Scher *et al. Harm Reduction Journal (2024) 21:216*
https://doi.org/10.1186/s12954-024-01099-3

Harm Reduction Journal

PERSPECTIVE **Open Access**

Exploring drug consumption rooms as 'inclusion health interventions': policy implications for Europe

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Abstract

People who use drugs are among the most socially excluded groups in Europe. Qualitative research on Drug Consumption Rooms (DCRs) has reported various benefits to clients, including increased feelings of well-being, safety and connection, however, few studies have explored in-depth client narratives of belonging and social inclusion. In this article, we explore this literature and describe the ways in which DCRs foster social inclusion and feelings of belonging amongst their clients. With a view towards the future of DCR implementation in Europe, this argument positions DCRs as effective 'inclusion health interventions'. The shift in analysis from DCRs as a purely harm reduction or overdose prevention and response intervention to one of 'inclusion health' could work towards a wider recognition of their effectiveness in addressing broader health and social inequities. At a policy level, this shift could result in increased political support for DCRs as recognized interventions, which through their design, effectively promote social inclusion.

Keywords Inclusion health, Social inclusion, Belonging, Drug consumption rooms, Overdose prevention centres, Safe consumption facilities

Introduction

In June 1986, the first drug consumption room (DCR) in both Europe (EU) and the world opened in Berne, Switzerland. Today there are 101 DCRs of varying models across 13 EU countries (EUDA, [32]). Where implemented, these facilities successfully reduce overdose risk, connect structurally vulnerable people who use drugs with auxiliary services, and reduce public drug consumption and drug related litter [18, 53, 97, 103]. DCRs are typically evaluated based on their ability to impact upon public health and public order outcomes [48]. While the significance of these outcomes is important, so too, are the broader social dimensions of drug use and risk reduction and, in particular, the mechanisms of how these interventions initiate engagement and keep people engaged with supervised consumption and related auxiliary services [103].

Understanding the ways in which clients experience DCRs helps to mitigate unintended consequences such as service avoidance or service discontinuation [10, 19, 73]. In addition to understanding barriers or exploring peoples' negative experiences with DCRs, understanding positive experiences can help maximize potential service facilitators and the value of a service. While measuring core public health priorities is important [96, 99], expanding these core outcomes to include ethical considerations and an exploration of the value added to people's

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lives beyond traditional biomedical public health metrics is essential [80, 118].

Whilst qualitative research has reported various benefits of DCRs, such as increased well-being, safety and connection [34, 47, 50, 66], in this article, we describe the ways in which DCRs foster social inclusion and feelings of belonging amongst their clients. With a view towards the future of broader DCR implementation in Europe, this argument positions DCRs as effective 'inclusion health' interventions [62], building on a recent realist review describing overdose prevention centres or DCRs as spaces of safety, trust, and inclusion [103]. This realist review drew on 391 articles and described how DCRs work through contexts, mechanisms, and outcomes applying realist methodologies [77]. Here, we draw primarily on qualitative findings, and explore the theoretical basis for DCRs to be seen as explicitly inclusion health interventions in Europe. The shift in analysis from DCRs as a purely harm reduction intervention to one of 'inclusion health' could work towards a wider recognition of their effectiveness in addressing broader health and social inequities beyond overdose mitigation and response, that DCRs send the 'right message' [56, 72]. At a policy level, this shift could result in increased political support for DCRs as recognized interventions, which through their design, could work specifically to promote social inclusion [97].

Context

Over the last 2 decades, rates of fatal overdose have remained steady in most EU countries [78, 112]. Despite this, experts have raised concerns, warning that these numbers could spike in the coming years due to the recent appearance of synthetic opioids within the illicit drug market [4, 30, 44, 52]. Scholars have suggested that policy opportunities to expand DCRs across the EU have been created by both the COVID-19 pandemic [85] and the political necessity for policymakers to respond to increased localized rates of overdose [109]. Research across fields of study seeking to optimize the design, delivery and client experience of DCRs is therefore timely.

Typically implemented in urban settings with high, concentrated numbers of people who use drugs, the consistent objective of these services, irrespective of the model of operation (mobile, stand-alone, integrated, or temporary) [97], is to offer a safe, hygienic and supportive environment for people to consume illicit substances under the supervision of trained staff (traditionally a variety of peer workers, harm reduction workers, nurses, or doctors). Whilst the primary aim may be to respond to overdoses, evaluations have highlighted that offering supervised, well-resourced alternatives to public drug consumption environments can produce several additional positive effects [48, 53, 97]. These include reductions in substance-related mortality [63], substance-related ambulance callouts [88], reductions in community-transmission of bloodborne infections including HIV and Hepatitis C [35, 101] and reductions in public drug consumption [74]. Studies have also noted their ability to mitigate wider risk factors such as interactions with police [22, 110], facilitate access to wider care and support [66], and increase perceived feelings of safety and trust [103]. Additionally, researchers have noted increases in social inclusion and feelings of belonging in relation to these services [36, 50, 67, 72, 80, 84], findings under-investigated and under-theorized within the literature.

Theoretical background

Social exclusion

Scholars [1, 2, 82] have described social exclusion as a common feature of societies globally and to this day it remains a persistent problem in Europe [26, 58]. Although related to the concept of poverty, social exclusion is a term which extends beyond a purely financial indicator to encompass broader structural barriers that prevent individuals or groups from participating fully in society [58, 89, 115]. Madanipour [57] suggests that social exclusion is an "institutionalized form of controlling access to places, activities, resources, and information" (p.189).

Originating in France in the early 1970s, the term 'social exclusion' gained prominence across European social policy literature as it recognized the interplay and compounding nature of factors such as poverty, inadequate and insecure housing, poor health, restricted access to health and social services [87] and its impact on participation in democratic, legal and welfare systems [5]. Since then, the concept has been applied and recognized far beyond Europe. For example, a large body of historical social policy literature in North America has examined the ways in which exclusionary policies were devised during the eras of colonisation and slavery [13, 37, 58]. Likewise, in South America, Asia and Africa, practices which excluded people and groups along lines of race and socio-economic status were distinctive of colonial control. These histories have led to enduring disparities in relation to access to resources, health and social services and civic participation [24, 31, 43, 71]. Today, spatially, exclusion is often made visible through deprived inner-city or peripheral urban areas [45, 57, 113]. Across global contexts, scholars have emphasized the importance in both recognising and better understanding the nature of social exclusion as a way of influencing policies which promote the right of all citizens to participate in societal institutions and civic life. Scholars have also argued that a central role and duty of democratic governments is to shape social policies in ways which prevent exclusionary processes [76, 87].

Structurally vulnerable people who use drugs often face multiple forms of social exclusion. Bardwell et al. [6] define this population as people that experience "significant vulnerability based on intersecting social and structural factors, including but not limited to: (1) structural inequities, such as drug policies and laws; (2) perceptions, stereotypes, and social norms that stigmatize particular behaviours (e.g., addiction, injection drug use) and groups (e.g., Indigenous peoples, women, immigrants); and, (3) social inequities in terms of power, status, class, and income" (p.41). Challenges like housing insecurity, homelessness, substance use, food insecurity, and stigma can work to further alienate people from society, including health and social services [7, 14, 51, 61, 81, 90, 108]. These characteristics and experiences are frequently reported among DCR clients [22, 59, 95, 116]. This exclusion is compounded by policies that criminalize drug use [93] which create barriers to services and can work to push people who use drugs into unsafe, often isolated settings, thus, increasing the risks of mortality, morbidity, and health inequities [29, 91, 104]. The high prevalence of HIV and hepatitis C among people who inject drugs in Europe [107] underscores the compounded social exclusion and health inequities faced by this population [3] and in DCRs particularly [70].

Beyond services and policies which seek to mitigate risks and adverse outcomes, addressing social exclusion requires the creation of services, environments, opportunities and experiences that actively counteract exclusionary forces [56]. Within this framework, the concept of belonging emerges is a key element [46]. A need to feel connected to others is a basic human need [65]. By fostering a sense of belonging to services we not only improve peoples' subjective experience of inclusion but also the accessibility and impact of the service being utilized [11]. The intertwined notions of social inclusion and belonging are central to understanding both why people feel valued, connected, and empowered within DCRs but also the broader potential impact of conceptualizing them as inclusion health interventions.

Belonging

Mahar et al. [60] suggest that a perceived sense of belonging refers to feeling accepted and connected to a group or community. When describing the politics of belonging, Yuval-Davis [119] states that belonging is dependent on being valued and recognized within political and cultural life. Practically this means having equal rights and civic recognition as other group members. Additionally, perceived feelings of physical and political safety (not being targeted by members of a community) have been described as key to one's sense of belonging to that community [33]. Belonging is in essence the glue which allows individuals to feel connected to wider social groups [21]. Within drug policy literature, a perceived lack of belonging among people who use drugs has been associated with social exclusion resulting from the structural processes described previously [6, 46].

A contemporary interpretation of belonging has led to its introduction to the sociological discourse surrounding social inclusion, the opposite of social exclusion [79]. In psychological terms, inclusion supports opportunity alongside capability and motivation for successful behaviour change [95]. Social inclusion refers both subjectively to a sense of belonging and objectively to a physical, structural, and political involvement within the community [42]. Social inclusion has been described as the political manifestation of belonging and entails having rights, connectedness, citizenship and equal access to health care within the community in which the individual or group is situated [114]. The social exclusion of structurally vulnerable people who use drugs is associated with a perceived lack of belonging to their communities and wider societies [11, 94]. Social exclusion is a product of perceived or actual stigma due to value and/or moral judgements on peoples 'identities' [39]. This social stigma, through interactions with others, can lead to self-stigma and poorer wellbeing and quality of life [54, 93]. When analysing the existing evidence from participant experiences of DCRs, it becomes clear that these interventions can and should be conceptualized as powerful interventions for fostering belonging both in relation to the physical space of the DCR but also to their wider community and society [95, 97]. This appears true for both sanctioned and unsanctioned sites [8, 66, 98].

Discussion

DCRs as 'inclusion health interventions'

Health inequities arise from and are compounded by social determinants like employment, stigma, and housing rather than just healthcare access [105]. Social, economic, policy, and physical environments also influence individuals' vulnerability to health risks, rather than solely individual behaviours [83]. Through this recognition, inclusion health interventions focus on addressing the multiple complex health and social needs of the most socially excluded and vulnerable groups in society [62]. This approach to research, service design and policy [3] goes beyond the traditional scope of health equity, which primarily seeks to ensure fair and equal access to healthcare resources to reduce disparities [12]. While health equity seeks to address systemic inequalities in healthcare distribution and outcomes, inclusion health broadens the focus to encompass the social and interpersonal dimensions of inclusion by bringing into focus both healthcare needs as well as the broader determinants of health such as housing, education, and social support [15]. Finally, inclusion health acknowledges that factors such as stigma and social exclusion can have profound effects on health and well-being [25, 40], in particular in creating barriers to service access [62]. Inclusion health offers a framework for research, service provision and policy that considers these wider factors and barriers aiming to reduce stigma and foster a sense of belonging and participation among vulnerable populations [27, 55], all of which are key components of DCRs.

Implications

The conceptualization of DCRs as inclusion health interventions provides a framework for policy development that goes beyond overdose mitigation to addresses the complex health and social needs of structurally vulnerable people who use drugs in Europe. Indeed, DCRs have extended social and community functions which can support and facilitate the 'wrap-around services' that are often reported as inaccessible to vulnerable populations in Europe [16, 17]. Shifting this frame of analysis could have important implications for future adaptations and expansions of DCRs. Below we outline four ways in which future DCR policy and practice could work to promote broader social inclusion and civic engagement among often marginalised people who use drugs.

Integrating health and social services

Although funding and logistical constraints mean that comprehensive DCRs with on-site health and social services are not possible or appropriate in every context, as an intervention, integrated DCRs or DCRs which are well linked with external services are effective in widening access to services for people who may not engage with other, more traditional forms of health and social care [97]. One of the primary implications of viewing DCRs as inclusion health interventions is to highlight their unique ability as points of engagement towards a range of other services. Moura et al. [68] survey of EU DCRs highlights that many DCRs already provide a wide range of auxiliary services and crucially consult service users with regards to what and when services should be offered. To be clear, overdose prevention and response should remain a priority, and inclusion health services should only be offered, by consent, to effectively reduce social exclusion and bridge the gap between healthcare, social services, and structurally vulnerable people who use drugs [56]. Unsanctioned sites should also be linked to wider service provision [98]. When evaluating the effectiveness of individual sites, expectations regarding auxiliary services should be realistic and tailored to each site's capacity.

Increasing client involvement

Actively and meaningfully including clients in the planning, implementation, and evaluation of DCRs [64] promotes feelings of belonging and increases the chance of service continuation. In recent years, an increasing number of participatory studies [92, 111] have evaluated DCRs by working with peer interviewers [9, 75] and peer guides during ethnographic field sessions. Whilst clear and distinct benefits have been noted in relation to the quality of the data generated and the experiences of those involved, scholars, and activists [28, 69, 86, 100] caution against ways in which community-based participatory research can reproduce and reinforce stigma and harms if not done correctly and instead encourage 'community-led' projects to mitigate unintended risks. Lastly, services should consider expanding the practice of employing peers in DCRs as it enhances the client experience by making people feel more comfortable and willing to engage [20, 49]. Additionally, it provides opportunities for clients to contribute to its operations [117] which can offer a high degree of purpose and meaning [41].

Expanding civic participation

A central element to the concept of inclusion health is the creation of environments and avenues through which people can participate in society. In this respect, by providing on-site or referring to off-site services that help individuals register to vote, obtain identification, and access benefits, DCRs have great potential in facilitating civic engagement. This practice is already done in many DCRs around Europe [68]. Community volunteering through the DCR can also enhance whole community cohesion and integrate people who use drugs with the neighbours located around the DCR [102]. By offering these opportunities, DCRs can strengthen individuals' sense of stability whilst reinforcing their status as equal citizens deserving of rights, opportunities, and equal access to healthcare [72]. Finally, a strong message about the importance of inclusion health policies and interventions is sent by the symbolic presence of DCRs in communities as places where individuals are treated with dignity and respect [103]. It emphasizes once more the importance of viewing people who use drugs as citizens rather than patients or criminals, as currently instructed through criminal law [93].

Implications for researchers and funders

Re-framing DCRs as inclusion health interventions could create a shift in the way in which researchers and funders seek to evaluate them as interventions. Firstly, this could result in researchers designing more interdisciplinary evaluations that use qualitative, community-engaged methods to assess the broader impacts of DCRs beyond the traditional public health or public order metrics [48]. This approach would encourage the examination of not just immediate health or community outcomes but also long-term social inclusion and community social cohesion outcomes [23] and compliment initiatives to standardise measurement in DCRs internationally [99]. Funders could also come to recognize the value of broader, more holistic evaluation metrics that go beyond traditional indicators to include measures which speak to the social inclusion and well-being of clients as a direct result of their ability to access DCRs.

Conclusion

DCRs have broad potential to address social and health inequities, beyond their proven harm reduction benefits. By framing DCRs as inclusion health interventions, we highlight how by providing or facilitating access to services such as health and housing support, legal aid, and employment assistance, DCRs reduce barriers to service access whilst working to address both immediate health needs and the broader factors that contribute to social exclusion and structural vulnerability. Adapting the current view of DCRs from a purely harm reduction intervention to one of inclusion health could work to foster increased political support for them as evidence-based interventions which reduce overdose risk whilst simultaneously addressing multiple factors which contribute towards social exclusion.

Abbreviations

DCRs	Drug consumption rooms
EU	European Union

Author contributions

All authors contributed to the conceptual and theoretical framing of the manuscript. BDS wrote the first draft. All authors edited and reviewed the manuscript prior to submission.

Funding

The lead author is a doctoral student funded by the Society for the Study of Addiction.

Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Declarations

Competing interests

The authors declare no competing interests.

Received: 13 July 2024 Accepted: 3 October 2024

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