INHSU 2017

Drug Consumption Rooms as a Measure of Harm Reduction to Reduce Infection Risks - Experiences and Practice

Speakers

- Eberhard Schatz, Netherlands
- Marie Jauffret, France
- Elisabeth Avril, France
- Andreas Bänninger, Switzerland
- Jason Farrell, Netherlands
- Tessa Windelinckx, Bel;gium

Discussion with the audience

Correlation
European Network
Social Inclusion & Health

Improve access and quality of health and social services for marginalised groups

- European network since 2004
- More than 180 partners in all European countries
- Hepatitis C Initiative since 2014
- Host of the International Network of Drug Consumption Rooms

Overview on Drug Consumption Rooms worldwide

History

Legal aspects

Country reports

History of DCR's

- HIV/AIDS epidemic begin '80
- Harm Reduction
- Experiments in the Netherlands, Germany, Switzerland by the end of 1980
  - 1986 Switzerland, 1992 Germany 1998 the Netherlands
- Begin 2000 Canada, Australia, Norway, Luxemburg, Spain
- Lately Denmark, France 2016
- Serious efforts in Greece, Slovenia,…, Italy, Portugal, Belgium
- Coming: USA, Ireland, Canada+

HR17

Legal Aspects

- national legislation > pilot projects
- international legislation
  - United Nations
    - International Narcotics Control Board (INCB)
    - United Nations Office on Drugs and Crime (UNODC)
    - European Drug Strategy

Legal Aspects

National:

A DCR operates within the legal system of the particular country in which it has been established, either as an independent legal entity, as a unit of a healthcare facility, as a non-governmental organisation (NGO), which is very common, or as part of a local governmental or public health service. In most countries, it has been necessary to modify specific laws in order to decriminalise drug consumption in the DCRs.

International:

The International Narcotics Control Board (INCB), the UN body responsible for monitoring the implementation of the UN drug conventions has repeatedly expressed its concerns regarding the development of DCRs **but changed position in 2016.**

The United Nations Office on Drugs and Crime (UNODC) came to the conclusion in 2002 that many interventions, including DCRs, were not contrary to the conventions.

The European Drug Strategy, a not binding recommendation, expresses favor for a comprehensive, well balanced drug policy including measures like drug consumption rooms.

Publications

Methods

- **Integrated DCRs** are part of a wider network of services for people who use drugs. The drug consumption room provides an important additional component of services alongside services like OST, drop in centres and counselling.
- **Specialist DCRs** focus on protected places for hygienic consumption of drugs in a non-judgmental environment. They are usually set up close to other drugs services and located near open drug scenes. They can refer to other services.
- **Mobile DCRs** are specially fitted out vans with 1 – 3 injections booths inside. Mobile DCRs avoid the risk of making one building the focus of all activities and they can reach people where they are.
- DCRs for women/housing projects and shelters

ONLINE CENSUS OF DRUG CONSUMPTION ROOMS AS A SETTING TO ADDRESS HCV: CURRENT PRACTICE AND FUTURE CAPACITY

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International Network of Drug Consumption Rooms
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Drug Consumption Rooms (DCRs) / Safe Injecting Facilities (SIFs) & HCV

- provide space for self-administration of drugs in hygienic conditions and under the supervision of qualified staff (EMCDDA, 2016)
- demonstrated to attract the most vulnerable people who inject drugs (PWID), see e.g. (Hadland et al., 2014, Kimber et al., 2008, Kimber et al., 2003, Reddon et al., 2011, Stoltz et al., 2007, van Beek et al., 2004, Wood et al., 2005, Wood et al., 2006):

  HCV prevalence among DCR/SIF clients: 63 % in Germany (Scherbaum et al., 2009) or 43 % in Spain (Bravo et al., 2009)
- decrease risky injecting behaviours as an outcome of DCR use, see e.g. (Bravo et al., 2009, Kerr et al., 2005, Kinnard et al., 2014, Stoltz et al., 2007a, Wood et al., 2005b, Zurhold et al., 2003)
- specific HCV prevention & treatment in these settings haven't been described.
- **There are no international DCR standards for HCV practice and research is yet to address how DCR clients and their access to HCV prevention, treatment or supportive services.**

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1] Survey aims and participants

2] HCV prevalence and services

3] Needs and opportunities

1] Survey aims and participants

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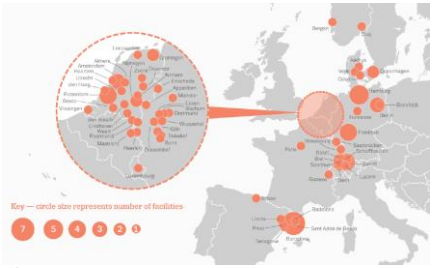
Online survey of DCRs/SIFs

Research questions

- What are the characteristics of DCR clients with respect to HCV?
- What is the range of HCV services currently offered at DCRs and what are their operational capacities?
- What are the gaps, needs and/or resource requirements needed to increase HCV awareness, prevention and treatment among DCRs?



Exhaustive sampling - 92 DCRs operating in 10 countries:

- Norway (n=1)
- Denmark (n=5)
- Germany (n=24)
- Luxembourg (n=2)
- Spain (n=13)
- Switzerland (n=13)
- Netherlands (n=30)
- Australia (n=1)
- Canada (n=2)
- France (n=2)

EMCDDA (2017): Drug consumption rooms - an overview of provision and evidence; Perspective on drugs.

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DCR[13] INTERNATIONAL NETWORK

Survey participants

Response rate

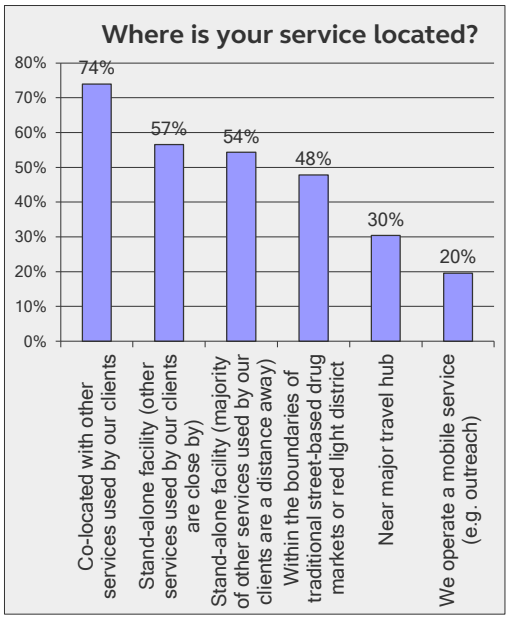
- answered by service managers, no question was obligatory
- n=51 valid responses (55%); each country where DCR/SIF(s) operate was represented

Organisations:

- not-for profit (67%)
- local or central government (40%)
- private entity (7%)
- charity / religious organisation (n=1)

Funding:

- local/municipal (71%), state / regional (36%) or national government (13%); charity (9%); social / drug subsidies (4%)



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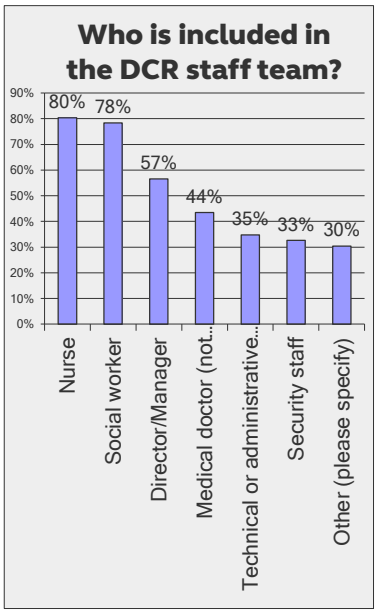
DCR INTERNATIONAL NETWORK



DCR/SIF capacity and day-to-day operation

- Mean **7.4 paid and 0.5 unpaid** workers present onsite on average day of operation
- On average, **6 places** for drug consumption in each DCR; the max no of places was:
  - ✓ 23 for injecting
  - ✓ 40 for smoking
  - ✓ 16 for inhaling
- The **average number of visits** each day was:
  - ✓ 72 to inject
  - ✓ 51 to smoke
  - ✓ 12 visits to snort/inhale

Correlation European Network Social Inclusion & Health | Uniting | DCR International Network

Are these offered to your clients ONSITE or do you refer them elsewhere?

	Onsite	Perc	Refer clients elsewhere	Perc
Condom provision	41	89%	6	13%
Overdose management, emergency/ambulance	41	89%	12	26%
HIV-related counselling	32	67%	19	41%
Case management	29	63%	18	39%
HIV testing / screening	25	54%	25	54%
Out-patient counselling	21	46%	24	52%
Mental health care	20	44%	27	59%
Referral to care/treatment facilities (e.g. drug treatment, primary and mental health care facilities)	43	94%	n.a.	n.a.
Needle/syringe distribution (clean equipment to take away)	43	94%	n.a.	n.a.
Provision of drug paraphernalia (e.g. foil, filters, ascorbic acid)	43	94%	n.a.	n.a.
Use of a phone, phone charging facilities	42	91%	n.a.	n.a.
Coffee/ tea	41	89%	n.a.	n.a.
Personal care (e.g. shower, washing clothes)	35	78%	n.a.	n.a.
Support with financial and administrative affairs	34	74%	n.a.	n.a.
			answered question	46
			skipped question	5

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2] HCV prevalence and services

DCR/SIF clients

Client characteristics:

- **82 %** men
- **70 %** ever in treatment
- **57 %** in treatment
- **39 %** homeless
- **15 %** HIV positive

HCV-related:

- up to **100 %** HCV tested (median 80 %)
- up to **90 %** HCV positive (median 60 %)

	What proportion (%) of your clients/visitors do you estimate have been tested for HCV?	What proportion (%) of your clients/visitors do you estimate are HCV positive?
No information available	n=6	n=4
Provided an estimate	n=41	n=41
MIN	15	1
MAX	100	90
MEAN	71.1	57.1
MEDIAN	80	60
25 perc	50	50
75 perc	90	73

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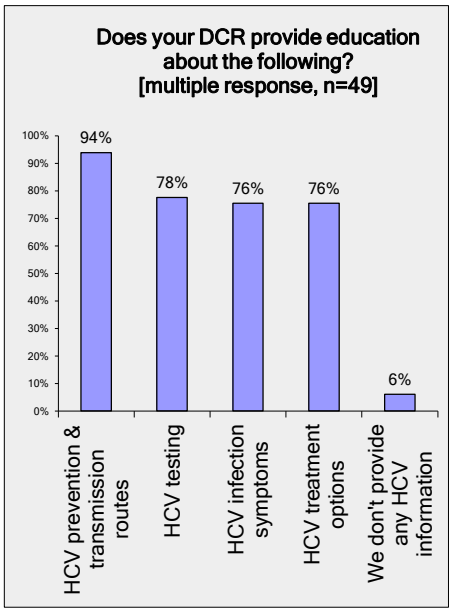
HCV-related education

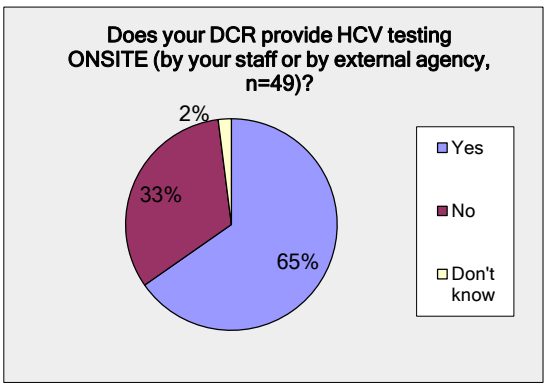
- HCV-related education pertaining to transmission routes, testing, symptoms and treatment provided in (almost) all DCRs

Education provided through:

- brochures and pamphlets (89%)
- individual client consultations (88%)
- posters (70%)
- digital resources (20%)
- (20%) educational campaigns or quizzes
- group educational sessions (17%)



HCV testing



- **2/3** of DCRs in the survey provide HCV testing onsite
- pre- (**65%**) and post-test (**68%**) counselling
- **57 %** referred offsite

HCV testing methods:

- blood sample taken from the vein (68%)
- via saliva (32%)
- with a finger prick test (32%)
- other (20 %), e.g. PCR testing (n=2).

From those that currently weren`t providing HCV testing onsite (n=17), eight said that they were planning to provide HCV testing onsite in the future.

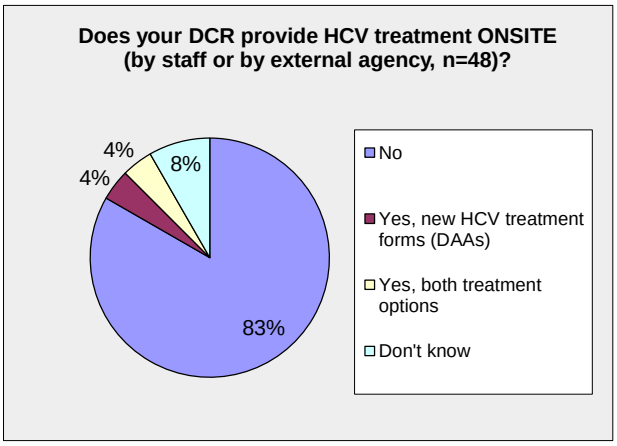
HCV support services

- HCV support was available for clients offsite (**94%**)
- Clients referred elsewhere (**96%**).
- half of the DCRs (**51%**) planning to expand their HCV support services in future

Does your DCR provide support to HCV positive clients ONSITE? [multiple response]

Answer Options	Response Percent	Count
Yes, referral to other services that can provide HCV treatment	80%	37
Yes, disease self-management support (e.g. alcohol consumption, healthy diet, obesity)	50%	23
Yes, liver health/cirrhosis monitoring/assessments (e.g. Fibroscan, blood test)	24%	11
No, we don`t offer any support services to HCV positive clients ONSITE	15%	7
Other (please specify)	7%	3
answered question		46
skipped question		5

HCV treatment



- new treatment (**92%**) or interferon-based treatment (**50%**) **available for clients offsite**
- not planning to provide it in the near future (**95%**)

DCR/SIFs served as a referral point to these treatments (86%).

3] Needs and opportunities

What would your service need to allow you to provide MORE HCV services?

	Percent	Count
More staff time	51%	24
More staff training	45%	21
More funding for equipment and services	38%	18
More educational and training materials for staff	38%	18
More educational materials for clients	30%	14
Hire staff with different qualifications	30%	14
Change in national-level treatment guidelines that encourage HCV treatment for active drug users	23%	11
Capacity for peer workers to contribute	21%	10
Specific approvals to provide services on our site	15%	7
Change in national-level policies to facilitate access to health care reimbursement to our clients	17%	8
Not applicable - We DON'T need anything further to support HCV services and support	11%	5
We CAN`T support HCV services any further (not within our purpose)	6%	3
answered question		47
skipped question		4

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Increasing DCR/SIF capacity in HCV service provision

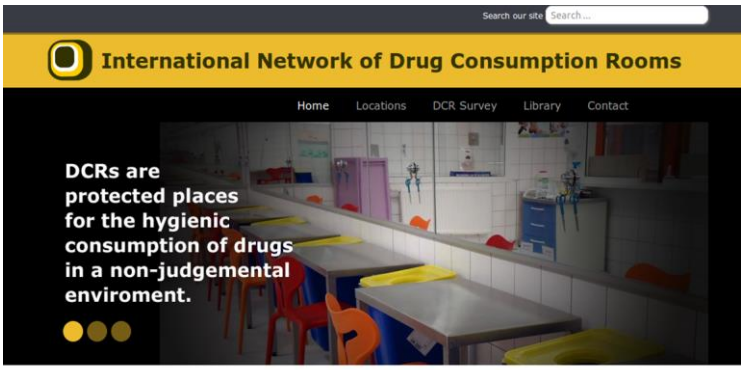
How would you spend any additional HCV related funds (n=46):

- employ additional medical staff (52%)
- spend it on additional staff training (46%)
- develop policies and procedures for staff (26%)
- develop client education around HCV (52%)
- fund educational materials for clients (41%)
- employ peer support workers (26%)
- funding a needs-assessment (24%)
- develop referral pathways to a specialist (24%)

Two organisations mentioned that they would purchase a fibroscan and one organisation mentioned that they would fund advocacy for the possibility of providing HCV treatment to "clandestine" persons.

Conclusions

1. DCRs/SIFs provide a broad **range of social and health services**
2. safe environment for **marginalised populations of drug users**
3. **high infection rates for HCV** among the DCR/SIF clients
4. **prevention of blood borne infection** diseases among the priorities for these facilities
5. DCRs/SIFs provide some HCV related services already or are **interested to do so in the near future**
6. **easy to apply new testing and treatment**
7. financial resources for **capacity building** and specialized staff needed



"Research to prove that injecting inside drug consumption rooms is safer than injecting elsewhere, is like needing to prove that jumping from a plane with a parachute is safer than jumping without one."

Joan Colom I Faran in Viral Hepatitis in Europe, 2014

More information

Reports will be made available soon on

http://www.drugconsumptionroom-international.org/

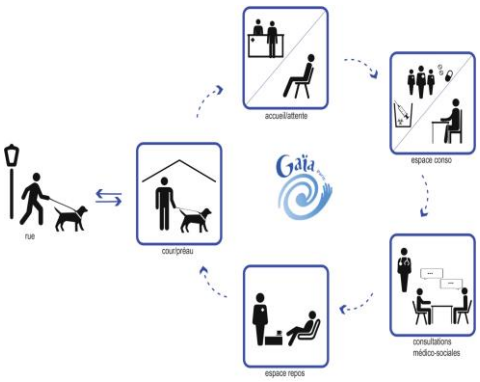
Thank you !

FUNCTIONING OF THE DCR

- Team composed of **GPs, nurses, social workers, security agents** and **peer workers**.
- The DCR is opened 7/7, from 1:30 PM to 8:30 PM.
- 1 **injection room** with 12 booths, 1 **inhalation room** with 4 booths

OPERATING RULES

- Only for **PWID**, over 18 years old
- **Free and anonymous**
- Inclusion interview at the 1st visit,assessement, operating rules linked to the signature of a contract
- **20 minutes** for each consumption
- No restriction on products allowed
- No limited time in the resting area
- **Services** : medical and social consultations, refering to substitution treatments



CHARACTERISTICS OF THE PUBLIC

- Sex ratio 0.1326
- Average age : 37.8 years old (21-69)
- 40% without income
- 28% with no health coverage
- 52% homeless
- 48.33 % have a medical follow up
- 27% with no social or medical follow up
- 45% VHC+ (40% with no access to care)
- 5.4% VIH+
- 42% clients : last screening>6 months

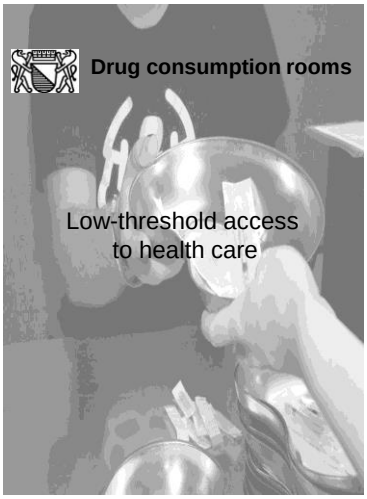
September 2017

Drug consumption rooms of Zurich

Hepatitis C Testing in drug consumption rooms – 6 years of experience

City of Zurich
Social Services and Facilities

Hepatitis C Testing:
A Collaboration with Arud Centres for Addiction Medicine



City of Zurich, Social Services and Facilities
Consumption rooms

Procedure

- HCV workshops with consumption room teams
- Hep C Information Days
- Rapid saliva test and counseling
- Positive test: clarification for chronic hepatitis C
- Liver fibrosis assessment
- Medical advice
- Therapy delivery

City of Zurich, Social Services and Facilities
Consumption rooms

Conclusion

- Ideal setting to reach the unreached
- Great interest from the client side
- Harm reduction element with positive medical and social effects
- Important role of care
- Successful cooperation between two different Suppliers
- Testing as an annual offer

Thank you for your attention!

andreas.baenninger@zuerich.ch

City of Zurich, Social Services and Facilities
Consumption rooms

15 years
Hepatitis C
management at
Free Clinic Antwerpen

Low threshold centre, working with PWUD,
OST, NSP,
C-Buddy care,
and counseling.

Continuum of care

Diagnosis

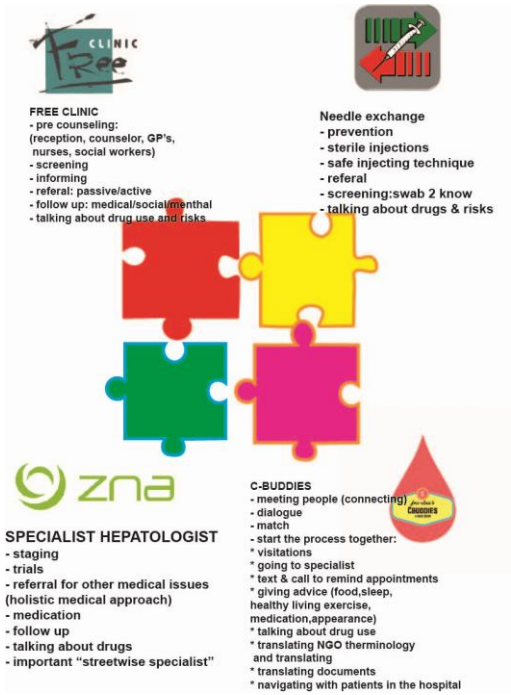
Screening
Case-finding
Diagnosis
Awareness

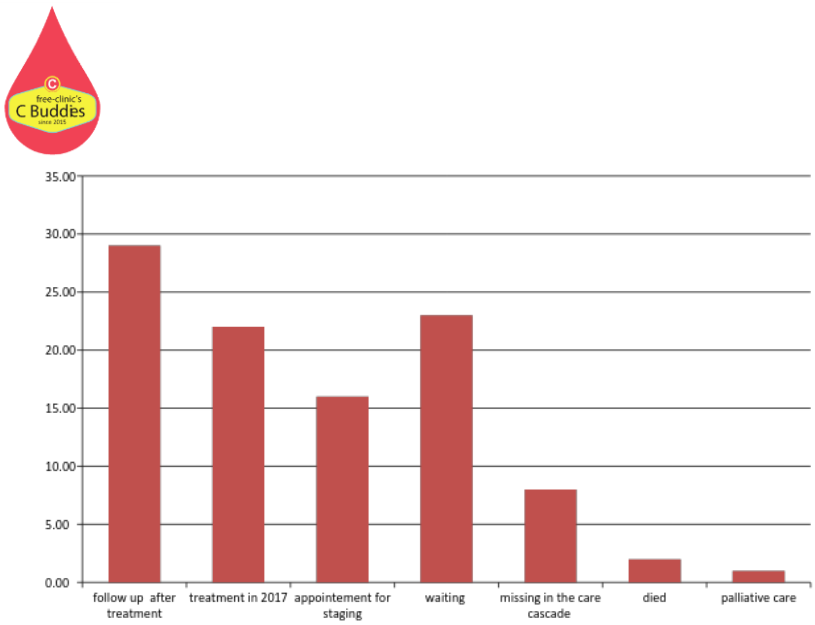
Linkage to care

Treatment

Assessment
Initiation
Adherence
completion

Prevention of reinfection


CLINIC
Free
FREE CLINIC
- pre counseling:
(reception, counselor, GP's,
nurses, social workers)
- screening
- informing
- referal: passive/active
- follow up: medical/social/menthal
- talking about drug use and risks
Needle exchange
- prevention
- sterile injections
- safe injecting technique
- referal
- screening:swab 2 know
- talking about drugs & risks
zna
SPECIALIST HEPATOLOGIST
- staging
- trials
- referral for other medical issues
(holistic medical approach)
- medication
- follow up
- talking about drugs
- important "streetwise specialist"
C-BUDDIES
- meeting people (connecting)
- dialogue
- match
- start the process together:
* visitations
* going to specialist
* text & call to remind appointments
* giving advice (food,sleep,
healthy living exercise,
medication,appearance)
* talking about drug use
* translating NGO therminology
and translating
* translating documents
* navigating with patients in the hospital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follow up after treatment
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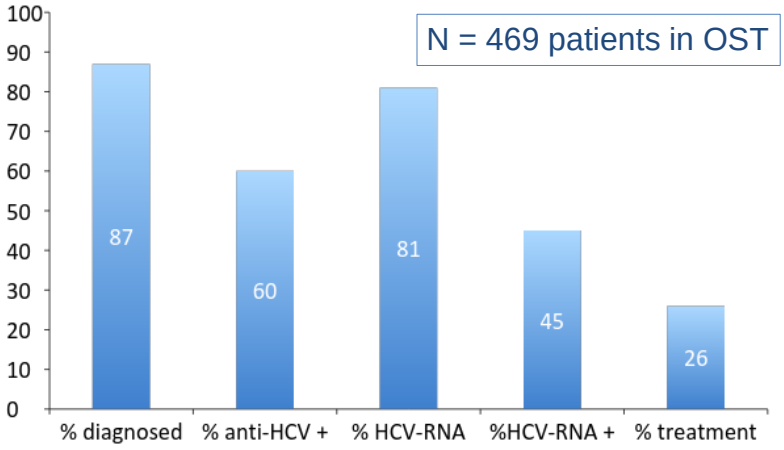
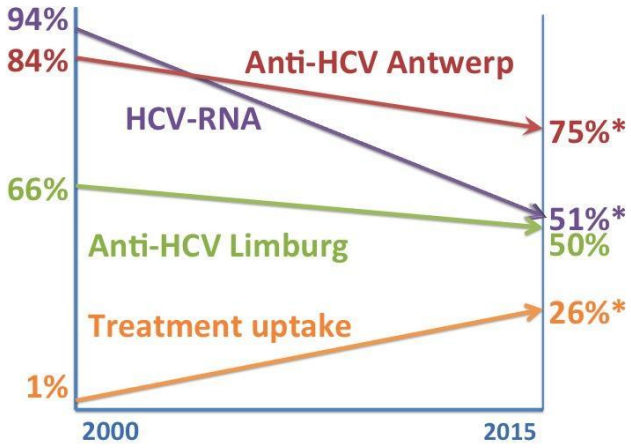
missing in the care cascade
died
palliative care

Hepatitis C care continuum Free Clinic 2015



Evolution over time



* p<0.05

HCV management in Antwerpen :

a team effort

All dedicated workers who got "caught" by the Hepatitis C Virus.

- Hepatologist ZNA : **dr Stefan Bourgeois**
- Addiction centre Free Clinic: **dr Cathy Matheï**
- Reference Nurse: **Griet Maertens**
- NSP Flanders: **Tessa Windelinckx**
- C-Buddy Team: **Stefan Bratovanov, Tonny Van Montfoort, Anton Van Dyck**
- All health care providers from Free Clinic and other organizations.

Challenges in the DAA era

- Alcohol use
- Drug use during treatment
- General health condition of clients
- Stabilising clients in all living conditions

JOIN INN

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- Cathy.mathei@free-clinic.be
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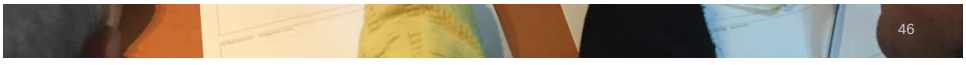
- stefan.bratovanov@free-clinic.be
- Tessa.windelinckx@free-clinic.be
- facebook: C-Buddy C-Buddy

PREVENTING HCV AMONG INJECTORS

Capacity Building for Harm Reduction Programs

Jason Farrell, Correlation Network



ACKNOWLEDGEMENTS

- We would like to thank AbbVie and Gilead for their generous support for our HCV Capacity Building Initiative.
- We would also like to thank the INHSU conference committee for supporting our workshop presentation.

OVERVIEW

- During the months December 2015 to March 2017, HCV Capacity Building Trainings were conducted in six European countries Denmark, Greece, Italy, Norway, Portugal, and Spain.
- Each site had up to 20 participants, including translators when needed.
- Organisations and countries where chosen based on a eligibility criteria including;
  - Capacity of the organisation
  - Willingness to implement and/or enhance HCV services
  - Dedicated peer workers or staff to provide HCV services
  - Linkages with medical facilities for testing and treatment
  - In a country with high HCV prevalence among PWID
- Organisations chosen received € 2,000 to pay for translators, lunch, and to provide travel assistance as needed for PWID peer worker participants.

GOALS AND OBJECTIVES

- To provide the technical support needed for harm reduction programs and drug consumption rooms to become key components in reducing HCV infections and connecting individuals to treatment.
- To enhance the capacity of harm reduction programs to provide effective prevention services, testing and treatment support to stop new infections among drug injectors.
- To improve the knowledge about HCV among staff and peer workers
- To improve staff and peer workers skills on how to engage participants in outcome driven prevention counseling and testing services.
- To collectively prepare a implementation plan that supports staff, peers and the organisation to provide comprehensive integrated prevention services designed to connect individuals to HCV treatments, and minimise risk behaviours that can result in re-infection post treatment.

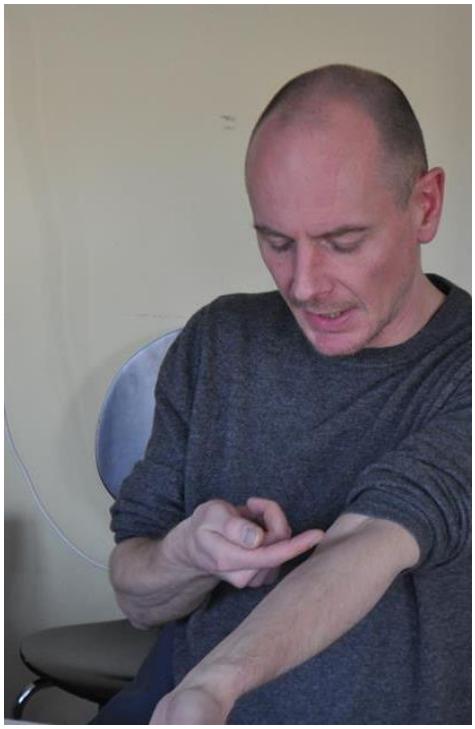
OUR TRAINING

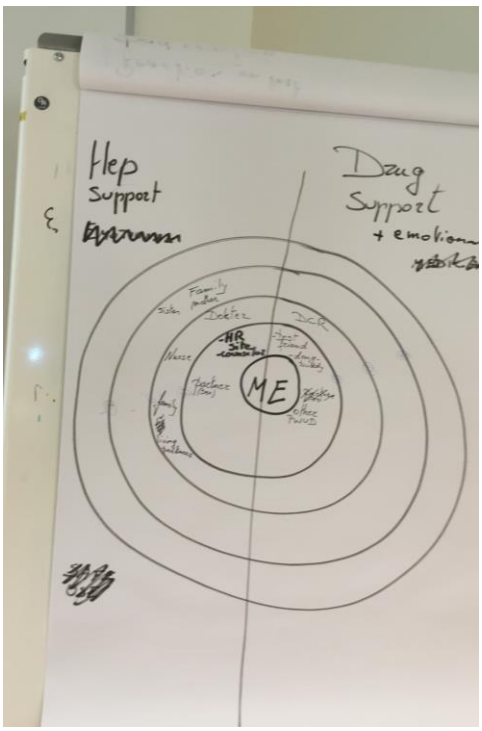
- The training consists of six modules, provided in two days.
- Modules varied from 90 to 120 minutes long, with 30 minute breaks between each module.
- Throughout the training we had several opportunities for role playing, teams working together, and larger groups to work together.

OUR TRAINING

The two-day curriculum included:

- Prevalence of HCV in EU and locally
- The liver and hepatitis virus
- HCV testing and screening
- HCV rapid testing demonstrations HCV pre/post test counselling
- HCV prevention for drug users
- Injection techniques/demonstration
- Behaviour counselling-interventions
- Prevention planning demonstration
- HCV services integration planning
- Anonymous training evaluation





BEHAVIOUR CHANGE

- The social network behavioural intervention we recommend is designed to assist with supporting safer behaviours post treatment to prevent re-infection.
- We offer a structured step by step process for supporting the elimination of risk behaviours over a period of time keeping the individual engaged in care.
- The goal is to assist the injector identify risk behaviours, create a prevention plan and steps towards eliminating or minimising the risk behaviours during the HCV treatment time period and waiting for HCV treatment.
- Post treatment the injector will have incorporated newly learned safer behaviours, and have a new social support network in place to maintain safer behaviours whereby preventing re-infection.

FINDINGS

- Our post training evaluation showed the training provided direly needed information and support.
- When asked what topic/module was most important, three modules were indicated:
  - transmission risks for PWID
  - other risks of HCV transmission
  - risk behaviour counselling.
- We found many who participated in the trainings never had formal harm reduction counselling training, safer injection training, or had knowledge of the various HCV prevention needs for drug users/injectors.
- Follow up support requested at almost every site was asking to remain additional day's post training to shadow staff during the implementation of the behavioural intervention and prevention planning/counselling.

LESSONS LEARNED

- We found at many sites there is a lack of appropriate injection equipment available to prevent HCV, and at sites where there was equipment inadequate amounts were being distributed. The amount of, and specific type of injection equipment distributed will impact the NSP's ability to prevent or increase HCV infections.
- There was an overwhelming number of staff, peer workers and volunteers who lacked basic risk reduction counselling skills, and knowledge on how to engage in discussions about risk behaviours with drug users. Without these skills HCV prevention will not be effective.
- Our training experience has showed there are significant gaps in knowledge and experience among management staff regarding harm reduction counselling, safer injection skills and HCV prevention needs for injection drug users.
- Numerous studies have shown peer workers are extremely important for providing testing, injection risk counselling and treatment support. Therefore, we strongly recommend peer workers must be well trained and supervised.
- At each training participants reported receiving very little, if any supervision/support or formal training. We strongly recommend clinical and administrative supervision and support for all workers and volunteers.

NEW TRAINING

- Based upon our findings we have revised our training to address gaps in HCV knowledge, behavioural counselling skills among management and supervisiors.
- We have modified our capacity building training for drug consumption rooms. The training was piloted in Amsterdam.
- Our revised training will dedicate more time on stages of change, showing how the individual can move from one stage to another within the intervention.

MOVING FORWARD AND TRAINING

- We are presently re-visiting a few organisations we trained to assist integrate the behavioural counseling intervention, HCV testing in time for European HIV/HCV Testing Week
- We are also going to re-visit other organisations we trained to support and shadow staff with the implementation of their identified HCV prevention service plans.
- Due to the lack of appropriate supervision, experience or basic skills of knowing how to engage PWID in conversations directed towards behaviour change outcomes we will dedicate the first morning to team leaders and managers; covering harm reduction and counselling techniques; basic overview of motivational interviewing; stages of change and skills needed for supervising drug using peer workers.
- If harm reduction programs and drug consumption rooms are to become key stakeholders for community testing, connecting high risk individuals to treatment and preventing re-infection, the core components of our training are direly needed.

WHAT ARE YOUR EXPERIENCES?

- Based upon our findings we would like to know what your experiences have been, and what you think is needed to improve skills, knowledge and services.

- What are your experiences addressing risk behaviours?
- Management skills
- Supervision?

- What gaps do you see or experience to provide effective HCV prevention and treatment support?

- What would be needed?

CHALLENGES

- Unstable persons
- Working with peers
- How to address the myths
- Social environment
- Dcr – relation hospital

THANK YOU