Safe Consumption Facilities: Evidence and Models

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Introduction

Safe consumption facilities are “professionally supervised healthcare facilities where drug use can use drugs in safer and more hygienic conditions.” The terminology to describe these facilities varies; terms used include “supervised/safe injection facilities,” “supervised/safe consumption facilities,” ”supervised consumption sites.” In Europe they are generally called “drug consumption rooms.” For the purpose of this report, I will use the term “safe consumption facility” (SCF), unless referring to a specific facility that employs a different term. This report will give an overview of the history and goals of SCFs, basic facility model and staffing considerations, and a review of relevant published evidence, Lastly, I will discuss some important equity and social justice topics that should be considered.

History of Safe Consumption Facilities

The first successful sanctioned drug consumption room (DCR) was established in Berne, Switzerland in 1988, though unofficial facilities had been operating across Europe since the 1970’s. DCR’s were established in several European countries throughout the 1990’s. In 2001 a medically supervised injecting center (MSIC) was opened in Sydney, Australia. In 2003, InSite, North America’s only supervised injection facility (SIF) opened in Vancouver, BC. As of 2014, there were approximately 90 official safe consumption facilities (SCFs) in Europe, Australia, and Canada.

Goals of Safe Consumption Facilities

The stated goals of SCFs vary somewhat across the literature and between facilities, but generally fit into three aims and objectives described by Hedrich et al.:

- Provide an environment for safer drug use
- Improve health status of target group
- Reduce public disorder

Evaluation of SCFs is based on the degree these goals are being met.

Discussion of Evidence Base

The majority of English-language peer-reviewed literature is based on data from Vancouver’s InSite and, to a lesser degree, Sydney’s MSIC. While there are a handful of published English-language reviews of European studies and data, there is an unfortunate dearth of accessible primary source information.

Dozens of studies have been published in well regarded peer-reviewed journals showing that SCFs meet their aims and objectives. Studies on SCFs face multiple limitations including establishing
causality and methodological challenges due to limited and variable data collected by facilities. Nonetheless, the published scientific evidence is overwhelmingly positive.

**Impact on Morbidity and Mortality**

Reducing drug-overdose mortality is a major goal realized of SCFs by providing supervision and medical intervention in case of an overdose. Following the opening of InSite in Vancouver, drug-related overdose deaths in the vicinity of InSite fell 35%, compared to only 9.3% citywide. It is estimated the SIF averts between 1.9 and 11.7 deaths annually. In Sydney, ambulance calls for opioid-related overdoses decreased 68% during the times the MSIC was open. Most overdoses at the Vancouver and Sydney facilities were successfully treated with oxygen, 87% and 70% of cases respectively. Naloxone was administered in 27% and 25% of cases.

Perhaps most notably, despite millions of supervised injections over the years, the literature only references one fatality at a SCF. This occurred at a German facility in 2002 and was due to anaphylactic shock.

Several studies from Vancouver looked at blood borne viral transmission but did not find a direct impact of SCFs on the reduction of viral transmission. This was largely due to methodological challenges. A review of European studies claims reductions in HIV and HCV incidence found by several facilities, but evidence supporting the claims is not cited.

SCF use has been associated with safer injection practices that would theoretically reduce the likelihood of viral transmission. SCFs promote safer injection practices by providing education to drug users, providing clean supplies, and creating a clean, unhurried environment to inject without fear of interaction with police. A meta-analysis estimates a 69% reduction in the likelihood of syringe sharing among SCF users. Another study found an association between SCF use and a decrease in syringe reuse, a decrease of injecting in public, taking the time needed, safe disposal of syringes and other safe injection practices. SIS use was also associated with an 8% increase in condom use during intercourse. SCFs also can offer or facilitate testing for blood borne infections such as HIV and hepatitis B and C viruses, provide risk reduction counseling, and link infected persons to care.

**Cost-effectiveness**

Four studies have looked at the cost-effectiveness of Vancouver’s InSite based on estimated HIV, HCV, and overdose deaths prevented by the SIF. One model estimated a cost savings of $14 million and 920 years of life over a ten-year period. Another study estimated a yearly $17.6 million cost medical cost offset compared to InSite’s yearly $3 million operating cost.

The validity of these studies should be called into question, however. The studies are largely based on estimations of prevention of HIV infections, yet there is no solid evidence showing that SFCs decrease HIV infection rates. This is an area that requires and deserves more rigorous study.

**Impact on Substance Use**

A common concern regarding SCFs is that they may appear to be condoning drug use and lead to an increase in substance use. Two studies in Vancouver found that 25 months after the opening of InSite, there was no significant increase in local people who inject drugs (PWID), no significant decrease in those who started methadone therapy, and no significant increase in relapse rates.
At the same time, there was no significant reduction in the number of PWID. The concern that the establishment of a SCF would increase drug use appears to be unfounded.

**Impact on Public Nuisance and Crime**

Another common concern about SCFs is that they may increase public nuisance and crime in the surrounding neighborhood. Studies in both Vancouver and Australia found no increase in crime, violence, or drug trafficking in the immediate vicinity of SCFs after opening. Similarly, studies in the Netherlands and Switzerland found no observed increase in acquisitive crime after the opening of SCFs. Most European reports have similar results, though a few studies show an increase drug dealing, aggressive incidents, and petty crime around facilities.

A study counting dropped syringes in the vicinity of InSite found a decrease in syringes and injection related litter following the opening of the SCF. Several studies have found fewer people injecting in public spaces following the opening of the SCF, based on local observations and self-reports of facility visitors. (Wood, 2004, Salmon, 2007).

Public perception and opinion of SCFs tend to improve in the time following the opening of facilities in Europe. A survey of SCF managers in Europe showed a perceived increase in acceptance among treatment facilities, shelters, police, and neighbors.

**Critiques**

Many critiques of SCFs exist outside of mainstream peer reviewed publications. The most credible papers critical of SCFs appear to be published primarily in The Journal of Global Drug Policy and Practice. This journal is controversial, and has been criticized as being “driven more by political agenda than by science.” Furthermore, the journal does not return any search results in PubMed.
Nonetheless, an extensive article critiquing many studies on InSite was published in 2007. The author writes “serious problems are noted in the evaluations reporting and interpretation of findings” and goes on to offer critiques of the harm reduction approach in general, as well as 13 articles published about Vancouver’s InSite. 18 The critiques tend to be focused on methodological weaknesses.

An extensive keyword search of PubMed revealed no articles claiming that negative consequences outweigh the positive effects of SCFs.

Service Delivery Models

SCFs vary considerably in size, organization, and staffing models. There does not seem to be one best-practice when designing and implementing an SCF. Characteristics of SCFs and staffing models employed reflect the unique situation of the areas where they are located.

The three basic models of consumption facilities are Integrated; Specialized; and Mobile. A description and some of the key advantages and disadvantages are discussed below.

Integrated

Integrated SCFs are the most common type. The SCF is part of a broader and interlinked network of services housed in the same facility. Examples of services offered include: drop-in center with showers and laundry facilities, counseling and testing for blood borne viral infections, needle and syringe exchange, psychosocial care, employment programs, medical services, wound care, medication-assisted treatment.

- Advantages: “One-stop-shop” offers convenient access to other important health and social services; consistent with current emphasis on offering integrated and coordinated care for persons with complex medical conditions.
- Disadvantages: Integrating a drug consumption space with medication-assisted treatment (MAT) places a burden on individuals picking up their medication. These individuals may be trying to stay away from areas of active drug use; complexity, cost.

Specialized

Specialized SCFs focus on providing a safe place for hygienic consumption of drugs in a non-judgmental environment, while providing referrals to other services. The SCF is usually located in close proximity to other services and near an open-air drug market.

- Advantages: Single focus requires less operational complexity. Referrals to other services are available, just not in house; less expensive to site and operate then more comprehensive models.
- Disadvantages: Access to additional services is not as convenient as an integrated model, creating a potential barrier to accessing services.

Mobile

Mobile SCFs are specially outfitted vans that provide space for 1-3 injection booths inside. They offer a limited range of other services such as syringe and needle exchange and blood borne virus testing and are able to provide referrals to other services not available directly on the van.

- Advantages: Able to reach populations outside the service range of stationary SCFs.
- Disadvantages: Low throughput capacity, limited services offered.

Female-only

Female-only SCFs are focused on addressing needs and care of women who use drugs and also may work as sex-workers. This model offers services to, and is staffed exclusively by, females. An alternative option is to provide female-only hours. In a female-only SCF survey, 80% of respondents reported feeling more comfortable and safe among women only compared to mixed gender SCF.19 90% said they could speak more openly about their problems and trusted staff more readily, which made it easier to accept offers of help.19

Staffing

A survey of European SCFs showed most were staffed by case managers (97%), nurses (87%), and managers (58%). Some utilized students (42%), guards (29%), and people who formerly used drugs (23%). Most offered office hours for a physician (60%) or nurse (84%).16 Staff numbers ranged between 8 and 71, where high staffing numbers were due to use of part time employees. No data was given regarding staff per shift.

Vancouver’s InSite hosts 13 injection booths and is staffed by 9-10 staff per shift; 5 social workers, 2-3 peer staff (most of whom are active users), and 2 RNs.

Conclusion

Safe consumption facilities have existed in Europe for nearly three decades and published studies from Vancouver, BC and Sydney, Australia support their effectiveness and absence of significant harms. There has been one documented fatality at an SCF, despite millions of injections. Very little credible literature critiquing SCFs exists. A variety of service delivery and staffing models have been documented.
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| **Australia** | Location 1 in Sydney  
Staff 1 in injecting room Training: At least 1 nurse, 3 officers with health training | **Eligibility**  
18 years and over  
Already drug dependent  
Not pregnant nor with child  
Not intoxicated  
No dealing of drugs on premises | **Client profiles**  
12,050 clients between May 2001 and April 2010  
3 new clients a day on average  
74% men / 26% women  
33 years of age on average  
13 years of average time injecting | **Cost-effective**  
Contacts vulnerable groups – 9,500 referrals to health and social welfare services  
4,400 overdose interventions (no fatalities)  
Reduced risk of blood-borne virus transmission  
Reduced public injecting and injection-related litter  
No adverse impact on local community (e.g. increase in drug-related crime in area) |
| **Canada**   | Location 1 in Vancouver called 'Insite'  
Staff 9 staff Training: nurses, programme workers (PHS), peer support workers | **Eligibility**  
No admission criteria | **Client profiles**  
1.8 million visitors since 2003  
Between 1st Jan 2010- 31st Dec 2010:  
312,214 visits by 12,236 clients  
855 average daily visits  
587 average daily injections  
74% men / 26% women  
17% identified as Aboriginal | **221 overdose interventions (no fatalities)**  
3,383 clinical treatment interventions  
5,268 referrals to other social and health services  
458 admissions to Onsite detox programme (completion rate in 2010: 43%)  
Reduced risk of blood-borne virus transmission  
Reduced public injecting and injection-related litter  
No adverse impact on local community |
| **Germany**  | Location 26 in 17 cities country-wide  
Staff Number of staff variable according to size of DCR and financial constraints Training: Doctors, nurses, educators, qualified student assistants and freelancers | **Eligibility**  
Age eligibility varies according to state regulation  
Already drug dependent  
Not under OST (except in Hamburg)  
Not intoxicated | **Client profiles**  
In Frankfurt from 2003 to 2009:  
Up to 4,700 visitors per year  
26-35 years of age on average  
85% men / 15% women  
Principal substances used  
82% heroin  
36% crack | **Since 1994, no drug-related deaths recorded in Germany**  
Increased client awareness of safer use techniques  
Less drug-related health problems (e.g. fewer abscesses)  
Data from North Rhine Westphalia (2001-2008):  
3,271 drug emergency cases  
710 CPRs |
| **Luxembourg** | Location 1 in the City of Luxembourg called ‘Abrigado’  
Staff 23 multilingual staff Training: Medical staff, psychologists social workers, educators, sociologists | **Eligibility**  
18 years and over  
Already drug dependent  
Not under OST  
Not pregnant or with child  
Not intoxicated  
No dealing of drugs on premises  
Sign a ‘terms of use’ contract | **Client profiles**  
170,000 supervised drug consumptions (since 2005)  
26,929 visits to DCR in 2011  
207 average visitors per day (Kontakt Café)  
96 average visitors per day (DCR)  
25-34 years of age on average  
80% men / 20% women  
Principal substances used  
87% heroin  
8% cocaine  
5% mixtures | **1,025 overdoses successfully managed (n=3,000)**  
General decrease in overdose deaths and proportion of people who inject drugs in newly diagnosed HIV infection cases since the opening of the DCR  
Citizens hotline established to encourage public acceptance of DCR  
A few complaints from neighbouring communities recorded |
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<tr>
<th>Country</th>
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<tr>
<td>The Netherlands</td>
<td>Location: 37 in 25 cities country-wide</td>
<td>Eligibility: Registered in city where DCR is located  Sign a ‘terms of use’ contract  No dealing of drugs on premises  Different admission criteria according to each DCR  <strong>Staff</strong>  3 staff members  Training: Medical staff, social workers, former drug users, security staff  <strong>Services</strong>  5 ‘stand-alone’ DCRs, others are integrated within low-threshold services  Separate rooms for injectors and smokers  15 booths for smokers, 5 for injectors  Medical and safer use counselling</td>
<td>24 clients per day on average  60% clients are non-injectors  45 years of age on average11  90% men / 10% women12  Principal Substances used: Heroin  Crack/cocaine base</td>
<td>Decrease in needle sharing  Only 4% of new diagnoses of HIV, Hepatitis B and C among people who use drugs  HV incidence rates among people who inject drugs dropped from 8.6% in 1986 to 0% in 2000  94 acute drug-related deaths in 2010 with 20 non-municipal registered people  Significant decrease in public disturbance  High acceptance of DCRs (80%) by social/health providers, neighbourhoods and police</td>
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<td>Norway</td>
<td>Location: 1 in Oslo</td>
<td>Eligibility: Heroin only substance allowed  18 years and over  Sign a ‘terms of use’ contract  Long term history of injecting heroin  <strong>Services</strong>  Limited to one dose of heroin per client per visit  Integrated with harm reduction services  Links with social and health services  Links to drug dependence treatment programmes</td>
<td>2,480 registered clients since 2005  1,500 clients per year  109 clients per day on average (2011)  37 years of age on average  70% men / 30% women  Principal substances used: Heroin is the only substance allowed to be used in the DCR</td>
<td>Reduced perception of social exclusion among the user group  Increased access to professional assistance in overdose situations  Increased access to health and social services</td>
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<td>Spain</td>
<td>Location: 7 in 4 cities country-wide, including 1 mobile DCR</td>
<td>Eligibility: 18 years and over  Sign a ‘terms of use’ contract (in the Barcelona DCRs)  <strong>Services</strong>  3 DCRs allow smoking  Links to social and health services  Links to drug dependence treatment programmes  In Barcelona: HIV testing and counselling, health care and social, psychological and legal support</td>
<td>105,804 visits from 5,063 clients (2009)  34 years of age on average  80% men / 20% women  Principal substances used: Cocaine most popular (except in Bilbao and Sala Balaud in Barcelona, 2009)  Heroin most popular (Barcelona, 2011)  Speedball most popular (Madrid, 2011)</td>
<td>Decrease in overdose deaths from 1,833 in 1991 to 773 in 2008  Decrease in new HIV infections among clients from 19.9% in 2004 to 9.2% in 2008  High acceptance and demand for DCRs  Reduced injection-related litter in public spaces  Community awareness about DCRs as a public health strategy  Development of common guidelines on harm reduction and DCRs</td>
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<td>Switzerland</td>
<td>Location: 13 in 8 cities country-wide</td>
<td>Eligibility: 18 years and over  Already drug dependent  Have official documentation  No dealing of drugs on premises  No consumption tolerated outside the DCR itself (e.g. canteen, toilets)  <strong>Services</strong>  Booths for intravenous use, smoking and sniffing (numbers vary according to the DCR)  Canteen with food and non-alcoholic beverages  Medical treatment  Consultations for social problems  Hygiene services (showers, provision of clothes)  NSP  Links to drug dependence treatment programmes and clinics</td>
<td>No country-wide data  In Berne:  38 years of age on average  992 registered clients a year  74.1% men / 20.9% women  Principal Substances: No country-wide data  In Berne:  Heroin  Cocaine  Benzodiazepines  Cannabis  Substitutes  Alcohol</td>
<td>Decrease in drug-related deaths  Increased client awareness of safer use techniques  Reduces risk of blood-borne virus transmission</td>
</tr>
</tbody>
</table>

Source: IDPC Briefing, 2012
References


