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Factors concerning access to a potential drug consumption room in Dublin, Ireland

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Abstract: Drug consumption rooms (DCRs) are a harm reduction service used by more than ten countries worldwide as a means of addressing localised problem drug use. Ireland is now in the process of introducing a DCR. Internationally, each DCR has its own rules and regulations addressing access, which are suited to the local drug using community. A qualitative exploratory case study design was implemented during 2016 with the aim of determining approaches to access for a DCR with input from participants working inside and outside drug services. Nineteen participants were interviewed in depth including service users and staff from a large city centre drug service, and key informants with experience working in drug policy within the Ministry of Health. The interview guide addressed their experiences and knowledge of problem drug use in Dublin, alongside their opinion of the viability of established DCR rules for a Dublin location. Participants were supportive of a Dublin-based service, and in general concurred with the existing rules of other DCRs. However, there were concerns about how a DCR and health and drug services in Dublin would coordinate. Other key issues that emerged here were problems surrounding drug using parents, addressing the public approach to problem drug use, and support for staff working in services. This study also highlighted the difference in opinion between stakeholder groups, and the implications this will have on the development and implementation of a service.

ABOUT THE AUTHORS

Emma Atkin-Brenninkmeyer conducted this research as part of her Master's program in Global Health at Trinity College Dublin, under the supervision of Dr Fiona Larkan. After completing her research, Emma worked with Professor Catherine Comiskey as a research assistant, complementing the professor's research in the health and drugs field in Ireland, as well as presenting on behalf of the team at international conferences. Most recently, Emma has been working at the EMCDDA in the Public Health Unit on new trends in drug use, as well as doing research for a Lisbon-based drug service *In Mouraria*. Emma's interest in this area stems from volunteer work for *De Regenboog Groep* in Amsterdam, as well as from her previous studies in anthropology at the University of St Andrews.

PUBLIC INTEREST STATEMENT

A drug consumption room is a space in which drug users can use illicit substances in a safe and supervised environment. Although different names are given to these services; "safe-injecting facility," "medically supervised injecting centre," *et cetera*, all aim to reduce drug-related harms, especially overdosing. Nevertheless, this service affects more than just the service users; those working in and around the service must also be protected. This can be addressed by developing clear rules and regulations for who can access the service: the focus of this research. All participants had concerns, as well as differences in opinion, which highlighted the importance of including all stakeholders in the discussion and for a degree of flexibility in any final decisions. Nonetheless, there was also support for the service; therefore despite concerns, it is clear that introducing a service such as a drug consumption room will benefit those to whom it matters most.

Subjects: Sociology & Social Policy; Europe - Social Policy; Public Health Policy and Practice

Keywords: drug services; drug consumption rooms; drug policy; harm reduction

1. Introduction

A Drug Consumption Room (DCR) is a generalised term used to describe a facility where “illicit drugs can be used under the supervision of trained staff.” (European Monitoring Committee for Drugs and Drug Addiction [EMCDDA], 2015) The aims of a DCR are to reduce disease transmission, overdose-related deaths, as well as public nuisance related to drug use (Potier, Lapr evote, Dubois-Arber, Cottencin, & Rolland, 2014). Where they have been installed, DCRs have become an integral part of harm reduction, which is defined by the World Health Organisation (WHO) as “a concept aiming to prevent or reduce negative health consequences associated with certain behaviours,” (as cited by Moore, 2004).

Ireland has a relatively recent history of public problem drug use. In 1979 an “opiate epidemic” occurred, when heroin became increasingly available (O’Shea, 2007). Growing rates of Human Immunodeficiency Virus (HIV) in the 1980s led to an increased interest in public health and a withdrawal from a criminal response to the drug problem. In 1989 the first needle exchange was established and through these services research began to show a prevalence of public injecting and risk behaviours. Statistics showed that in 2003, 5.6 per thousand of the Irish population use drugs (Moore, 2004). At present, drug induced mortality rates in Ireland are at 71.1 per million, with 214 deaths in 2015 (EMCDDA, 2016).

This research commenced in December of 2015, around the time that the Cabinet approved the drafting of the legislation of a bill to allow for a “supervised injecting facility,” a version of a DCR (Duffin, thejournal.ie, 24 December 2016). As of 10 May 2017, the *Misuse of Drugs (Supervised Injecting Facilities) Act* has been approved by both the Dail and the Seanad. The Health Service Executive (HSE) issued tender documents for a pilot service at the start of August, with the hope that a service provider and location can be decided on by the end of October 2017 (D’Arcy, irishtimes.com, 12 September 2017).

The focus of this research is factors concerning conduct and access to a DCR, and therefore how to make the DCR as accessible, and manageable, as possible. DCRs are developed to best suit their drug-using population, specifically the drugs available and their quality, the preferred route of administration, and socio-cultural and legal precedents (Hunt, 2006b). Factors concerning access can have two effects, either limiting those who wish to use the service and therefore reducing its impact, or allowing certain groups to use the service and possibly recruit new drug users (Hunt, 2006b). It is important that any policy decisions surrounding these services are made with these possibilities in mind.

2. Methodology

This research took place in one of Dublin’s drug and homeless services, which is also a potential candidate for a DCR. This service already provides a needle exchange, providing clean needles, and associated paraphernalia, as well as injecting advice. Ethical approval was received from the Health Policy & Management Ethics Committee at Trinity College Dublin (06J/2016/01).

Semi-structured interviews were used with service users, policy makers and medical professionals, and a focus group was used for staff members. Asking multiple stakeholder groups is a common approach in garnering opinions about DCRs (Fry, Fox, & Rumbold, 1999; Kimber & Dolan, 2007; Small, Ainsworth, Wood, & Kerr, 2011; Watson et al., 2013). This broad range of participants was considered important to gain a comprehensive and local understanding of involvement within this setting (Kimber & Dolan, 2007; O’Shea, 2007; Watson et al., 2012; Zurhold, Degkwitz, Verthein, & Haasen, 2003).

	Service users (Clients)	Staff members	Key informants
Sampling criteria	18+, Current drug users, using drugs for 12 consecutive months, registered at the drug service for 6 months+	18+, worked in drug services for at least 1 year, worked in needle exchange for 6 months+	18+, worked in the field of drug policy for 3 years+, for local contacts, worked in Ireland for 1 year+
Data collection method	Interviews	Focus group	Interviews
Number of participants	6	6	7
Recruitment methods	Convenience sampling through staff members	Random sampling through poster with criteria advertising for focus group	Purposively through two drug service contacts with experience in drug policy and services

Prior to the commencement of data collection, the researcher conducted a literature review to develop a relevant question guide, and to prepare the researcher for any questions that participants might have.

The literature review addressed the English language literature on DCRs worldwide. The majority of this material addressed the DCRs in Sydney and Vancouver, as these are the only services in the English-speaking world, which were controversial in their introduction. Within this, only a few directly addressed rules and regulations of the service. These studies found that, on the whole, rules were generally accepted by users and if not, the issue was a result of rules that affected cultural practices, such as sharing drugs and assisted injecting (Fry, 2002; Fry et al., 1999; Hunt 2006a; Kerr, Wood, Small, Palepu, & Tyndall, 2003; Small et al., 2011; Small, Moore, Shoveller, Wood, & Kerr, 2012).

Although there is limited English-language literature on services in Europe, these studies also found a general acceptance of rules (Anoro, Ilundain, & Santisteban, 2003; Solai, Dubois-Arber, Benninghoff, & Benaroyo, 2006; Zurhold et al., 2003). Additionally they highlighted the importance of continuous evaluation of the rules, particularly with the input of the service users. Only one publication, O’Shea (2007), directly addressed DCRs in Ireland, and similar to this current study, interviewed different groups of stakeholders for a comparison of opinions. This study concluded that there was an overall willingness of drug users to utilise a service but that “key informants” were unsure of its acceptability in the political climate at the time.

As interviews progressed, the question guide was updated to rephrase questions that participants did not understand, and to add questions to prompt further discussion (Small et al., 2011), including addressing rules and regulations at existing DCRs. All participants read and signed the consent form. All interviews and the focus group were audio recorded with the permission of the participants, anonymised, and transcribed by the researcher verbatim, including non-verbal communication, to preserve context and tone (Coleman & Unrau, 2011). Transcripts were then analysed thematically using Strauss and Corbin’s (1990) three-step coding process. All interviews and the focus group were transcribed verbatim from audio recordings, and data was carefully analysed at all stages. The research is specific to the context in which it was conducted, and therefore is not generalizable. However, it may be relevant in other similar contexts, therefore it is transferrable.

3. Findings & discussion

The findings and discussion have been divided up into themes and factors concerning access, and the participants into four groups: clients, staff members, and key informants who were divided into medical professionals and policy makers. The data was presented in this way to provide a comparison of opinions, and therefore possible generate a solution that is acceptable to each group involved in the service. The majority of the current research addresses the views of only one or two groups at time. Below are two tables showing the progression of analysis of themes to the final three key themes (Table 1) and four key factors (Table 2) that were the most contentious.

Table 1. The thematic analysis of the data within the different participant groups and emergent three key themes

Key themes			
Clients	Staff	Medical	Policy makers
Image	Routine	Vulnerable	Cultural
Endless	Prejudice	Inevitable	Chaotic
Privacy	Accountability	Advocacy	Pragmatic
Visibility	Discontent	Protection	

Table 2. The four key factors (in bold) that emerged from the data

Key factors			
Opening hours	Sharing and dealing	Registration	Pregnancy
Time limits	Residency restrictions	Opioid substitution	Intoxication
Location	Types of drugs	Methods of use	Criminal record
New users	Age restrictions	Assistance & supervision	Children

3.1. Visibility

For clients, it is the notion of not being visible, by either going away to rehab, or having a place to use away from the dangers of the street, (Small et al., 2012), “...It would be great, you know, somewhere to come in and smoke heroin off the street, if you’ve nowhere to go, you know...” (C1)¹. For staff, it’s about what is visible to them on a daily basis, and the frustration that they cannot address all the problems they see because of limitations of their position, “I love the needle exchange, I love that area, I love the safer injecting, I love it, but that’s my niche, but I know when overdoses happen, I’d love to be able to give the Narcan², we can’t do it, I’d love to be able to administer oxygen, so I can’t do it...” (S2). For medical professionals, drug use is visible to them in services, and in public. “The very first person I saw injecting heroin was in a pub toilet where I walked in the door and she was injecting into her umbilicus, and she was about seven months pregnant...” (M2). These three groups shared anecdotes about their experiences in services, but this was not the case with policy makers. Visibility for them was embodied through public concerns, as some policy makers do not have direct experience in drug services. (O’Shea, 2007). “...People would like go about their business and not see any visible signs of drug use, and I think that we have to manage expectations around that, because they will still see people who are, you know, who are a bit out of it...” (P3).

3.2. Discontent

For clients, their discontent was directed at their own community’s behaviour, especially regarding nuisance surrounding public injecting (Green, 2004; O’Shea, 2007; Watson et al., 2013) “when I’ve finished using I put all me stuff back in the bag and I bring it in here and I get rid of it, I’m telling ya there’s few and far between that do that, you know what I mean, the rest just throw their s**t where they want...” (C2). However there was also sincere frustration with the disregard with which service treat drug users, “I’ve had so many friends die from it, me best friend died a few doors away from me...it was four days before, like, the staff never even checks at all, ever, and the day I moved in, until the day I moved out, I never got a room check from staff, and they still don’t, you know, but it was four days until they found him...” (C6). Staff too, saw services as struggling to provide basic amenities, and the worry that this will only get worse in a DCR if the staff are not provided with the tools to do their job, or paid properly for the nature of the work they are doing. “I’ve seen it, great bleeding staff members leaving because they didn’t feel they were getting the money that they should have done, and they are losing staff all the time, I do believe that, but I still think that it has to come from, safer injecting it has to come from a passion...” (S3). Medical professionals and policy makers saw politics as playing too big of a role, and in designed services around palatable evidence, instead of in the best interests of clients, “that was very clearly a political decision about um, you know, the

arguments that they couldn't win, um, so I think it quite clear that those exclusions were never based on medical evidence..." (M1). For policy makers, it was their discontent with the power of the court of public opinion, and even with the limited acceptable of opioid substitution treatment, there was still room for improvement, "...you're condemning him to a life of drug use, a life of methadone maintenance, a life of shuffling in and out of a state of derangement and needle exchanges and places like that, um, but then what the hell is the option?" (P4). There is a clear need for improved drug services including an improved awareness of the realities of drug use, particularly for staff and service users.

3.3. Protection

For clients, they need to protect themselves and others from overdose (Fry et al., 1999; Green, 2004; Kimber, et al., 2005; Small et al., 2011, 2012), and a DCR can offer that exact protection, "...people that's intoxicated if they use, they are probably going to OD³, so if they are going to use they might as well do it in the company of people that are there to help them if they can, do you know what I mean, but ehm, as I says they'll just go elsewhere and just use elsewhere you know?" (C5). The staff are there to keep the clients alive, but they are also aware that they themselves need to be protected and supported, "...if you were working in an environment where they're injecting all the time there's a high risk of overdose, they are sort of living on the edge or waiting for something, it's very intense, so I think supervision for the staff has to come before anything." (S3) Medical professionals saw the importance of protecting the client's agency and therefore their decision to use, "...it's their choice to share that with you so your job is to create an open environment that allows them the opportunity to feel safe and to share whatever they want to share with you..." (M2). There is also a clear need to protect the service both legally through good governance, but also by maintaining a healthy relationship with the surrounding community, (Watson et al., 2013). "I mean the reality is, you know, everybody has to kind of work together to deliver solutions for ehm, Dublin city, and this isn't something that's going to be a solution in isolation, you know, you need to have everybody, everybody on board..." (P2). Drug services are complex and convoluted environments that create scenarios in which all stakeholders need to be protected by pre-emptive policy decisions.

3.4. Themes conclusion

The key themes address the outside influences on the potential service, in particular the public and political opinion of the running of the service (Butler & Mayock, 2005; O'Shea, 2007). Additionally, the themes address the effects that a DCR will potentially have on other services in Dublin. Some of the benefits, or consequences, of a DCR are not seen within the service. It is particularly important to remember this during the evaluation of a potential service (Anoro et al., 2003; Zurhold et al., 2003).

4. Key factors

4.1. Supervision and assistance⁴

Supervision and assistance was the main attraction for clients to a DCR, (Fry et al., 1999, 2002), but it also important to maintain privacy while injecting, "...I think it would be better if there was a professional there sitting with you, and teach you how to do it properly, and then like if you know how to do it, you pass that stage, you can go in and you can do it on your own, but there's always someone there like, watching ya, just in case you know..." (C6). However, for any staff it was important to be aware of the boundaries of assistance, and most felt that assisting with injecting was too risky, and was crossing an ethical line, "...you do not inject, you're shown by a safer injector how you do it, you know, but you don't go there, because that's, you know, another area, that's a grey area, that's their decision to use, but you teach them how to use..." (S2). This has proven to be problematic in several other DCRs (Kimber et al., 2005; Small et al., 2011), and there is the issue of how this can be accommodated to not isolate clients who do require assistance. Medical staff also drew attention to investigating why clients might not be able to inject, which could be cultural or personal (Small et al., 2011), "...people learn injecting practices, you know, in just ordinary situations and it isn't always good practices that they learn and misinformation perpetuates and things like that you know, so I think that it is important that staff are present for that, information is important as well you know,

that people have the right information...” (M1). Supervision and education as assistance is a key part of a DCR, however assistance with physically injecting brings up a number of legal issues for the service, and needs to be explored further prior to a service opening, “...it’s a kind of fine line between, being too detached and not really providing supervision and at the same time creating detailed intrusive things that are going to be off-putting to clients...” (P4).

4.2. Child protection

Another legal issue that emerged was child protection, and the responsibilities of both the parent and the drug service. Most service users have witnessed the effects of a drug using environment on a child, “I’ve seen it f**king with me own eyes, kids being told, you know what I mean, go in the bedroom you know, and don’t come out...” (C1), and didn’t want children coming into the service. Staff members struggled with child protection policies in both how it affected the users as well as the children, “...so a woman that is at home with a child and doesn’t know how to inject safely and is stuck in her house, because she’s afraid to come in here, because she will be reported to social services...” (S5). Medical professionals saw this situation as far more black and white when it came to children, “I would never be part of a service that wasn’t going, you know, just do the same as what every other health service is bound to do in terms of protecting the most vulnerable in terms of the kids in our community,” (M1). The discussion evolves into a weighing of outcomes for the children, alongside the legal responsibilities of the service. On the other hand, policy makers did not consider parents presenting with their children to be a frequent occurrence at the service, but felt that access should be adapted accordingly, and that an earlier intervention is better, “...people showing up with children, these are likely to be isolated incidents, they are not going to be everyday occurrences, if they do turn out to be kind of everyday occurrences, and people are turning up and it means that because there’s kids there that people aren’t able to access to the service, then obviously something needs to be put in place around that and there needs to be support for um, for those children,” (P2). There is a clear need for a discussion with not only the different stakeholder groups, but the different services involved in child protection to guarantee both the safety of the children, as well as the effectiveness of a DCR for the drug user.

4.3. Age restrictions and inexperienced drug users

Most participants felt that 18 was an appropriate age, including the clients who had all started using before this age, “...when I started off on needles I was only fourteen, but I wouldn’t want to see a 14 year old walking into a consumption room and using drugs...” (C4). Although this age restriction would limit legal issues with the service, there was also the risk that this could limit the most vulnerable users, and that there is a clear advantage to receiving the correct information about injecting from the start. For staff, this similarly applied to inexperienced users, “I think a first-time user, it makes no odds, because once, at least if they are first time users they are getting the proper information around safely injecting, and you’re doing the harm reduction ...” (S5). Inexperienced drug users would arguably be less of an issue than younger drug users, the only country having reported admitting inexperienced drug users is Switzerland, where in Geneva, 4 out of 736 clients reported having their first injecting in the DCR (Benninghoff et al., in Hedrich, 2004). Medical professionals agreed, and added that limiting either younger users or inexperienced users could also restrict them from accessing other services available through the DCR, “...you want to inject, you’ve never injected, and I’m giving you the needle so I need to make sure that I’m giving you all the information you need to prevent, again it’s that harm reduction, harm reduction, harm reduction, so somebody like that eighteen-year-old, which I’ve met and there will be more...” (M3). Policy makers saw the importance of flexibility in the rules and regulations with this matter, “...it’s a fairly common restriction on access that naïve injectors shouldn’t be allowed in and it should only be people who have injected before, em, and you know, by and large, I think that’s correct, but in terms of em, again, making it an absolutely hard and fast rule, I don’t think that’s helpful...” (P2). Although this issue seemed to be less divisive between the stakeholder groups, there was nonetheless a general concern about creating a service that would not address one of the most vulnerable groups.

4.4. Key factors conclusions

Similarly to other studies addressing directly the rules and regulations of a service, here too the rules that affect existing drug behaviours are shown to be potentially problematic (Fry, 2002; Fry et al., 1999; Small et al., 2011, 2012). However, the key factors also highlight the importance of the staff in the service when it comes to making decisions surrounding these rules, and how the success of the service is in a major way determined by the relationship between clients and the staff (Solai et al., 2006).

5. Limitations and recommendations

5.1. Limitations

There is limited literature focusing directly on factors concerning access for DCRs. Research pertaining to harm reduction in Ireland, specifically DCRs, is also limited. This study only represents the views from one service in Dublin. As a DCR in Dublin has not yet been established, many of the questions were difficult to answer.

5.2. Recommendations

For any potential DCR, it is important that clients are involved in the development of factors concerning access, and all stakeholders continually evaluate these. The three factors mentioned should be explored by the potential service provider from a legal and service standpoint by looking at existing data from services addressing these issues, and to generate a clear stance on these issues to present to the public. It would be recommended to repeat this research in other drug services within and outside of the city, to understand if these views are service or city specific, and if there is a need for more DCRs. Furthermore, research addressing the non-drug service perspective must be completed to ensure support from all stakeholders. In a general sense, drug addiction and treatment services in Dublin, and any location potentially providing a DCR, need to be more researched, focusing on the availability and suitability of these services for both service users and staff. Constructive relationships between health and drug services need to be promoted, and limitations on these services from a drug culture standpoint should also be explored.

6. Conclusion

This study sought to explore factors concerning access for a potential DCR in Dublin, Ireland, and to discuss the different viewpoints of the various stakeholders in this service, an aspect which is not commonly represented in research addressing DCRs.

The thematic findings of the project show a need for a better understanding of the different approaches of the stakeholder groups in the operation of a DCR. Factors concerning access show that the attitudes in this research towards the existing rules are not so radically different in so far that a potential service in Dublin could look to existing literature regarding DCRs and their rules and regulations as a guide during the development process.

There is pressure on any new service to prevent any fatalities, as this has been considered to be a critical success factor of DCRs. However, expectations, and therefore access factors, need to be realistic and flexible; as such, a service cannot address all the variables of drug-related harms, or be seen as a solution to any city's drug problem. Instead, a DCR can aim to address existing barriers to access by making the DCR as accessible as possible to those who need it most. Furthermore, it is important to focus on what health and social services can be integrated into the DCR, and to develop it into more than a supervised injecting service through cooperation with other health, drug and social services.

It is also important to be aware of how the DCR may affect social and structural relations with the community both inside and outside the service. There is a lot of room for improvement in drug and related health services, and the participants' worry is that these will not be addressed by DCR, even possibly worsened. Despite the limited resources, there is an overwhelming sense of responsibility

felt by the participants to themselves, their clients and their service respectively, whether legally, professionally, ethically, or personally. Any concerns here can be mitigated in a DCR through clear rules and regulations.

Therefore, it is clear that to attempt to create a service that deals with an issue that is highly stigmatised and criminal, and with clients who are increasingly marginalised, it is necessary for each factor concerning access to be addressed from the perspectives, and with the participation of all stakeholders.

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Notes

1. A participant in Kimber, Dolan, and Wodak (2005) also said that these kinds of services were a place for those who had nowhere else to go (p. 258).
2. Narcan, among others, is the brand name for Naloxone, a medication used to block the effects of opioids, especially in overdose (www.drugs.com).
3. "OD"—overdose.
4. Supervision is a core aspect of a DCR, and is reflected in the title of certain services, such as the Medically Supervised Injecting Centre in Sydney Assistance has presented in the research in two ways, either offering safer injecting advice or directly assisting with injections, the latter of which is not allowed in almost all DCRs (Hunt, 2006b).

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