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Lausanne

SHORT APPRAISAL OF THE ROLE AND
USEFULNESS OF DRUG CONSUMPTION
FACILITIES (DCF) IN THE REDUCTION OF
DRUG-RELATED PROBLEMS IN
SWITZERLAND

Appraisal produced at the request of the
Swiss Federal Office of Public Health

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SUMMARY

The Swiss Federal Office of Public Health (SFOPH) commissioned the University Institute of Social and Preventive Medicine (IUMSP), Lausanne, to produce a short appraisal of the role and usefulness of drug consumption facilities (DCF) in the reduction of drug-related problems in Switzerland. This work is based on the best available knowledge, i.e. the results of research projects and evaluations conducted both in Switzerland and abroad.

Six questions were formulated for the purposes of the appraisal:

- Do DCFs help to reduce morbidity among drug users, in particular by reducing the transmission of viral infections (HIV, hepatitis)?
- Do DCFs help to reduce mortality among drug users, particularly by reducing the incidence of fatal overdoses?
- Do DCFs help to achieve better assistance to drug users, particularly by providing a point of access to the social-service and health-care network?
- Do DCFs help to improve the situation where public order is concerned, in particular by reducing drug use in public places?
- Do DCFs tend to increase the number of injecting drug users and/or the frequency with which they inject?
- Do DCFs have a negative effect on entry and retention in treatments for drug use, and on the success of such treatments?

An additional question was asked for DCFs with an inhalation room, resulting in a separate analysis.

In general terms, the appraisal, based on the best available knowledge, shows that to a large extent DCFs achieve the objectives set for them, and that the criticisms made of them are rarely justified. In fact, DCFs help to:

- reduce risk behaviour likely to lead to the transmission of infectious diseases, particularly HIV/AIDS, among the population of the worst affected drug users;
- reduce the incidence of fatal overdoses and, therefore, the mortality rate in this population;
- establish and maintain contact between this population and the social-service and health-care network, within which low-threshold facilities (LTFs) are often the First point of access because of the care and social assistance they offer;
- reduce public order problems, particularly by doing away with open drug scenes, reducing drug use in public places, recovering used syringes, and reducing the impact of drug problems on residential areas (apartment buildings).

At the same time, the available data do not indicate any specific detrimental effect on:

- the number of drug users and the frequency with which they use drugs; the figures are falling in both cases;
- entry and retention in treatment, because the majority of DCF users are undergoing treatment, the proportion of those in treatment is growing, this subject is tackled within the facilities, and the users themselves state that DCFs do not have any major influence on their treatment.

All of these observations relate to the overall level of public health and do not mean that DCFs may not have negative effects in some individual cases. However, on the basis of existing knowledge, it would appear that the overall effect of DCFs on drug-related problems is positive.

In the special case of DCFs with an inhalation room, the above is less convincingly proven. Although such facilities do indeed reach inhaling drug users, it has not yet been possible to ascertain whether or not they can achieve their declared objectives (establishing a point of contact between inhaling drug users and the social-service and health-care network, reducing public order problems, encouraging the switch to less high-risk forms of drug use). Further research is therefore required, especially in respect of:

- the capacity of DCFs with an inhalation room to serve as a point of contact between inhaling drug users and the social-service and health-care network;
- the toxicity of the different substances inhaled and the measures that need to be taken in consequence;
- the extent to which users switch to and continue in another form of drug use, and the consequences.

1 INTRODUCTION

The Swiss Federal Office of Public Health (SFOPH) has commissioned the University Institute of Social and Preventive Medicine (IUMSP), Lausanne, to produce a short appraisal of the role and usefulness of drug consumption facilities (DCFs) in the reduction of drug-related problems in Switzerland.

1.1 NATURE OF THE APPRAISAL

There has been considerable growth in research and evaluation in the field of drug-related problems in the last fifteen years, with a consequent rapid increase in data and publications on this subject. However, the nature of these problems, their long-term character and the diversity of interventions targeting drug users make it difficult to build up a body of scientific evidence in this field. This is true of both prevention and assistance (treatment and harm reduction) activities. Therefore, a scientific appraisal in this field has to be made not by gathering a body of irrefutable proofs, but by summarising the best available knowledge. The work presented here is of this kind. It attempts to answer a series of questions, arising from the arguments of both supporters and opponents of DCFs, by referring to the best existing information and data.

1.2 QUESTIONS FOR THE APPRAISAL

There are two types of questions on which an assessment of the role and usefulness of drug consumption facilities (DCFs) can be based. The first are concerned with the objectives set for such facilities and the extent to which they achieve them. Questions of the second type are concerned with the principal criticisms made of these facilities, the truth or falsehood of which needs to be verified.

The first four questions are concerned with the extent to which DCFs achieve their principal objectives:

- Do DCFs help to reduce morbidity among drug users, in particular by reducing the transmission of viral infections (HIV, hepatitis)?
- Do DCFs help to reduce mortality among drug users, particularly by reducing the incidence of fatal overdoses?
- Do DCFs help to achieve better assistance to drug users, particularly by providing a point of access to the social-service and health-care network?
- Do DCFs help to improve the situation where public order is concerned, in particular by reducing drug use in public places?

The two following questions are concerned with the two principal criticisms made of DCFs:

- Do DCFs tend to increase the number of injecting drug users and/or the frequency with which they inject?
- Do DCFs have a negative effect on entry and retention in treatment for drug dependence, and on the success of such treatment?

Four Swiss towns (Zurich, Basle, Berne and Biel/Bienne) have recently been equipped with DCFs with an inhalation room. This new development merits separate analysis, and each of the above questions also needs to be asked in respect of these facilities. In addition, facilities of this type attract a particular criticism, which also needs to be examined:

- Do DCFs with an inhalation room tend to aggravate drug-related problems, in particular by encouraging users to switch from drug use by inhalation to drug use by injection?

Taken together, these questions are specifically concerned with whether DCFs tend to alleviate or aggravate the problems associated with drug use. However, these facilities do not operate in a social or institutional "vacuum", therefore one can only rarely isolate their specific effects and give a definitive answer to the questions set out above. To date, it has not been possible to carry out experimental research (RCTs), mainly for technical reasons. Therefore, in order to answer the questions, it is often necessary to adopt an "environmental" approach based on comparisons between towns/cantons with DCFs and those which do not have them, and on general trends in the indicators used for measuring drug use in Switzerland.

1.3 DATA USED FOR THE APPRAISAL

Switzerland has a large body of data concerning DCFs and their users. The primary sources are evaluations and analyses of facilities with an injection room¹⁻⁹ and, in some cases, also an inhalation room¹⁰⁻¹⁴. Moreover, the activities (making of contacts, distribution of syringes) of low-threshold facilities (LTFs) in Switzerland, including those with an injection room, have been monitored each year since the First half of the 1990s^{15,16} and studies of their clients have been conducted on four separate occasions (1993, 1994, 1996, 2000¹⁷⁻²⁰).

Data of Swiss origin can now be supplemented by or compared with data from other countries that have introduced DCFs (Germany²¹, Netherlands, Spain, Australia). The knowledge acquired as a result of evaluations and analyses of these facilities has been summarised on two occasions in recent years^{22,23} and is currently being summarised again by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), which will be publishing a report on this subject in the First quarter of 2004. A special edition of a scientific periodical was also devoted to this topic in 2003 (Journal of Drug Issues, Vol 33, No. 3).

Epidemiological data concerning drug use in Switzerland have been gathered from various sources (health surveys, statistics relating to treatments, deaths, HIV infections, criminal charges in respect of drug use, confiscations of drugs, etc). These data have been summarised on four occasions by the IUMSP as part of its global evaluation of the Confederation's measures to reduce drug-related problems (ProMeDro)^{20,24-26}.

2 SWITZERLAND'S DRUG POLICY AND THE ROLE OF DCFs

Initially, the Swiss drug policy consisted exclusively of activities intended to reduce the supply of drugs (legal action against trafficking) and to reduce demand (action against users, primary prevention, treatments geared to abstinence). In the mid-1980s, several Swiss towns and cantons developed a new area of activity – harm reduction – to counter the acute problems associated with an increase in the intravenous use of heroin and the spread of HIV/AIDS. The objective was not to replace activities intended to reduce the supply of and demand for drugs, but to complement them.

This model was taken up by the Federal Government in the early 1990s and given official sanction in 1994 under the name of the "Four-Pillars Policy" of prevention, treatment, harm reduction and law enforcement^{27,28}. The adoption and development of this policy was based in particular on the findings of the work carried out by various federal commissions of enquiry^{29,30}, and also on the support given by three of the country's four main political parties.

The strategic model adopted by Switzerland, and now widely used in other parts of Europe³¹ and in Australia and Canada, is pragmatic in its approach, based on the identification of concrete problems associated with drug use (morbidity, mortality, social problems) and the development of the most effective measures for reducing them. Prevention, treatment, harm reduction and law enforcement constitute a broad range of complementary interventions, the overall effectiveness of which needs to be constantly improved, particularly by the application of research and evaluation.

2.1 HARM REDUCTION

The third pillar of the federal policy is concerned with a specific population group: drug users who are not ready or able to stop using drugs. Its objective is to limit the risks and harm associated with drug use. The measures concerned are intended not only to reduce morbidity and mortality rates, but also to enable users to look forward to their future reintegration into society.

Harm reduction comprises both health measures (distribution and exchange of syringes, supervised drug consumption facilities, information on the dangers associated with substances and the different ways of using them) and social measures (contact and counselling, assistance in finding employment and accommodation). In some cases, the two types of measure are combined within one and the same facility. Today, all the Swiss cantons are implementing harm reduction measures.

2.2 FACILITIES WITH A CONSUMPTION ROOM (DCFs)

Most Swiss cantons have low-threshold facilities (LTFs) which distribute syringes. In six cantons, at least one of these facilities has a drug injection room. At present, there are thirteen DCFs, in seven different towns^a. The principal objectives of these facilities are:

- to reduce deaths, infectious diseases and other health problems affecting drug users;
- to provide a point of contact and social support;
- to facilitate access to the care and treatment network;
- to improve the situation in the neighbourhood and get drug users off the streets.

^a According to information supplied by the BRR (Office for the Reduction of Drug-related Harm).

Most of the DCFs in Switzerland (10) now also have a room where clients can inhale substances^a. The provision of these facilities is presented as a response to the emergence of new groups of drug users and changes in practice where drug use is concerned. The overall aim is to continue to offer low-threshold facilities for heroin and cocaine users in pursuance of the harm reduction strategy, and provide counselling and referral to the social-service and health-care network. In addition, the provision of inhalation rooms is seen as a way of getting drug users to reduce or abandon injecting and switch to a lower-risk form of drug use.

Contrary to the widely held view, it is not true that the activities of DCFs are limited to the supervision of drug use (injecting and inhaling). The facilities in fact provide a range of easy-access services (contact, meals, washing facilities, health services, distribution of syringes and condoms, etc.) for the worst affected drug users, and they also act as mediators with the general public in the districts most prone to drug problems. In addition, they are often the First point of access to the social-service and health-care network set up to manage drug-related problems.

The following table summarises other features of the service provided by DCFs.

Table 1 Features of DCFs in Switzerland¹¹

Services	Coverage
Cafeteria / contact point	All
Showers / washing machine	Several
Basic medical care: dressings, doctor in attendance on a weekly basis	Most
Emergency resuscitation	All
Information, counselling, guidance regarding the care network	All
Services specifically for women (separate times, gynaecologist, etc.)	In two towns
User participation (meetings, satisfaction questionnaires)	All
Work with the public (information, visits, etc)	All
Networking with other care and treatment structures	All
Support groups (authorities, other facilities, neighbourhood, etc.)	In three towns
Restricted access:	
Minors (< 18)	All
First (i/v) use of drugs	In two towns
According to place of residence (town/canton) or status (asylum seekers)	Several

Source: BRR data

Three successive surveys have shown that a majority of the Swiss population (63% in 1991, 76% in 1994 and 72% in 1997) are in favour of the provision of supervised injection rooms³².

3 EPIDEMIOLOGY OF DRUG DEPENDENCE IN SWITZERLAND

3.1 NUMBER OF DEPENDENT DRUG USERS IN SWITZERLAND²⁰

The most recent estimate (arrived at by comparing data from different sources) of the number of people who regularly use heroin was made in 1997. The number was reckoned to be between 23,400 and 32,000, with an average figure of 28,000³³. This estimate is in conformity with the estimate made for the period 1992-1993, when the number of regular heroin users was reckoned to be between 20,000 and 36,000, with an average value of 30,000³⁴. It is generally thought that the number of dependent heroin users rose in the late 1980s and early 1990s, before levelling out, then beginning to fall towards the end of the 1990s. There are no such estimates for the regular use of cocaine.

3.2 MODES OF CONSUMPTION²⁰

Data for the ways in which drugs are used can be obtained by conducting surveys of drug users¹⁷. In Switzerland, it is the national survey of clients of low-threshold facilities supplying injection material (LTFs) which serves this purpose³⁵.

Most of the clients of these facilities use drugs intravenously. Approximately 90% have already injected drugs and a slightly lesser percentage have done so during the last six months. However, the surveys show that the level fell from 85% in 1993 to 79% in 2000. Similarly, the proportion of new injecting drug users (i.e. those who have injected for less than two years) also fell sharply between 1993 and 2000, dropping from 30% to 7%. The figure for the average number of injections per week has also been falling, from 18.9 in 1994 to 13.7 in 2000.

Heroin is the substance used most regularly, several times a week in the case of half the clients of LTFs, though there seems to be a slight decrease in regular consumption. Use of cocaine and cocktails (mixtures of heroin and cocaine) increased between 1993 and 1996, then showed a decrease in 2000.

There is still very little information about drug use by inhalation because, until very recently, LTF services were intended mainly for injecting drug users. A recent survey of new clients (N= 471) of an LTF which has both an injection room and an inhalation room shows that more than half of the clients indicated inhaling (28%) or inhaling and injecting (24%) as their principal mode of drug use¹⁴. These results are corroborated by others: in 2001, 28% of a group of patients beginning methadone substitution therapy in a Zurich outpatient clinic (ZOKL1) had used heroin exclusively by inhalation¹². Finally, various sets of data, also from Zurich but relating to the second half of the 1980s and the First half of the 1990s, show that there was already steady growth in this mode of drug use at that time³⁶.

3.3 SOCIAL AND DEMOGRAPHIC CHARACTERISTICS OF DRUG USERS²⁰

From the survey of LTF clients and from treatment statistics (outpatient and residential), it is possible to draw a profile of drug users in Switzerland. Women account for between 23 and 30%. The average or median age of users varies from one type of facility to another: it is highest (approximately 32 years old) in the case of LTF clients and those who are prescribed heroin under medical supervision, lowest (approximately 28) among those undergoing outpatient and residential treatments. However, it is observable that the average age of all these groups is increasing.

Where accommodation is concerned, the situation has improved slightly in recent years, with a decrease in the number of people who are homeless. On the other hand, there has been no improvement in access

to employment. The situation of LTF clients would seem to be the most precarious in terms of both accommodation and employment.

3.4 EXPOSURE TO THE RISK OF INFECTION AND ADOPTION OF PROTECTIVE MEASURES^{37,38}

The surveys of LTF clients cover the issues of exposure to risk and the adoption of preventive behaviour. The proportion of users who have recently (i.e. in the six months preceding the survey) used a syringe/needle already used by someone else is around 10%, and may perhaps be rising slightly (9% in 1994, 11% in 1996, 12% in 2000). Sharing of the material used to prepare an injection is more common, and this may explain the high rate of hepatitis C infection (see below). Nevertheless, this practice decreased slightly between 1996 and 2000 (from 68% to 51% for the sharing of spoons and from 46% to 38% for sharing of filters).

A distinction can be made between users who run the risk of infection from previously used material and those who do not: the former tend to be slightly younger and are more likely to be women. Their state of health is poorer, they tend to live in more precarious circumstances (unemployed, homeless, no work qualifications), and they are more likely to have spent time in prison in the recent past. They use and inject cocaine more regularly, and they inject with greater frequency.

3.5 INFECTIOUS DISEASES

New cases of HIV infection associated with drug use began to fall sharply in the late 1980s and this trend continued until 1998. Since then, this indicator has remained stable, with a very slight increase in recent times³⁹.

The clients of LTFs and those undergoing outpatient and residential treatments have been tested on a massive scale. The percentage of those stating that they have undergone at least one HIV screening test is 90% or over in LTFs (91% in 1994, 93% in 1996 and 95% in 2000), with a majority (70%) having been tested recently, and this is also the case in the residential treatment sector (between 90% and 94% for the period 1997-2001). In outpatient treatment centres, the proportion was 84% in 1996 and 86% in 1999²⁰.

The percentage of persons reporting having tested positive for HIV decreased sharply in the early 1990s and has remained relatively stable since 1995. The reported prevalence of HIV infection was approximately 10% among LTF clients between 1993 and 2000; 16% among those taking part in the heroin prescription programme (1996), who tend to be highly dependent; between 11 and 13% among those undergoing outpatient treatment (1996-1998); and approximately 5% among those in residential treatment (since 1997)²⁰.

Although the reported prevalence of HIV has remained fairly low, that for hepatitis C and hepatitis B is very high. The proportion of drug users reporting a positive test for hepatitis C was 59% in the case of LTF clients (in 2000), and between 30% and 41% for those in the residential treatment sector (1997-2001). Where hepatitis B is concerned, the figures were 40% (LTFs) and between 22 and 28% (residential treatments) respectively. In the case of persons being prescribed heroin under medical supervision⁴⁰, the prevalences were even higher: between 1994 and 1996, more than 80% of the patients embarking on this programme were tested, showing prevalences of 82% for hepatitis C and 73% for hepatitis B. Finally, a survey conducted in Basle showed that 55% of persons beginning a course of methadone substitution therapy in 2000 were infected with the hepatitis C virus (HCV)⁴¹.

3.6 MORTALITY

Drug-related deaths multiplied by four in the space of a decade (109 in 1982, 419 in 1992). In 1995, the death rate began to fall and, since 1998, has levelled off at about 200 deaths per annum (167 in 2002). AIDS-related deaths among drug users reached a peak (of 318) in 1994, then fell rapidly as new treatments were introduced. Consequently, the total number of deaths per annum in this population rose from approximately 100 at the end of the 1970s to over 700 in 1994, then declined again to approximately 200 in 2002.

3.7 ACCESS TO TREATMENT

The number of courses of methadone substitution therapy dispensed has increased considerably since the late 1980s, rising from just under 2,000 in 1987 to approximately 18,000 in 2002. Moreover, more than one thousand drug users (1,230 in 2002) are receiving heroin-assisted treatment under medical supervision. In addition, it was estimated that in 2002 there were roughly a thousand places in residential treatment institutions, with an occupancy rate of 80%. It is therefore the case that the majority of dependent drug users are following a course of treatment. Compared with other countries⁴², Switzerland has one of the highest treatment coverage rates in Europe.

3.8 SUMMARY

Switzerland still has a large population of regular heroin users, even though this group seems to be ageing and gradually declining in numbers. Injection is still the principal mode of drug use, but inhalation has also become more widespread over the last ten years. To reduce the problems associated with drug use, a significant array of treatment and harm-reduction measures have been introduced. This has undoubtedly helped to reduced deaths and the incidence of HIV infection in the population concerned. However, there are still some major problems (prevalence of the different forms of hepatitis, social situation of drug users, poly-drug use), which make it necessary to go on improving the measures deployed to reduce drug-related problems.

4 ANSWERS TO THE APPRAISAL QUESTIONS

The purpose of the two preceding chapters was to present Swiss drugs policy and the epidemiological situation in Switzerland, in other words the context in which DCFs operate and the role assigned to them within this framework. This chapter is concerned with the seven questions specific to the appraisal.

4.1 DO DCFs HELP TO REDUCE MORBIDITY AMONG DRUG USERS, IN PARTICULAR BY REDUCING THE TRANSMISSION OF VIRAL INFECTIONS (HIV, HEPATITIS)?

The introduction of DCFs was occasioned by an increase during the 1980s in the number of injecting heroin users and the rapid spread of HIV/AIDS among this population. One of the objectives of these facilities was to reduce risk behaviours (promoting better control of drug use, reduction in the frequency of injection, reduction in the risk of infection, and better hygiene when injecting) and, consequently, the transmission of viral infections.

To date, the international literature on this subject does not prove that the use of DCFs has had an impact on the transmission of infectious diseases⁴³. However, there has been an observed reduction in risk behaviours in this area^{22,23}. In particular, there has been an improvement in the conditions in which drug users inject (hygiene, cleanliness), a reduction in the sharing of syringes and, in one case, a decrease in the number of days per week on which drugs are used by DCF clients. A number of evaluations of DCFs made in Switzerland come to the same kind of conclusions where the reduction of risk behaviours is concerned^{8,9,44,45}. It should also be borne in mind that the risks associated with the injection of a drug are generally lower in a DCF than in any other setting in which drugs are used.

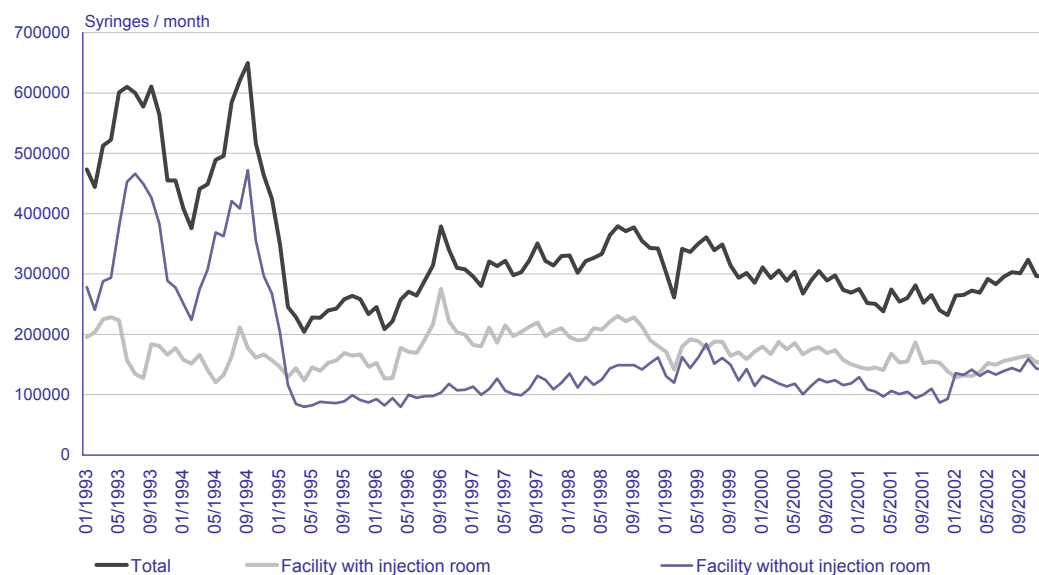
For Switzerland as a whole, the following indicators enable us to assess the impact of DCFs on risk behaviours:

1. Trends in the volume of syringes distributed by LTFs (with or without injection room);
2. Trends in syringe sharing (potential exposure to the risk of infection with HIV) and in the reported prevalence of HIV in places with/without an injection room.

4.1.1 Distribution of injection equipment

The following diagram shows trends in the distribution of injection equipment in LTFs, from 1993 to 2002. After peaking in 1993 and 1994, the number of syringes distributed by LTFs dropped sharply in 1995, falling from 6,400,000 in 1993 to 3,000,000 in 1995. After 1995, the number of syringes increased gradually until 1998, when 4,100,000 were distributed, then oscillated between 3,800,000 (in 1999) and 3,100,000 (in 2001). In 2002, 3,500,000 syringes were distributed by all LTFs, which represents a monthly average of 290,000. The distribution of equipment by DCFs has shown a general downward tendency over the last five years. However, of the various structures which distribute syringes (heroin-assisted treatment programme, pharmacies, DCFs, LTFs without consumption room), DCFs continue to distribute the largest quantity.

Figure 1 Trends in the number of syringes distributed by LTFs in Switzerland, 1993-2002*



* Number of low-threshold facilities (LTFs): 1993: N=28, 1994: N=23, 1995: N=23, 1996: N=25, 1997: N=26, 1998 and 1999: N=27, from 2000 to 2002: N=26

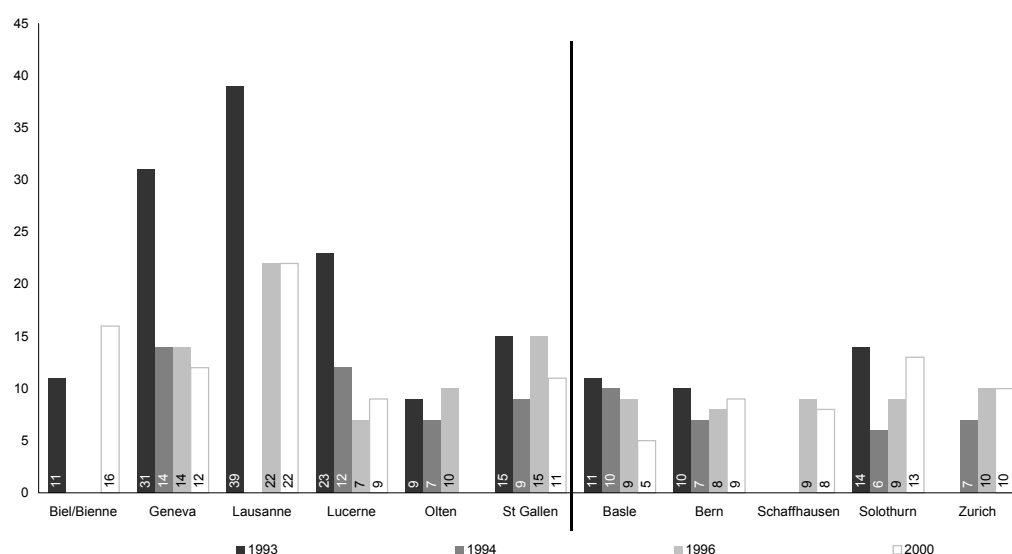
IUMSP/UEPP

4.1.2 Influence on the risk of infection

The following diagram shows trends between 1993 and 2000 in the proportion of drug users frequenting LTFs who stated that, in the preceding six months, they had injected with a syringe already used by another person. On the right are the data for clients of LTFs in towns with an injection room; on the left, the data for clients in towns with one or more LTFs but no injection room. In towns with an injection room, the proportion of drug users running the risk of infection was already low in 1993, and has remained so. In four of the six towns without a DCF, the proportion of drug users having shared a syringe in the preceding six months was over 10% in 2000 (one in five for towns with a DCF).

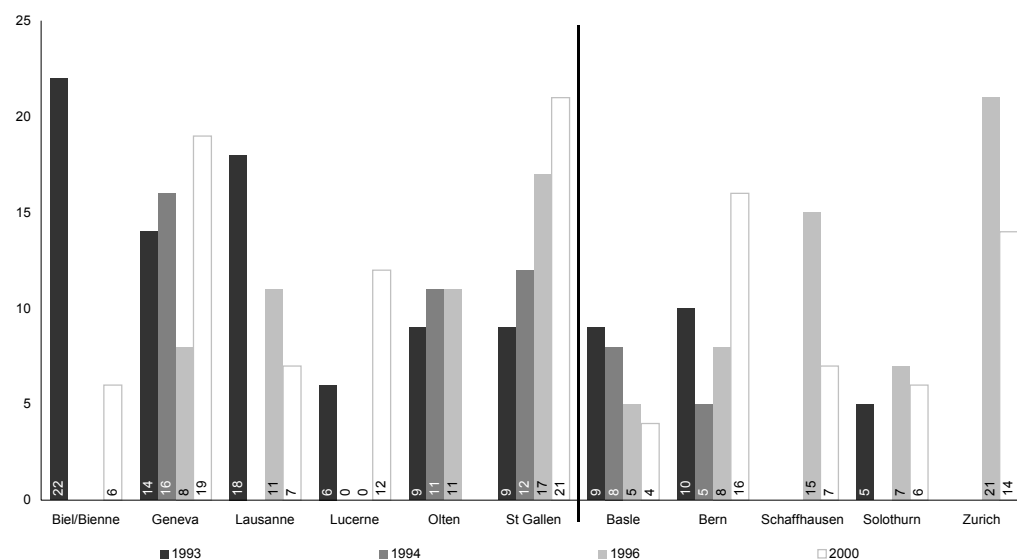
Regarding the prevalence of HIV as reported by drug users frequenting LTFs, it emerges that trends are more erratic, with no clear difference between clients in towns with DCFs and clients in towns which do not have one.

Figure 2 Syringe sharing in the preceding 6 months, 1993-2000, in various LTFs in Switzerland (in %)



IUMSP/UEPP

Figure 3 Reported prevalence of HIV in various LTFs in Switzerland, 1993-2000



IUMSP/UEPP

4.1.3 Summary

The answer to the First appraisal question can be summed up as follows:

- It has not yet been demonstrated that frequentation of DCFs has reduced the number of cases of HIV or HCV infection. This is due primarily to the methodological approaches and technical problems associated with evaluating the impact of these facilities.
- The results of an increasing number of evaluations, carried out in Switzerland and in other countries, indicate that frequentation of DCFs has a positive impact on some risk behaviours (syringe sharing, hygiene and cleanliness of injection material).
- DCFs play an important part in the distribution and exchange of syringes in Switzerland – a measure whose effectiveness is now internationally recognised.
- A comparison of towns having an LTF with an injection room and towns with an LTF but no injection room does not show any great difference where risk behaviours and HIV, HCV and HCB infection rates among the drug users frequenting these facilities are concerned. However, it is observable that there is slightly less syringe sharing in towns with a DCF. A comparison with towns not having any sort of LTF would undoubtedly be useful, but no such study exists at present.
- The general trend in health indicators for drug users in Switzerland shows an improvement where the reduction of HIV transmission is concerned, but a more problematic situation in the case of hepatitis. DCFs have probably contributed to the control of the HIV/AIDS epidemic among drug users, but it is not possible to make a judgement as to their effects in respect of hepatitis.

In conclusion, it would seem reasonable to claim that the introduction of DCFs has helped to reduce some risk behaviours and keep them at a low level, particularly where the transmission of HIV is concerned.

4.2 DO DCFs HELP TO REDUCE MORTALITY AMONG DRUG USERS, PARTICULARLY BY REDUCING THE INCIDENCE OF FATAL OVERDOSES?

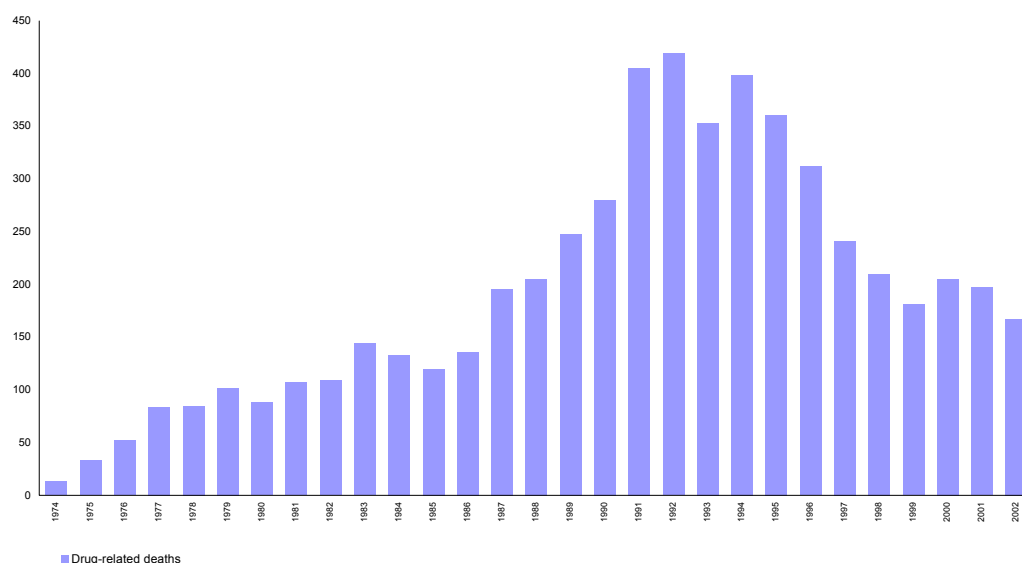
According to the surveys of clients of LTFs in Switzerland carried out between 1996 and 2000, half of the users of these facilities reported having experienced an overdose at some time in their lives, and the average number of overdoses per person was a little over four. More than a quarter (28%) of the respondents in 2000 also reported having experienced an overdose in the preceding two years, a slightly higher percentage than that recorded in 1996 (22%).

Internationally (Madrid, Germany and Sydney), overdose rates in DCFs have recently been measured at, respectively, 1.1, 6.4 and 7.0 overdoses per thousand visits to an injection room²³. In Switzerland, two recent evaluations have yielded rates of 0.7 (Biel/Bienne, August 2001 to August 2002) and 1.7^b (Geneva, August 2002 to December 2002) overdoses per thousand instances of drug use. To date, there has only been one reported case of a person dying in a DCF (in Germany) and this was due to anaphylactic shock²³. Otherwise, the existing data tend to show DCFs as having a positive impact on the incidence of overdoses and their seriousness, but as yet there is no definitive proof⁴³.

The virtual absence of deaths in DCFs must be ascribed to the measures taken to avoid them. In Geneva, for instance, the injection room communicates directly with the First-aid room, which is equipped with breathing apparatus. The staff member present in the injection room also has a pager enabling him to contact his colleagues in the reception area and so call for emergency assistance. The moment a situation is judged too problematical, the emergency medical services (29 cases between April and December 2002) or the emergency doctor (SOS médecins) are contacted and asked to attend immediately⁵.

In Switzerland, fatal overdoses are recorded in the statistics for drug-related deaths, which also specify deaths due to accidents and to long-term drug use. However, it is estimated that fatal overdoses account for a large proportion of deaths recorded. As the following diagram shows, the number of drug-related deaths increased rapidly between the mid-1980s and the early 1990s, reaching a maximum of 419 deaths in 1992. Since then, this number has declined steadily and in 2002 stood at 167 deaths, a lower figure than was recorded in 1987 (196).

Figure 4 Trend in drug-related deaths in Switzerland



Source: FOP

^b Overdoses and excessive doses.

4.2.1 Summary

Drug users in Switzerland still often overdose, and a significant number of them die each year as a result of such overdoses, accidents or the consequences of long-term drug use. Although the proportion of LTF clients who have recently (in the last two years) experienced an overdose is not decreasing, the number of drug-related deaths is in decline. DCFs, which have not had to report any deaths in Switzerland, have undoubtedly contributed to this reduction in the death rate among drug users and, in particular, among those most seriously affected by drug-related problems. As the example of Geneva demonstrates, DCFs have developed special measures to prevent deaths arising from the injecting of drugs, and these measures seem to have been effective.

4.3 DO DCFs HELP TO ACHIEVE BETTER MANAGEMENT OF DRUG USERS, PARTICULARLY BY PROVIDING A POINT OF ACCESS TO THE SOCIAL-SERVICE AND HEALTH-CARE NETWORK?

One of the key ideas behind low-threshold facilities was that they would provide a way of reaching the most marginalised drug users and offering them support and assistance. DCFs are also intended to serve this purpose, and there is a need to know whether, as well as preventing the spread of infectious diseases and overdoses and facilitating access to treatment (see below), they are able to provide individual counselling, re-establish social contact and guide clients towards and within the social-service and health-care network.

There are two kinds of data which can shed light on this question:

- data regarding DCF activities, in particular the nature and volume of the services offered under the heading of "assistance and guidance";
- data gathered from DCF clients, particularly regarding the use they make of services not directly connected with the injecting of drugs.

4.3.1 Volume and nature of activities concerned with the "assistance and guidance" of DCF clients

Table 1 in chapter 2 of this appraisal shows that DCFs offer a range of social and health-care services in addition to the provision of a consumption room: readiness to listen and counselling, basic medical care, referrals to other structures, access to washing facilities (showers, washing machines), a place of safety, etc. The following data have been gathered from similar facilities in other countries²³:

- in Sydney, one visit in four leads to the provision of a medical or social service, the most frequent being advice on safety when injecting or the care of veins; one visit in 41 leads to a referral to a specialised drug treatment centre, another care centre or a structure offering social assistance;
- in Münster, Germany, one visit in seven results in the provision of a medical or social service, or in a referral to another facility. In Madrid, the corresponding figure is one in nine.

Data of this kind is also available for Switzerland:

- in Berne¹¹, a detailed breakdown of the time devoted by each staff member to the different activities run by the DCF reveals that 16% of the time available is devoted to counselling, 7% to physical care, and 5% to safety-related interventions. The same evaluation showed that understaffing could be directly detrimental to the DCF's support and counselling activity;
- in Geneva⁵, one visit in 50 to an injection room leads to care being provided in a specialised facility, and 20% of such interventions are followed by a referral for health care; one visit in

eight leads to a social assistance being provided (in this order: listening, conversation, stress and violence management, referrals, information, showers, support/advocacy outside the DCF).

4.3.2 Opinions of DCF users

A number of surveys of DCF clients have been conducted in Switzerland^{5,6,11,44,45} regarding the usefulness of the services such facilities offer. These surveys show that the most important thing for the clients is to be able to inject without disturbance, in hygienic conditions, sheltered from the attentions of the police and protected against the immediate risks associated with injecting. Other material factors are also regarded as essential: being able to rest, eat and drink and have access to basic care. The readiness of staff to listen, their availability, non-judgemental attitude and advice are also often mentioned as being important to clients. The surveys also indicate that not all clients use DCFs in the same way: some come mainly to inject and leave immediately afterwards; others, generally the more socially marginalised, make more use of the various services on offer, in particular taking advantage of the social and health-care services and, more generally, the attentions and caring attitudes which maintain or re-create social contact.

4.3.3 Summary

Social, health-care, counselling and guidance services are a far from insignificant part of DCF activity, in Switzerland and in other countries. These services are used and appreciated by clients, particularly the most marginalised among them, and certainly help to maintain health and social contact. It is therefore reasonable to claim that DCFs often serve as a point of access to the social-service and health-care network, provided of course that they are adequately staffed.

4.4 DO DCFs HELP TO IMPROVE THE SITUATION WHERE PUBLIC ORDER IS CONCERNED, IN PARTICULAR BY REDUCING DRUG USE IN PUBLIC PLACES?

The establishment and development of DCFs in Switzerland was also related to the existence of open drug scenes and the problems of public order to which they gave rise. The political debate regarding the development of harm reduction measures often took place at the local level,⁴⁶ involving conflict between coalitions of players⁴⁷ representing divergent ideas and interests. Therefore, the introduction of DCFs also had to take account of local community problems, and one of the tasks of these facilities was to improve the situation as regards the use of drugs in public places, the discarding of used syringes and other related problems.

4.4.1 Drug use in public places and discarding of used syringes

The international literature^{23,48} indicates that the establishment of DCFs tends to reduce the use of drugs and discarding of syringes in public places. Whether or not the surrounding community accepts these facilities seems to depend primarily on the absence of open drug scenes (dealing and use) in the neighbourhood concerned. If the residents observe an increase in drug-related activities, conflict will arise. However, local attitudes can change, as has been proved in Rotterdam.

The data for Switzerland yield similar results, in other words DCFs have been a factor in reducing open drug scenes^{13,44,45}. However, it is also true that the extent of the improvement has often been judged insufficient by the surrounding community. In many cases, this is because the very high expectations of DCFs have been unrealistic, particularly as regards their opening times, the number of places available and other aspects of their work⁴⁵.

Where the discarding of syringes in public places is concerned, the first point to be made is that, where they exist, LTFs are the main collecting point for used syringes. However, some DCFs have had to come to terms with an increase in the number of used syringes left in public places. In such cases, as in Geneva, the facility has had to develop or reorganise a system for collecting used syringes discarded by its clients⁵.

Nationally, the survey of clients of LTFs indicates a decrease in the percentage of people using a public place as the principal setting in which they injected drugs during the preceding six months (19% in 1994; 6% in 2000). However, there does not appear to be any difference between clients living in towns having an LTF with an injection room and those in towns having an LTF without this additional facility. There is, however, a difference in the numbers of clients reporting their place of residence as the setting in which they most frequently injected in the preceding six months. In 2000, the figure for clients in towns having an LTF with an injection room was distinctly lower (between 32% and 58%) than that for clients in towns having an LTF without an injection room (between 71% and 95%). It would therefore seem that the existence of a DCF does not necessarily have a specific impact on drug use in public places, but does have an impact on the use of drugs in people's places of residence (including illegal shooting galleries).

4.4.2 Summary

In Switzerland and in other countries, results show that DCFs have been a factor in reducing public order problems, particularly the problem of open drugs scenes. DCFs have also played an important role in recovering used syringes and preventing them from being discarded in public places. Generally speaking, DCFs have also taken account of people's fears and the problems arising in their neighbourhoods, and have found ways of alleviating them. Finally, there are indications that residential space (apartment blocks) benefits most from a reduction in drug use when a DCF is established.

4.5 DO DCFs TEND TO INCREASE THE NUMBER OF INJECTING DRUG USERS AND/OR THE FREQUENCY WITH WHICH THEY INJECT?

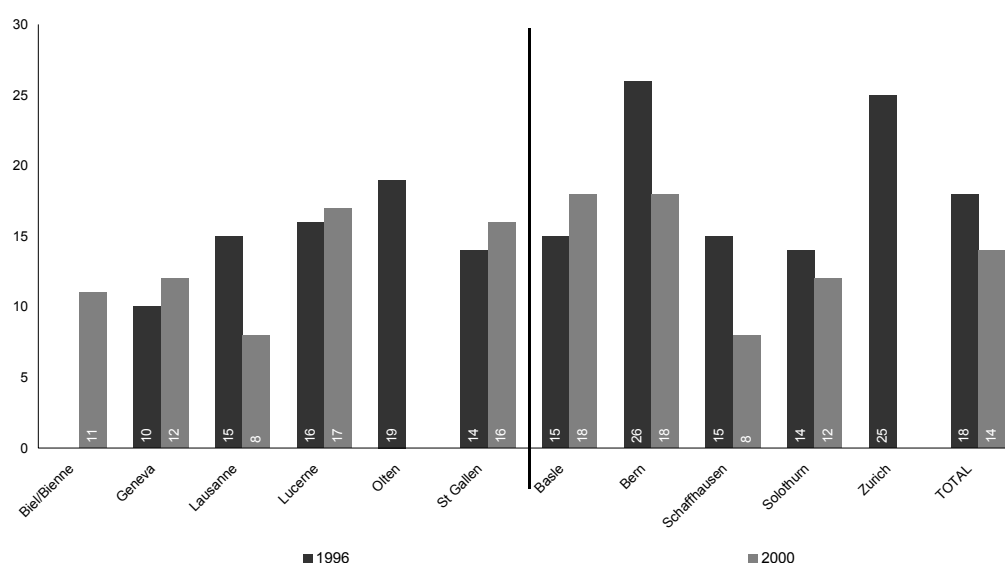
One of the principal criticisms made of DCFs is that they encourage drug use, both among non-users and existing users. The most recent review of the literature on DCFs²³ reports only one publication – from the Netherlands – which covers the subject of injection frequency. The researchers in this case observed a decrease in the number of days on which drugs were used by DCF clients. In Switzerland, a number of sources shed further light on this issue:

- estimates of the number of dependent drug users (cf. chapter 3.1);
- surveys of LTF clients covering drug use and modes of consumption²⁰;
- monitoring of the number of syringes distributed in low-threshold facilities (with and without injection room) in Switzerland (cf. chapter 4.1.1);
- interviews with drug users (panel studies⁴⁹, qualitative studies of the use made of DCFs)^{5,6c}.

Estimates of the number of dependent drug users show a decrease in users of heroin, which is still the most commonly used substance. In recent years, research has revealed an increase in the regular use of cocaine by injection. Among LTF clients, however, the proportion of injecting drug users, and the average number of times they inject per week, showed an overall decrease between 1993 and 2000 (this was also true for the period 1996 to 2000). And yet, during this period, a number of towns already had a DCF. If we compare towns (see Figure 5), we find that the average number of injections tended to decrease in three of the four towns with a DCF for which information is available, whereas the number of injections tended to increase in three of the four towns without a DCF for which information is available.

^c Preliminary evaluation results, Geneva DCF, 2003, F. Benninghoff, IUMSP, personal communication.

Figure 5 Average number of injections per week among LTF clients, 1996-2000, towns with and without DCF



IUMSP/UEPP

Monitoring of the syringes distributed in LTFs (see chapter 4.1) clearly shows a downward trend in the overall volume of material distributed in facilities with an injection room between 1997 and 2002. There is therefore no evidence of an increase in the number of injecting drug users or the frequency with which they inject, either generally or in DCFs. There are some local or qualitative studies which provide more detailed analysis, often confirming the general picture. In 1991-92 a panel study^d conducted in Zurich showed that during the period in question, roughly half of the respondents had not varied the frequency with which they used drugs^e, roughly a quarter were using drugs less, and another quarter were using drugs more. Nor had there been any change in the pattern where mode of consumption was concerned. Three qualitative studies of small groups of people conducted in 1996 (in towns with DCFs), 2002 (Geneva DCF) and 2003 (Geneva DCF) came to the same conclusions: these three sets of interviews showed that, for a majority of the respondents, there was no connection between the frequency with which they injected and the fact that they frequented a DCF. Any changes in habits were attributed to other causes (product availability, mental state, financial resources, etc.). On the other hand, among these three sets of interviewees there were some who said that the fact of frequenting a DCF had enabled them to stabilise or decrease their use of drugs, and a few who reported that their attendance had led to an increase in or a desire to increase their consumption (the temptation of seeing other people inject, fewer obstacles to injecting). These two opposing situations balanced each other out^f.

Two studies mention individuals who injected drugs for the first time in a DCF^{5,8}. Though very uncommon, this does happen. Generally, permission to use the injection room is granted by staff members only if all the signs are that the person will inject in any case, and in conditions more dangerous than those prevailing in the DCF.

^d Interviews conducted in two waves, seven months apart, with drug users recruited in all low-threshold facilities (including a low-threshold, low-requirement methadone substitution therapy centre).

^e By injection or otherwise.

^f In Geneva, 2002: increase 3, decrease 2, no change 11 ; 2003: increase 4, decrease 4, no change 7.

4.5.1 Summary

The available data provide no evidence that DCFs encourage drug use by injection or increase the frequency with which drugs are injected. Generally speaking, the factors mentioned by clients as influencing their drug habits were of a different kind. For some clients, however, DCFs were a factor in enabling them to stabilise or decrease their use of drugs, while for others they were a factor in increasing their consumption. Only a minority of clients were in either of these situations, which seemed to balance each other out.

4.6 DO DCFs HAVE A NEGATIVE EFFECT ON ENTRY AND RETENTION IN TREATMENT FOR DRUG DEPENDENCE AND ON THE SUCCESS OF SUCH TREATMENT?

The second criticism frequently made of DCFs is that they are an obstacle to people embarking on and continuing in treatment, and that they undermine the success of such treatment. In discussing this criticism, we shall draw on data deriving from:

The international literature;

Statistics for methadone substitution therapy (predominant in Switzerland): the number of courses of treatment administered per canton (2000) and how numbers changed between 1993 and 2000, and a comparison of cantons with and without DCFs;

Surveys of LTF clients: the proportion of clients reporting themselves to be in treatment, comparison of cantons with and without DCFs;

Interviews with clients: their own view of the relationship between their frequenting an injection room and whether it might have an encouraging or discouraging effect on their undertaking treatment.

4.6.1 The connection between treatment and harm reduction in the existing literature

A number of studies carried out in other countries have shown that participation in a syringe exchange programme has a positive effect on the identification of health problems among dependent drug users and on their embarking on treatment⁵⁰⁻⁵³. These observations cannot of course be transposed without reservation to facilities with injection and inhalation rooms, but there is nevertheless a presumption that the effects of such facilities could be similar.

The problems of assistance to drug users which emerge from these studies are generally connected with the overall functioning of the care network and, more precisely, with coordination and communication between the structures and players involved in harm reduction and those engaged in treatment activities. The general idea which emerges from these studies is that improvements in the assistance to drug users should not be sought by emphasising therapy at the expense of harm reduction, or vice-versa, but by working for better coordination between the two areas.

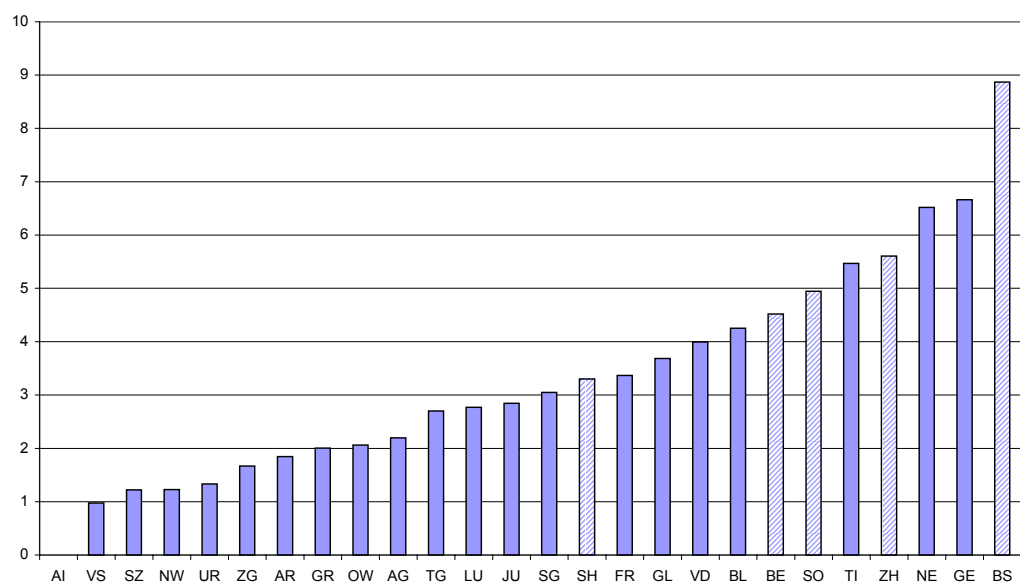
The most recent reviews concerned with DCFs do not go into this issue. However, they do report that DCFs help to improve health, reduce risk behaviour and improve links between the social and health-care services²³. A number of Swiss studies^{5,12,13} examine the work done by staff members in low-threshold facilities with an injection and/or inhalation room. These studies indicate that the interaction between drug users and staff members enables the latter to tackle health issues and suggest solutions – be they harm reduction practices or referral to the treatment network – which drug users can then adopt for themselves. Therefore, the task of advising and raising the awareness of drug users which would encourage them to embark on and continue in treatment is generally performed by DCFs.

4.6.2 Number of courses of methadone substitution therapy per canton

In 2000²⁰, the five cantons (Basle, Zurich, Solothurn, Berne, Schaffhausen) which provide injection rooms were among those with the highest rates for persons currently undergoing methadone substitution therapy (see Figure 6: the cantons providing injection rooms are cross-hatched in the diagram).

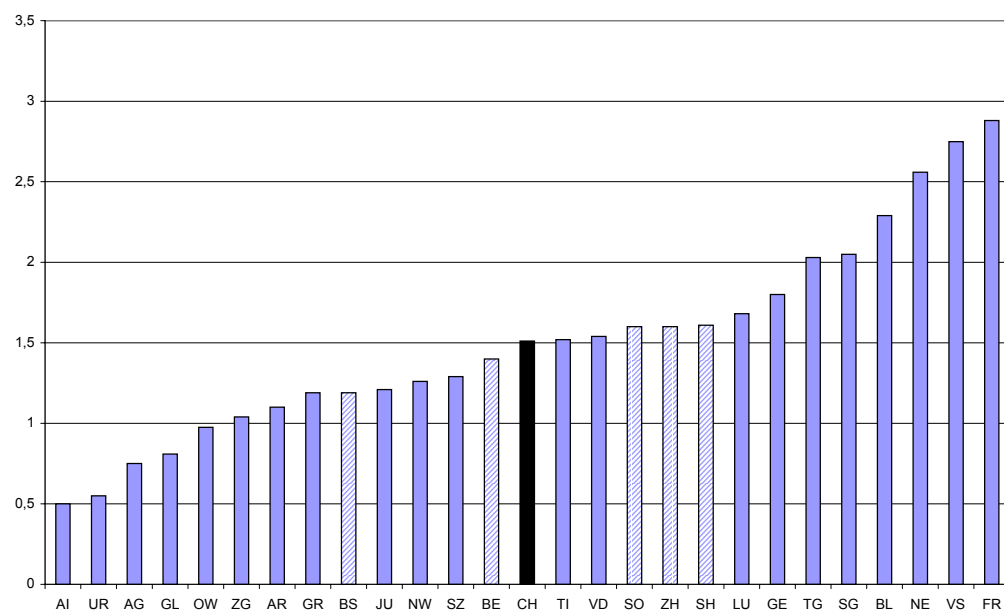
The rate of increase in the number of courses of methadone substitution therapy administered between 1993 and 2000 was approximately 1.5 for Switzerland as a whole (Figure 7). Three of the five cantons providing injection rooms were above the national average. It is worth noting that Basle, which is below the average, is the Swiss canton with the highest methadone therapy rate per 1000 inhabitants.

Figure 6 Number of courses of methadone substitution therapy per 1000 inhabitants aged 20-64, by canton, 2000



Source: National Methadone Statistics

Figure 7 Rate of increase in the number of courses of treatment between 1993 and 2000, by canton



Source: National Methadone Statistics

4.6.3 Drug users in treatment / not in treatment in different types of LTF

The First point to make is that increasing numbers of LTF clients are in treatment: for the First time in 2000, the proportion for all LTFs taken together exceeded 50%. This probably reflects the general increase in admissions to treatment²⁰. In places without an injection room, the proportion of clients in treatment is slightly higher than in those which do have this facility. However, the difference is very small and has reduced slightly over time. The main point is that in both situations there has been a steady increase in the proportion of persons in treatment. Individuals who continue to inject and to frequent LTFs are probably a minority who cannot be weaned off drugs completely by treatment^g or have suffered a relapse. Nevertheless, in LTFs, clients who are in treatment use drugs and inject less frequently^h than those who are not following any treatment³⁷. It should also be remembered that the majority of individuals who frequent low-threshold facilities have a long history of uncompleted treatments and relapses behind them.

Table 2 Proportion of clients reporting themselves to be in treatment: comparison of places with and without injection rooms, surveys of LTF clients, 1993-2000ⁱ

Year	Places with injection room				Places without injection room			
	n	methadone treatment %	heroin treatment %	total in treatment %	n	methadone treatment %	heroin treatment %	total in treatment %
1993	674	32	0	32	445	40	0	40
1994	686	43	10	53	221	52	6	58
1996	685	42	11	53	259	53	11	64
2000	480	55	3	58	444	58	5	63

IUMSP/UEPP

Two more recent sets of data confirm that a large proportion of DCF clients are in treatment. In Biel/Bienne¹⁴, a short survey of the clientele of a low-threshold facility showed that 80% (39/49) of the users of the injection room and 67% (14/21) of the users of the inhalation room were undergoing substitution therapy. In Geneva⁵, a similar survey revealed that 72% (59/82) of the users of a facility with an injection room (Quai 9) were following a course of treatment.

The Geneva study also showed that, in the First year of opening of a facility with an injection room, a majority of the clients attending (59%) were already in treatment. However, it was observed that this proportion tended to diminish over time (from 64% in the First three months to 45% in the final quarter of the year) and it was possible that the facility would gradually come to cater for an undertreated group compared with the local or national average^j.

^g The issue of treatment quality and requirements must however be raised in this context. It has been shown that methadone substitution therapy in Switzerland is generally underdosed⁵⁴. In 2000, for example, the median dose of methadone reported by LTF clients undergoing methadone substitution therapy was 60 mg/day and the average duration of treatment 46 months (F. Benninghoff, IUMSP, personal communication).

^h Only heroin is less used; where cocaine and benzodiazepines are concerned, there is no observable difference.

ⁱ Fabienne Benninghoff, UEPP/IUMSP, personal communication.

^j It should also be said that the fact that users of injection or inhalation rooms are not in treatment does not mean that they have never had access to treatment. In fact, the vast majority of dependent drug users in Switzerland have been admitted to treatment on one or more occasions.

4.6.4 How DCF clients view the relationship between DCFs and treatment

The question of the relationship between treatment and frequentation of a DCF was put to users of the Geneva facility in the course of semi-structured interviews conducted in 2003 (N=15). Most of the users (12), whether they were in treatment or not, reported that the DCF had had (and was having) no influence on their plans to enrol for, their having enrolled for or their continuing in treatment. Some said that they had discussed the matter with staff members. Three users, all of them in treatment, said they had been supported in their plans or the steps they took to enrol for treatment. No user reported that the DCF had had a negative effect with regard to a current or planned course of treatment.

4.6.5 Summary

The available data do not support the contention that DCFs have a negative impact on entry or retention in treatment. In fact, a majority of DCF clients are in treatment, the proportion of those in treatment is growing, DCF staff members tackle this subject with clients, and the clients themselves do not believe that the existence of these facilities has a decisive influence on their attitude to treatment. If there is a problem, it has more to do with the coordination of harm reduction and treatment services, particularly the need for better joint identification of the real capacities and needs of drug users. Treatment quality could also be an issue.

The recent recommendation made by the International Narcotics Control Board⁵⁵, that it would be wise to make a wider range of treatments available rather than develop DCFs, makes little sense in Switzerland, where treatment services are among the best in Europe in terms of accessibility and diversity. The important thing is that drug users be able to follow a course of treatment and that, in the event of a temporary or permanent relapse, there be a support service which offers them the opportunity to return to treatment at a later date. Drug users' case histories in fact show that they usually experience repeated relapses when it comes to substitution therapy and weaning off drugs. Harm reduction services, including DCFs, must therefore be there to safeguard their state of health, social situation and interest in abandoning drug use, so that they can pursue or renew their attempts to do so.

4.7 DCFs WITH AN INHALATION ROOM

Inhalation rooms have recently been opened in several Swiss towns (Berne, Basle, Zurich, Biel/Bienne), and they also exist abroad (Germany, the Netherlands). Their introduction is the result of signs that the prevalence of drug use by inhalation is on the increase, among both new users and existing users switching to a mode of consumption which entails a "lower risk" of HIV transmission, overdosing, and other problems associated with injecting.

As in Zurich¹², the complementary aims of these DCFs are therefore:

- to adapt services more effectively to the needs of drug users (new or existing);
- to support users in adopting low-risk or lower-risk modes of consumption^k;
- to provide places where this type of drug use is accepted, and to reduce the level of public nuisance (smoke, creation of a "drugs scene").

We have few data regarding facilities of this type. Several evaluations have been carried out in Switzerland^{10,12-14}; these, however, have focused on the process of setting up the facilities. Nor does the international literature shed any more light on the subject.

^k The aim here is as much to prevent users switching to injecting as to encourage the switch from injection to inhalation.

We shall nevertheless attempt to review the questions raised in relation to facilities with injection rooms and apply them to those with inhalation rooms, bringing together the very limited amount of pertinent data at our disposal. Before reviewing these questions, however, we need to ask how attractive this service is, and in particular what type of drug user is drawn to it.

An evaluation made in 2001-2002 of the DCF in Biel/Bienne, which has both an injection and an inhalation room, gives some idea of current trends¹. Of all the individuals who attended this DCF for the First time over a six-month period (N= 441), 28% identified inhalation as their principal current mode of consumption (as against 48% for injection and 24% for both). An ad hoc survey of clients using the facility (N=70) confirmed this distribution and provided a clearer definition of the two clienteles (users of the inhalation room only, as distinct from users of the injection room or of both):

- The users of the inhalation room were on average younger (31.6 years old) than those of the injection room (35.0). They faced fewer social problems: none of them was homeless (as against 11% in the second group); they were more likely to be employed (54% in full-time employment, as against 22%); and they had been imprisoned fewer times (11% had been to prison during the preceding two years, as against 38%).
- The users of the inhalation room were in a better state of health: none of them reported being HIV positive (as against just under 10% of the injecting drug users); and a little under one third of them said they had hepatitis C (as against two thirds of the IDUs).
- Half of the users of the inhalation room had already injected drugs; almost all of them had used both heroin and cocaine; and one third of them were still using both substances.
- A high proportion of both groups were following a course of methadone substitution therapy (67% of the inhalation room users and 76% of the injection room users).

There would therefore seem to be two subpopulations of inhalation room users: those who have a long history of drug dependence and have injected in the past and those who have never injected but nevertheless, on the whole, have been using drugs for many years (only 10% were under 25 years of age). An evaluation of the Zurich facilities (2001-2002) yielded comparable results: staff members estimated that 40% of the inhalation room users were already frequenting the injection room, and that a proportion of the newcomers were persons already known to clients of the injection room and/or had been on the margins of the facility¹¹. The two structures subject to this evaluation very quickly reached an occupancy rate of 90%. An evaluation of the pilot project in Olten (2001) showed that half of the inhalation room users also injected drugs, and that only a quarter^m were new to the facility¹⁰.

Where **reduction of the risk** of HIV transmission is concerned, using drugs by inhalation does not present any danger, even if equipment is shared. In the case of hepatitis, in particular hepatitis C, we cannot exclude the possibility that the sharing of inhaling equipment (pipes, mouthpieces, straws) may result in infection. There is no evidence of this, but in any case prevention of inhaling equipment being shared is part of the service offered by all DCFs with an inhalation room.

One case of overdosage emerged from the three evaluations. There were also cases of medicines being used by inhalation with disturbing side effectsⁿ and of inappropriate solutions being used to prepare the substances concerned^o. Many questions also remain to be answered regarding the toxicity of the substances inhaled and the solutions used to dilute/extract these substances. Consequently, it is necessary to consider what types of substance should be permitted for use in inhalation rooms.

¹ Though these have to be treated with caution, given the small number of drug users questioned in each sample.

^m Over the five months covered by the study.

ⁿ Mentioned in the Biel evaluation.

^o Mentioned in the case of Zurich.

The switch from drug use by injection to drug use by inhalation is one of the forms of harm reduction it is desirable to promote. This has been observed in the case of some users. For the most part, these are injecting drug users who have decided to switch to another mode of consumption because of the state of their veins or the quality or price of the substance. They appreciate being able to make the switch. No instance of a switch from inhaling to injecting was described in any of the three evaluations.

There are few available data regarding the contribution of facilities with inhalation rooms to the better management of drug users. The three evaluations show that the service does attract previously unknown clients, though they account for only a proportion of the inhaling drug users who frequent DCFs. In addition, a proportion of the facilities' clients are already in treatment. Finally, it was stated several times that it is more difficult to engage in conversation with inhaling drug users than with persons using the injection rooms. Staff members do not go into the inhalation room – they can watch through a window – and users often leave the facility quickly, especially the younger users, who also sometimes come in a group. This situation was described as frustrating in two DCFs. Inhalation rooms do therefore provide an additional point of contact with drug users, but the importance of this function, particularly where referrals to the social-service and health-care network is concerned, may have been overestimated.

The question of whether or not inhalation rooms help to improve public order was not tackled in any depth in these three evaluations. They simply state that some of the individuals who previously inhaled drugs on the margins of a DCF now do so inside the facility itself.

4.7.1 Summary

DCFs with an inhalation room are a new development in Switzerland. They were introduced in response to a change in modes of consumption among both existing and new users of cocaine and heroin. Their objective is to reach these groups and offer them the sort of low-threshold services already enjoyed by injecting drug users. In addition, they might help to promote slightly lower-risk modes of consumption.

The very few data available indicate that the group targeted by these facilities does indeed exist and can be reached, at least to some extent. Apart from this finding, caution is called for, since making contact with inhaling drug users seems to be difficult, the toxicity of the substances used is in some cases uncertain, and there is little proof as yet of instances of a lasting switch from injection to inhalation in DCFs. On the other hand, it is important to note that negative effects, in particular people switching from inhaling to injecting or being less inclined to embark on treatment, have not been confirmed either. In conclusion, as with any new development, the introduction of DCFs with an inhalation room needs to be followed up with further research to enable an accurate assessment of their effects to be made.

5 CONCLUSIONS

The short appraisal presented in this document is based on the principal existing data regarding the role and usefulness of DCFs; it addresses seven questions covering, on the one hand, the objectives of these facilities and, on the other, the criticisms made of them. As stated at the beginning of the document, there is still limited evidence and we have had to rely on the best available knowledge in making this appraisal.

Generally speaking, it is reasonable to conclude, on the basis of the available knowledge, that to a large extent DCFs achieve the objectives set for them, and that the criticisms made of them are rarely justified. In fact, DCFs help to:

- reduce risk behaviour likely to lead to the transmission of infectious diseases, particularly HIV/AIDS, among the population of the worst affected drug users;
- reduce the incidence of fatal overdoses and, therefore, the mortality rate in this population;
- establish and maintain contact between this population and the social-service and health-care network, within which low-threshold facilities (LTFs) are often the First point of access because of the care and social assistance they offer;
- reduce public order problems, particularly by doing away with open drug scenes, reducing drug use in public places, recovering used syringes, and reducing the impact of drug problems on residential areas (apartment buildings).

At the same time, the available data do not indicate any specific detrimental effect on:

- the number of drug users and the frequency with which they use drugs; the figures are falling in both cases;
- entry and retention in treatment, because the majority of DCF users are undergoing treatment, the proportion of those in treatment is growing, this subject is tackled within the facilities, and the users themselves state that DCFs do not have any major influence on their treatment.

All of these observations relate to the overall level of public health and do not mean that DCFs may not have negative effects in some individual cases. However, on the basis of existing knowledge, it would appear that the overall effect of DCFs on drug-related problems is positive.

In the special case of DCFs with an inhalation room, the above is less convincingly proven. Although such facilities do indeed reach inhaling drug users, it has not yet been possible to ascertain whether or not they can achieve their set objectives (establishing a point of contact between inhaling drug users and the social-service and health-care network, reducing public order problems, encouraging the switch to lower-risk forms of drug use). Further research is therefore required, especially in respect of:

- the capacity of DCFs with an inhalation room to serve as a point of contact between inhaling drug users and the social-service and health-care network;
- the toxicity of the different substances inhaled and the measures that need to be taken in consequence;
- the extent to which users switch to and continue in another form of drug use, and the consequences.

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