating Procedures help communicate the roles and limits of each stakeholder. These agreements should be understood as procedural as they might be updated in light of new developments, etc.

The agreement between the DCR (contact drop-in centre/Anlaufstelle) and police (police command/EG Krokos) in Bern, Switzerland, is an example. Such agreement is handed out to all police officers to acquaint them with the basic interventions and behavioural codes.

\textbf{Joint Training Sessions}

Many stakeholders, including police officers, report a lack of formal police training on harm reduction. Equally, police forces and social/health workers are not familiar with the tasks and working methods of others. To gain a mutual understanding, training sessions with the support and participation of both DCR staff and police forces is a strategy to help improve the relations between professionals and allow them to learn from each other’s methods or legal backgrounds. Such training sessions can also help to overcome prejudices. On-the-job training sessions would be an additional strategy for both gro

\textbf{MORE INFORMATION} | \textit{Creating and sustaining cooperative relationships between supervised injection services and police: A qualitative interview study of international stakeholders} | \textit{Guidelines for police working}


HEALTH & SERVICE PROVIDERS

DCRs, as other low threshold services, provide support to people with multiple social and health needs. For that reason, even if providing a wide range of services in the DCR, it is important to build a solid referral system and collaborative work with other service providers.

It is important to take into account that referral uptake might vary according to the main drug used and the level of education. Individuals with a history of mental health issues may have a need for more intensive referral support. Strategies like producing a written receipt of health or psychosocial referrals can increase uptake65.

Escorting clients to medical appointments and facilitating patient-provider discussions can also be an effective strategy, especially if developed by peers66.

MEDIA & COMMUNICATIONS

A strategy for working with media, including social media, is an important component of a communication strategy. Opening a DCR will generate considerable media interest and activity in social media and online groups. Preparations include developing key messages and identifying spokespeople for media interviews. Providing spokespeople with media training is recommended.

In the process of working with the media, it is important to negotiate conditions with the media. Nomenclature is critical. Language transmits values and perceptions about the services provided and outcomes. It transmits what it is and what happens there. If it is explained in opaque language, it will not be clear information for the general population, and the people you are trying to reach will not think the message is for them.

Media will also want to interview potential clients of the DCR. While personal stories are often an effective way to inform about the purpose and benefits of a DCR, supporting clients who are willing to be interviewed is critical to ensure they are not exploited through this process. Ensuring client privacy and confidentiality is important.

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CARE DELIVERY
Alongside providing a safe, hygienic alternative to injecting in public, DCRs typically provide a diverse array of services, including low-threshold access to social, medical and mental health care and support.

DCRs provide services that reduce the risks and harms associated with drug use, so they primarily address drug use. Nevertheless, most DCRs work with people with a wide range of needs that go beyond drug use, per se. For that reason, it is important to consider the possibility of providing comprehensive services.

**TYPES OF SERVICES**

Existing DCR surveys confirm the availability of a wide variety of support services, especially at integrated DCRs. Information and training offered by DCR staff target the reduction of risk behaviours, morbidity and mortality among PWUD and the promotion of access to services. Health education at DCRs, often delivered by peers, aims at reducing behaviours such as sharing syringes and other used equipment that put users at risk of contracting infectious diseases, such as HIV and hepatitis C. Safer use training aims at empowering PWUD to use drugs more safely, inside as well as outside the facility.67 68

Emergency interventions provided at DCRs aim at reducing overdose-related morbidity and mortality among service users, thereby not only decreasing the strain on ambulance services but also reducing long-term health consequences and costs.

Furthermore, DCRs promote voluntary access to other types of support, including housing, social, economic and legal services and aim to serve as a conduit for accessing evidence-based detoxification and drug treatment services.

Finally, DCRs can provide valuable ‘real-time’ drug market monitoring data that can be used to alert PWUD, harm reduction service providers, public health professionals, researchers and law enforcement agents about highly potent or adulterated batches of drugs circulating in the community.

**DEVELOPMENT OF NEW SERVICES**

Increasingly, DCRs are incorporating services to address the risks associated with consuming adulterated drugs from the toxic drug supply. These services include incorporating drug checking services69, 70 and the provision of pharmaceutical grade alternatives to street drugs, such as a safe

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supplied\textsuperscript{71,72}, although these services are largely targeted to people who use opioids and often do not address the needs of people who use stimulants\textsuperscript{73}. As these services are relatively recent developments, they were not discussed in the included articles and, therefore, the extent to which they are incorporated within DCRs that allow non-injection routes of consumption remains unclear. However, the current emphasis on innovative solutions to the overdose crisis highlights the need for DCRs to be responsive to the needs of their clients.

Drug-checking services enable individuals to have their drugs analysed, providing information on the content of the samples, advice and, in some cases, counselling and brief interventions. Drug checking has mostly been implemented at music festivals and other community settings. However, recent experiences and studies provide evidence of the feasibility and usefulness of offering Drug Checking in conjunction with DCRs\textsuperscript{74}. The development of straightforward technologies\textsuperscript{75} in combination with the development of self-testing technologies offer opportunities for embedding rapid situation analysis integrated inside harm reduction responses such as DCRs\textsuperscript{76}.

**DCR Zurich**

In Switzerland, where DCRs have existed for decades, drug checking is increasingly seen as an additional harm reduction tool to be used within these services. Since 2020, Drug Checking has been a permanent offer in the Zurich DCRs. Since then, seven drug checking events have taken place periodically.

**DCR Barcelona**

In Barcelona, Energy Control has implemented on-site drug analysis in DCRs since 2019. In their experience, it has required highly portable equipment, conducting non-destructive analyses, the ability to detect a large number of different substances (including NPS) and having space to have conversations to take advantage of the climate of trust generated by these services.

**MORE INFORMATION**

| Ventura, M. (2022) Tailoring drug checking services to Drug Consumption Rooms |
| McDonal K. (2022) Implementing community-based drug checking services in two Canadian provinces |

**SERVICE DELIVERY**

DCR users bring their own pre-obtained drugs and consume them in the presence of staff. Depending on the site, drugs are injected, snorted/sniffed, inhaled/smoked or consumed orally. Trained staff are available to give


\textsuperscript{75} An example is NIRLAB, a portable, instant and destruction-free AI analysis technology for the identification of any narcotic substance. \url{https://nirlab.com}

advice on safer injection practices providing recommendations on the selection of injection site and techniques, as well as information on less risky practices. During and after the consumption process, staff monitor service users for signs of overdose or other adverse events in order to intervene if required. Staff help if there is an accidental overdose or if service users experience physical or mental distress for other reasons (e.g. cardiac arrest or an allergic reaction).

The space where drug consumption takes place is physically separated from other parts of the facility and access to it is controlled. Before entering, staff assess what substance the potential service user is planning to use, give out hygienic drug equipment and material and provide advice on safer use as required. After consumption, the service user moves to a recovery area where they remain under observation.

Besides providing a safe, hygienic alternative to injecting in public, clean consumption equipment and a non-judgemental environment, DCRs typically provide a wide array of services, including low-threshold access to social, medical and mental health care and support. Among a range of survival-oriented services and on-site assistance service users are assessed with regard to their need for referral to further medical services including voluntary drug treatment. Mobile facilities do not provide the same range of on-site services as brick-and-mortar sites due to the more restricted physical space.
FACILITIES & SUPPLY
LOCATIONS

Determining a suitable location for a DCR is important to have good prospects of being effective\textsuperscript{77}. Factors that lead (local) stakeholders to consider introducing a DCR, such as high levels of public drug use and an associated nuisance or a high prevalence of drug-related health emergencies, may point to the general locality where the service should be situated.

Spatial distribution of drug use, ease and proximity to public transportation, proximity to police stations, and the walking distance from areas heavily concentrated with drug use are all vital factors that should be considered when selecting a site for harm reduction projects\textsuperscript{78}. However, local legislation may apply and DCRs may only be located in areas that are not densely populated. Additionally, introducing a DCR in specific locations in town, such as near a school, may convey unintended, symbolic messages to some stakeholders, such as local residents, and contribute to a backlash from an otherwise disinterested community (NIMBY, not in my backyard reactions).

If a DCR is located too far or difficult to reach, a segment of the target population will not be reached. For instance, some studies\textsuperscript{79}, but not all\textsuperscript{80}, indicate that people who use drugs are generally not willing to travel great distances to use a DCR—meaning that the location and accessibility of the DCR are important factors to consider. The intensity of withdrawal symptoms may influence willingness to travel to a DCR\textsuperscript{81}. Travelling presents extra hassles as well as transportation costs, which is often described as a barrier.

VENUE

Understanding the programmatic and spatial requirements of a DCR or other SEIs is a complex process as it should ensure an accessible space where users of the service, staff, peers or volunteers feel safe, supported and motivated. In addition, as with other social or health facilities, specific local regulations regarding hygiene or emergency situations, among others, are expected to be incorporated into their architecture and layout.

To achieve this, it is important to depart from clearly defined goals for each of the services the DCR or SEI intend to offer and the programmatic needs it will require. In her research on DRCs spaces, Hanna Leyland identifies three main dimensions to be fulfilled to design a ‘successful’ service.

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Physical Dimension
The basic programme of the space to save lives, reduce harm and support emergency responses

Psychosocial Dimension
The social dynamics, supporting connection among individuals, and creating a social network of inclusion where people can feel safe and themselves.

Human Resources Dimension
It relates to the professional aspects of a DCR, creating a workplace where workers - including staff with and without lived or living experience of drug use and volunteers - feel safe, prepared, respected and appreciated.

Departing from these dimensions and the goals of the service, it then becomes easier to start identifying and operationalising the most adequate typologies of spaces or materials and its characteristics. Further on, a series of general spatial principles have been identified to contribute to the design and implementation of these decisions.

At the same time, it is also important to consider the timeline by which decisions are made and implemented, and by whom. For example, instead of having a new service available all at one time, building the facility over time would allow trust to be developed. Also, to provide opportunities to its users to co-produce it and 'make it theirs'.

SPATIAL DESIGN PRINCIPLES

Accessibility and visibility
DCRs must be accessible by all people, including those with mobility and cognitive challenges. People should be able to navigate and move within the facilities. Another concern is access to the facilities by ambulance personnel. Doors and hallways must be large enough to circulate stretchers. The facilities must also have appropriate lighting.  

Size
There should be space for multiple clients to enter and interact with staff and other clients. Places for rest and for activities and meetings (besides drug use) should be contemplated. It is important to consider enough space for storage, and places for the team/staff to rest.

Privacy
Private spaces should be available, especially for sensitive interventions such as counselling or health procedures, and phone calls (for referrals, appointments or other private matters).

Safety and Security
DCR spaces should be designed to foster safety for all its users, including people who use drugs, and staff members. Areas should permit easy exit. The design and the distribution of the space should also minimise problems such as opportunistic thefts and physical confrontations. All areas of the site, including the entrance, should be visible and accessible. In addition, spaces containing confidential records, valuable equipment, medication and money should be secured and...

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accessible to staff only.

Studies have found that people prefer spaces where they can sleep or ‘nod off’ without worry of being assaulted, or those with a ‘homey’ feeling where people can socialise. It is also important to consider how noise or high-volume, chaotic sounds may be experienced as stressful and generate a barrier to access, emphasising the importance of relaxation and comfort in these spaces.

Functionality
If possible, it is useful to have different entrances and an entrance separate from an exit. The space and services should be organised in order to avoid lines (queues) and to avoid the concentration of all clients in the same areas.

MAIN SPATIAL COMPONENTS

There are no standard spatial requirements for DCRs. It is, however, possible to consider areas with specific functions. Across different DCR service models, four main programmatic areas have been identified: pre-consumption; consumption; post-consumption; and referrals. During the design phase, each of these can be further unpacked or articulated into more specific spatial typologies according to the services to be provided.

Dimensions and the distribution of the different spaces can be adapted according to the needs and context. Spatial limitations, such as limited injection spaces, result in unmet demand, shape unsafe drug use practices and thereby the increased potential for drug-use related harms. At the same time, spatial constraints in a DCR or SEI can also lead to anonymity and privacy concerns, particularly when service access requires users to enter through an often busy entrance area.

Waiting area and living rooms
The proposed spaces are designed to accommodate participants who are, for example, waiting for access to injection/smoking rooms, or seeking other services. It can also be used for socialising, rest, serving snacks/food and drinks. The space should also be appropriate for informal conversations, group meetings and educational workshops.

Bathrooms
Besides toilets, it should also contain showers. It needs to be accessible to people in wheelchairs or reduced mobility. Even when there is a service to use drugs, some people will continue to use bathrooms to use drugs. This could happen to avoid waiting time to use the DCR or due to stigma, privacy, or fear of others knowing about the use of drugs. There are risks involved in using drugs in bathrooms, including overdosing alone, not allowing the possibility of receiving help. Reducing the risks for people who use drugs, staff and others is possible. Consider the possibility of implementing a plan to make bathrooms safer for people who use drugs, such as through the guidance provided in ‘The Safer Bathroom Toolkit’.  

Consulting room(s)
Consulting rooms can vary in size but should be closed, secured spaces to be used for medical consultations, counselling, and administration.

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Sinks/washbasins should be made available so that clients and staff can wash their hands, especially before and after physical examinations.

Locked closets allow the storage of supplies, including medication, medical records, or other sensitive equipment.

**Staff Room**
Located ideally at the entrance to the Injection/Smoking Room. This space can be used for storing equipment, supplies and medical records; participant registration; controlling access to the room; and dispensing and collecting injection/smoking materials.

**Injection room**
The injection room will allow a defined number of participants depending on the size of the DCR and local legislation. Long or individual counters should be available, made from easy to clean materials. Lights and mirrors can be included to promote safe injection practices. Counters can be located around the room to increase privacy and create space in the middle of the room for managing overdoses. The space should also include a sink for hand washing.

**Smoking room**
Smoking drugs can be done sitting together around a common table. The smoke can be directed immediately to a ventilation system in this format. A large canopy fume hood over the drug consumption table is the best way to collect smoke. It is better that air-borne particulates or residue are collected as close to the source as possible because burning drugs, especially fentanyl, can be risky.

A room can be adapted to allow staff to interact with those using the room without being exposed to the vapours and residues. The room can have a glass door, microphone and an adapted pass-through window to distribute materials easily.

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**SUBSTANCE-SPECIFIC SPATIAL COMPONENTS**

DCRs are encouraged to continuously develop strategies to accommodate the variety of drugs people choose to use and routes of consumption. This includes the spatial features of their services.

Research has shown that people who use drugs prefer individuals to be kept separate within the same DCR facility for three main reasons: (1) the different ‘highs’ produced from different drugs; (2) exposure to different methods of administering drugs; and, (3) concerns about behaviours often associated with smoking crack cocaine.

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In cases in which intranasal consumption could occur, often it takes place in the inhalation or injection spaces, rather than in separated areas. A systematic review found that integrating inhalation spaces in existing DCRs does not require increased resources to operate beyond physical infrastructure (for example, ventilation or outside spaces). However, the literature indicates – with the exception of the Netherlands - that DCRs should include more injection than inhalation spaces.

Next to political opposition, obstacles to its implementation include specific legal frameworks to supervised smoking or the lack of economic resources for the necessary infrastructure. Policies unique to inhalation include overdose interventions, workplace health and safety regulations, special emergency evacuation procedures, the legal framework under which a DCR may be established or compliance with legislation concerning smoking, tobacco and its by-products. Economic issues are usually linked to the development of specific mechanical ventilation systems.

In cases in which inhalation spaces do exist, concerns have been raised regarding how outdoor inhalation spaces are often unsuitable due to weather conditions (such as rain, cold temperature, or wind) and the limitations of provisional safer smoking rooms not specifically designed for drug inhalation.

For this reason, to support its implementation, it is recommended to ensure that funding for such infrastructure (including the ventilation systems required for inhalation areas) is available, either during the planning phase of a DCR or in specific budgets to support the expansion of already existing DCRs.


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A diversity of materials should be made available to better adjust to the drug, injecting site and individual preferences. Materials should be provided onsite and outside the DCR as part of a Needle and Syringe Programme (NSP). In NSPs, materials should be given with no limits and not linked to the return of material. Secondary distribution of equipment should be supported. People who take injecting equipment should be offered sharps containers to dispose and return used materials.

**SAFER INJECTING SUPPLIES**

**Syringes and Needles**
Sterile syringes and needles of different length and gauge should be made available. As a general rule, it is advisable to use smaller and thinner needles, as they effectively reach the vein or muscle. However, in any case, direct communication with the service users should guide choices in syringes and needles supply.

**Cookers**
Spoons or cookers are used for mixing and heating a drug. Some DCRs provide single-use cookers to prevent bacterial infections. Others sterilise spoons frequently for reuse.

**Filters**
Filters support safer injection as it removes fillers, such as powders, coatings) or other solid particles that may cause harm, such as infections, abscesses or damage to the veins, skin, heart or lungs. There are several filter types. The use of sterile, single-use filters is recommended, with the smallest holes possible to capture fine particles.

**Sterile Water**
Drugs may be sold as powder, crystals or tablets. Drugs should be fully dissolved in sterile water when injected to reduce the risk of vein damage and infections. The use of non-sterile water involves risk of bacterial infections.

**Acidifiers**
To inject some drugs, such as crack cocaine and some forms of heroin, the drug must be converted into a water-soluble form by adding an acid. Citric, ascorbic or acetic acid is added to the drug and water solution in a container, or ‘cooker’, to dissolve the drug. Using the smallest amount possible is recommended as a high quantity may damage the vein; ascorbic acid (Vitamin C) comes as a white powder.

**Swabs**
Pre-injection single-use swabs with alcohol are used for cleaning the injection site. Additionally, they may be used to clean fingers and thumbs. After the injection, dry swabs should be used to stop bleeding. Alcohol swabs after injection stimulate bleeding and bruising.

**Tourniquets or ‘Ties’**
A tourniquet, or ‘tie’, is a long strip of elastic that is ‘tied’ around the arm to help raise blood veins to the surface of the skin and even protrude outward. Their use facilitates injection, thereby reducing the risk of injuries.

**Sharp Containers**
Sharp containers are a safe place to dispose of used injection and inhalation materials. Sharp containers are made of hard plastic that needles and glass cannot perforate, reducing the likelihood of injuries. Other injecting paraphernalia, such as swabs and filters, can be placed in medical waste bags or containers.

Appropriate labelling on containers helps to ensure adequate disposal of materials. Containers can be found in a variety of sizes. Personal sharp containers are sized to fit a reasonable number of needles while still being convenient enough to carry. Sharps containers should never be filled above the ‘fill line’, where marked. Once full, they should be locked and returned according to the established protocols (e.g. local hospital).

SAFER SMOKING SUPPLIES

Foil
Kitchen foil has a coating that can be harmful to inhale when heated. For this reason, it is recommended to use specific harm-reduction foil. This material does not have a coating and is thicker to avoid the foil disintegrating and overheating the drugs.

Tubbing
Tubbing is made out of good grade vinyl, comes in different sizes for use in both straight (stems) and bubble pipes (bowls), avoiding burns or getting cuts from chipped edges. The mouthpiece (tubbing) should change per person when re-using or sharing the pipe. In case tubbing is not chosen, rubber mouthpieces may be used.

Screens
Instead of faucet screens, it is recommended to use specific harm reduction screens that do not release toxic chemicals at high temperatures. It is recommended to use several screens (up to 5) into the pipe to stop debris from entering the lungs.

Pipes
Pipes made of plastic, pop cans or copper can release toxic fumes when heated or burned. Generally, pipes made of safety glass are considered a safer alternative as they are less likely to break down and lead to cuts and burns. There are several types of pipes. Those with a bubble at the end are preferred by people who use crystal meth.

Push Sticks
Push sticks are used to pack and position screens inside the pipe, move screens to scrape some of the drug consumption or to clean the pipe. Wooden push stickers are safer than metal ones, as they may damage the pipe.

Lip balm or Vaseline
Prevents cracks and open sores as well as disease transmission.

Alcohol Swabs
It is recommended to clean the mouthpiece often with soap and water, or with alcohol swabs.

Sharp Containers
Sharp containers are a safe place to dispose of used injection and inhalation materials. See previous section.

OTHER SUPPLIES

Face Shields
Rescue breathing is a critical component of an opioid overdose response. Often, DCR staff have access to face shields or pocket
masks and know how to use them in the event of an overdose or other medical emergency. Unless staff have received specialised training and are experienced in their use, it is generally recommended against using bag valve masks.

**Safer Sex Supplies**
Including condoms, internal condoms and aqua lube.

**MEDICINES & MEDICATION**
Besides medication used for broad health care interventions, DCRs should have available medication to manage overdoses or the adverse effects of drug use, if allowed by local legislation\(^91\). It is important to define procedures for the use of these pharmacological interventions and to consider that drug overdoses can be caused by single or multiple drugs (including licit substances or medications).

**Naloxone**
Naloxone is a medication used to counter the effects of an opioid overdose. The medication has no effect if opioids are absent and can be administered by minimally trained lay people. It can be injected (in the muscle or vein) or administered in a nasal spray.

**Olanzapine and Diazepam**
In case of acute reaction or intoxication with cocaine.

**Flumazenil**
Flumazenil is used to reverse the effects of benzodiazepine. It should not be used routinely due to the risk of seizures and cardiac complications\(^92\). Although its use may be controversial in some contexts, we include it in here documenting its appearance in certain protocols.

**Glucosmon**
This can be an option if there is alcohol involved in an overdose. Although its use may be controversial in some contexts, we include it in here, documenting its appearance in certain protocols.

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