Feasibility study on drug consumption rooms in Belgium

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BACKGROUND

People who use illicit drugs (PWUD) experience a wide range of drug-related harms. Worldwide, countries have been converging on a core of drug policy options aimed at reducing these drug-related harms for many years, including *harm reduction* (Csete *et al.*, 2016; Strang *et al.*, 2012). This latter component, harm reduction, refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs, without necessarily reducing drug consumption. Harm reduction is grounded within a public health model, which primarily aims to improve the health and well-being of drug users alongside reducing community and societal level harms, and complements approaches that seek to prevent or reduce the overall level of drug use (EMCDDA, 2010).

International bodies identify harm reduction interventions as good practices, including opioid substitution treatment, needle and syringe (exchange) programmes, and heroin-assisted treatment (EMCDDA, 2010). One specific intervention includes *drug consumption rooms*[1] (DCRs), defined as legally sanctioned facilities offering a hygienic environment where individuals can use pre-obtained drugs in a non-judgemental environment and under supervision of trained staff. Although DCRs vary in operational procedures and design, the aims of DCRs are similar across sites. The overall rationale for DCRs is reach out to, and address the problems of, specific high-risk populations of PWUD, especially injectors and those who consume in public. For this group, DCRs aim to reduce the risk of transmission of blood-borne infections, to reduce the likelihood of morbidity and mortality resulting from overdose, and to help people who use drugs avoid other harms associated with drug consumption under unhygienic or unsafe conditions. In addition to these health-oriented goals, DCRs also aim to contribute to a reduction in drug use in public places and the presence of discarded needles and other related public order problems linked with open drug scenes. In sum, DCRs aim to reduce both individual-level and public-level harms associated with illicit drug use.

These harm reduction facilities have been operating since 1986; anno 2017, Europe counted 90 official DCRs in eight countries: Denmark, Norway, Spain, Switzerland, and Belgium's four neighbouring countries: France, Germany, Luxembourg, and the Netherlands (EMCDDA, 2017). A substantial body of scientific evidence has accumulated over the past three decades to support the effectiveness of DCRs; although heterogeneous in design and operation, DCRs have demonstrated that they can

[1] The term 'drug consumption room' is often used interchangeably with supervised injection facility (SIF), safe injection site (SIS), and medically supervised injection centre (MSIC).

produce beneficial effects, both for PWUD and for the community, particularly when they are part of a wider continuum of local interventions. Moreover, (frequent) DCR use has been associated with reductions in overdose-related harms, syringe sharing and injection-related injuries, without increasing either the number of local PWUD or rates of relapse. DCRs also serve as important entry points to external drug treatment and other health and social services for PWUD. At the community level, the establishment of DCRs has contributed to improvements in public order through reductions in public drug use and publicly-discarded injection-related litter, and has not been associated with increases in drug-related crime. Collectively, the available evidence suggests that DCRs are effectively meeting their primary public health and order objectives and therefore supports their role within a continuum of services for PWUD (Kennedy, Karamouzian, & Kerr, 2017; Potier *et al.*, 2014).

Despite this abundance of evidence, implementation of DCRs remains highly controversial. Yet, the debate about implementing new DCRs remains high on the political agenda in a number of countries worldwide (e.g., Ireland, Scotland, United States). To date, Belgium does not offer a DCR to its drug using population. The General Drugs Policy Cell published a working paper in 2016 devoted to the topic of DCRs in Belgium (ACD, 2016). They sought to investigate the feasibility and preconditions for the implementation of DCRs in Belgium, with specific attention to needs, and organisational, budgetary and legal aspects. One of the seven final conclusions was that, if one wishes to implement a DCR, a prior feasibility study is essential. Against this background, the Belgian Science Policy Office (BELSPO) commissioned a first-ever study to assess the feasibility of DCRs in Belgium.

AIMS AND METHODOLOGY

The objective of the current study was to identify (legal) preconditions, and design and operational considerations that would allow a DCR to be added within a continuum of policy initiatives for PWUD in five Belgian cities: Ghent, Antwerp, Brussels, Charleroi and Liège. The aims were fourfold: (1) provide an up-to-date overview of the effectiveness, models, and barriers of DCRs worldwide, with particular attention to DCRs in Belgium's four neighbouring countries; (2) conduct an in-depth analysis of the legal framework within a DCR could operate in Belgium; (3) conduct a feasibility study with local stakeholders and PWUD from each of the five cities; and (4) formulate recommendations specifically tailored to the Belgian context.

In 2017, on-site visits and interviews with local DCR managers were conducted by the research team in Paris, Frankfurt, Amsterdam, and Luxembourg. Between July and September, 46 one-to-one, semi-structured interviews were conducted with a diversity of professional stakeholders (recruited from various sectors: law enforcement, criminal justice system, policy development, mental health care, social welfare, drug treatment services, outreach, and harm reduction services) from the cities to identify essential preconditions, possible DCR models and delivery options, and organisational and operational considerations. In addition to interviews with professionals, a focus group with PWUD was planned in each city; a total of 62 PWUD participated in the five focus groups.

Importantly, the current feasibility study does not address the question whether there is a *need* for a DCR in Belgium or in one of the five cities, nor whether there is *support* among local stakeholders for a DCR. Rather, we investigated possible options and scenarios for a DCR, including the pros and cons, might it be deemed needed. If a Belgian city should decide to move forward with the implementation of one or more DCRs, the present study provides empirically-founded and hands-on recommendations. We categorized the recommendations chronologically in four groups; (1) essential preconditions; (2) main considerations when implementing a DCR; (3) the implementation process; and (4) monitoring and evaluation.

RECOMMENDATIONS

1. ESSENTIAL PRECONDITIONS

Legal framework

Establishing a clear legal framework is a fundamental precondition for the implementation of DCRs in Belgium. This stems firstly from the fact that Belgium, as party to the three basic UN Drug Conventions, is obliged to enforce the Conventions regime in good faith. This includes the obligation to respect the main prohibitionist principle enshrined in article 4 of the 1961 Convention, which requires the parties to take such legislative and administrative measures as may be necessary to limit exclusively to medical and scientific purposes the use and possession of drugs. As the Conventions are *health-oriented treaties*, they do not form a legal obstacle for the implementation of DCRs, as long as the DCR—as an extreme form of harm reduction—aims to reduce the adverse consequences of problematic drug use. This implies not only the need to take account of the relevant international legal (and soft law)

framework on harm reduction (such as the UN Resolutions UNGASS 1988 and UNGASS 2016, as well as the EU Action Plan on Drugs 2017–2020), but also the need to base the implementation of DCRs on a legal framework that clearly expresses the focus on the health and welfare of the users and follows an integrated approach (offering treatment, health and social integration services). As such, the DCR would meet the requirements of the INCB (as expressed in its most recent reports) and would not violate the international legal framework.

A further reason why a solid legal framework is imperative, stems from the fact that the implementation of DCRs in Belgium would lead to a number of legal questions, particularly related to their 'facilitating' effect, the 'illegal possession' by service users, and 'public safety and order' concerns. It is therefore required that the implementation strategy deals with these legal issues in order to provide a maximum level of legal protection for the (management of the) DCR, its staff and the users.

Three options for legally implementing DCRs in Belgium have been found, whereby the feasibility of each option is determined by the time span for its implementation and the amount of political support. A *first option* would be to provide an explicit exception to the principle embedded in Article 3, §2 of the law of 24 February 1921, thus creating an explicit legal basis for DCRs to operate. This option implies a long-term implementation and would therefore require a considerable amount of political support (the legislative change would at least require the signature of the Minister of Justice and the Minister of Health). If a statutory protection/recognition would be opted for, it is recommended to look at the legislative implementation of France, which serves as a good example of the way in which primary legislation (allowing for the establishment of a DCR and providing protection to the users and staff in the law of 24 February 1921) can be combined with secondary legislation (stipulating the preconditions and criteria in order for a DCR to be legally protected in a Royal Decree). In this respect, the 10 minimum criteria as introduced in the German legislation could be a useful inspiration.

If statutory protection through primary legislation would not be possible—or while awaiting the legislative process—a *second option* to establish DCRs could be to modify the reach of Article 3, §2 of the law of 24 February 1921 by means of a royal decree, on the grounds that these facilities would act as a specific harm reduction measure aimed at protecting the health of the users, justifying an exception to the application of the offence as mentioned in Article 3, paragraph 2 (a) and, as such, providing a significant degree of protection from prosecution under the basic law. This option would imply a mid-long-term implementation and would require a medium amount of political support (the Royal Decree would require the signature of the Minister of Health).

A *third option*, implying a short-term implementation and being feasible with even a limited amount of political support, is the implementation of DCRs—without prior legislative changes—in the form of a (temporary) scientific or medical experiment. This pilot would not only be in accordance with

the general aim of the UN Drug Conventions, but would also meet the recommendations of the UNGASS resolutions (1998 and 2016) and the recommendation of the WHO in its 2012 technical guide to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Given the sensitive nature of DCRs and the possible political implications, it is strongly recommended for such a pilot to acquire a ministerial recognition or authorisation (by the Minister of Public Health).

With regard to this third option, it should be noted that—although there is no legal obstacle for creating such a (soft) legal framework—its feasibility and sustainability are hugely dependent on the full support of (at least the local) prosecutorial authorities. Moreover, there is a risk of legal action to be undertaken against such a ministerial decision (of recognizing the pilot project) on the grounds that this recognition is deemed incompatible with the federal norm established in the Law of 24 February 1921 (although, should legal action be undertaken against the ministerial decision, there are strong legal arguments for ruling against this legal action in view of the basic health-oriented goal of DCRs and its compatibility with the UN Drug Conventions as discussed above).

In any of the foregoing options, it is deemed necessary to complement the implementation with an amendment to the prosecutorial guidelines on drug-related offences (see COL 15/2015) in order for the users to be freely able to possess a small amount of illicit drugs for personal use in the facility. The prosecutorial policy and subsequent agreements on (non- or soft) police intervention should include a clear procedure of registration of users, a definition of and/or criteria on the 'perimeter' in which no or an alternative action would be taken (in and outside the facility), as well as specific preconditions such as the absence of indications regarding sale or other aggravating circumstances as well as public nuisance. Furthermore, any change in the prosecutorial guidelines would have to take account of the need to provide (new) rules on the seizure of the (illicit) drugs for personal use in the DCR, as well as the relevant paraphernalia (additional to those already excluded from seizure according to COL 15/2015). Finally, a cooperation protocol or accord between the relevant actors should be considered for each location, including the management of the DCR, the administrative authorities (mayor), law enforcement authorities (prosecutor and police), and all relevant treatment services (including medical institutions).

Regarding the risk for liability and damage claims (resulting from drug-related deaths or serious health damage), a number of measures were identified which allow to minimise the risk and offer a sufficient level of protection for the staff, the users and the local government. These include the provision of a clean environment in which to use drugs, along with a clear set of house rules and protocols (including the response to overdose incidents). Finally, a contract between the DCR and the clients should stress the responsibility of the service users. In drafting these regulations, it is key to strictly limit the nature

of the intervention by the (medical) staff when supervising the injection/administration by users. Any form of active assistance during the injecting/administration should be ruled out, thereby taking into account the relevant provisions of the law of 10 May 2015 on health professions. Last, specific training should be provided to those working in or with the DCR, raising awareness on the criteria regarding (civil and criminal) liability.

Recommendation 1: Establish a clear legal framework

The establishment of DCRs in Belgium requires a legal framework that clearly expresses the focus on the health and welfare of PWUD and follows an integrated approach. Three options for legally implementing DCRs in Belgium have been identified, whereby the feasibility of each option is determined by the time span for its implementation and the amount of political support. In any of these options, it is necessary to complement the implementation with an amendment to the prosecutorial guidelines on drug-related offences. Finally, it is vital to take a broad range of measures in order to effectively minimise the risk of (civil and criminal) liability, thus offering a sufficient level of protection for the staff, the service users, and the local government.

Political support and funding

Besides a conducive legal framework, both political support and (subsequent) funding are essential conditions for (effective) implementation of a DCR. Support for implementing a DCR should be present amongst the relevant political bodies. In this respect, public ambivalence may be an important issue since decision makers are more likely to act when public opinion is supportive of policies and vice versa (Hyshka, Bubela, & Wild, 2013). Past experiences in other countries indicate that development of DCRs was highly politicized and their establishment was often contested in public referendums and in courts despite evidence demonstrating their effectiveness (Semaan *et al.*, 2011). Political opposition may hinder the implementation of such facilities. Even when political support would be articulated from the municipal (local) level, this will not suffice given the juridical (see RECOMMENDATION 1) and budgetary implications of DCRs. Regarding the latter, (prospects of) new facilities have to secure financial support from municipal, regional, and/or national authorities before they can practically move forward. According to professional stakeholders in our study, funding for a DCR would primarily be obtained through the regional health ministries in Belgium, which can be difficult if there is resistance from the municipal level (mayor) or the regional government in power. Specifically, costs of DCR implementation will depend on many factors, including its location, the type of service model (stand-alone *vs.* integrated), the capacity of the DCR, hours of operation, staff composition, level of on-site

services and resources. Since DCRs have shown to be cost-effective (Andresen & Boyd, 2010; Andresen & Jozaghi, 2012; Bayoumi & Zaric, 2008; Pinkerton, 2010, 2011), and are able to fill a unique niche of high-risk local PWUD, allocation of sufficient resources for DCRs is crucial.

Recommendation 2: Political support and securing funding are principal preconditions

Political support from municipal, regional, and federal levels, as well as securing financial support from (at least one of) these authority levels, are crucial preconditions before practically moving forward to the implementation of a DCR in Belgium.

2. MAIN CONSIDERATIONS WHEN IMPLEMENTING A DCR

Reasons for establishing DCRs and relations with law enforcement

Although professional stakeholders from all five cities cited multiple reasons for implementing a DCR, the most predominant one was to improve safety and health of PWUD. Many of them highlighted the opportunities a DCR would provide for health promotion advice, health care, and entry to treatment services. A large number identified the potential to reach particularly high-risk individuals who are not currently engaging with existing treatment options and to build trust in health care services. Reducing public nuisance and improving public safety was also deemed important, albeit to a lesser extent. This resonates with the views of PWUD, who cited that a DCR should essentially be a safe and peaceful environment where they are able to consume their drugs in a hygienic manner. Indeed, for DCR clients, a facility is often perceived as a 'safe haven' or as a 'refuge'. A survey in Sydney found that two-thirds used the service because it was clean and safer than using in public, assistance was available in the event of an overdose, sterile equipment was available and can be safely disposed of (NCHECR, 2007). Similarly, a survey in the Netherlands found that DCR clients' main reasons for attending the facility included safety, social interaction, and police avoidance (Peacey, 2014).

Recommendation 3: A DCR should primarily focus on health and safety of PWUD

A DCR should be implemented with the main objective of improving health and safety of local PWUD, by providing a safe and hygienic environment to use drugs under supervision of trained staff, as well as connecting users to health and social services. Additionally, the aim is to reduce public nuisance and improving public safety (e.g., public drug use and publicly discarded injection equipment).

Regarding police avoidance, many respondents from the focus groups raised concerns about police presence in the vicinity of the DCR. For obvious reasons, PWUD stated they would be reluctant to use the DCR if there would be no assurance that they would not be arrested for visiting the DCR. Likewise, literature indicates that PWID may be reluctant to use harm reduction services out of fear of police crackdowns or arrest (Rhodes *et al.*, 2006; Small *et al.*, 2007). Stakeholders in the interviews stated that clear agreements with police (often specified in the form of a written protocol) are certainly possible, since they already exist in most cities for other harm reduction programmes. They however stressed the 'controversial' nature of DCRs, making such agreements and partnerships key for the implementation, success, and continuity of a DCR. Indeed, a collaboration between law enforcement and the public health sector is central to police engagement in initiatives, and ensures that police practices do not interfere with these efforts and, instead, complement them (Mitra & Globerman, 2016). More specifically for DCRs, their success is contingent on clear agreements and good working relationships with local law enforcement agencies (DeBeck *et al.*, 2008). In the vast majority of countries where DCRs operate, local agreements have been reached, through which police agree not to target clients in the vicinity of the facility, nor to monitor its entrance or exit to ensure clients are not deterred from using the DCR, while still addressing other forms of crime in the neighbourhood and maintaining close ties with the facility and offer assistance if circumstances require it (Wood *et al.*, 2004c). Specifically, police should commit to clear and consistent operations with regard to a DCR, refer users to DCR services where appropriate (yet not coercive), and establish an agreement with DCR operators on how to handle possible user congregations and/or the presence of drug dealers in a demarcated area around a DCR. In Vancouver for instance, police were involved in the planning of *Insite*, and operational plans and protocols were put in place to clarify the role of police with respect to the DCR. This included outlining procedures for occasions when police need to enter the DCR (e.g., emergency access, fresh pursuit), and procedures for police response outside the DCR. Police and *Insite*'s operators also set up an alternative dispute mechanism with biweekly meetings. This process was effective in promoting communication, resolving frictions and conflicts, and building positive relationships between the police and the staff working at the DCR (Perks *et al.*, 2013).

When agreements and procedures are fully established, the international literature indicates that law enforcement officials are generally supportive of DCRs, and even help divert public IDU and drug-related activities to DCRs. All in all, it is essential—both for potential clients as well as for successful operation of the DCR—that local and well-defined protocol agreements are established; as is equally the case with other harm reduction initiatives (Mitra & Globerman, 2016; Wood *et al.*, 2003). Such involvement and cooperation with local police (before actual implementation) is recommended to ensure that police understand why and how the service will operate, and to clarify respective roles and responsibilities.

Recommendation 4: Agreement protocols and cooperation with law enforcement are imperative

Clear cooperation agreements (formalised in a protocol) with local police and law enforcement should be established in order to ensure safety, that everyone agrees in terms of what is acceptable and what is not, and prevent that fear of arrest will deter PWUD to use the facility, while still addressing crime in the neighbourhood and maintaining close ties with the facility.

Target group and admission criteria

Age

In keeping with other harm reduction programmes, where age restrictions often formally exclude this population (Fletcher & Krug, 2012), the vast majority of DCRs worldwide exclude individuals under the age of 18 (Schatz & Nougier, 2012; Woods, 2014). However, research shows that younger PWID engage in high-risk behaviours to a greater extent than older or more experienced users, including sharing needles and paraphernalia, increasing their risk for blood-borne diseases and other adverse outcomes (Barrett, Hunt, & Stoicescu, 2013; Hadland *et al.*, 2014). Since minors are almost without exception excluded in DCRs throughout the world, the existing evidence base regarding the effectiveness of services is largely limited to adults and says little about the feasibility or impact of providing services to young people (Hunt, 2008). Across all of the five Belgian cities, most respondents (both professionals and PWUD) felt that being 18 years or older was a necessary admission criterion for access to a DCR, which resonates with other recent studies (Watson *et al.*, 2015). Many felt that young PWUD should instead be referred to a drug treatment programme or other services than a DCR. On the other hand, opponents of an 18+ age limit stated that this would leave a particularly vulnerable group (albeit relatively few in number compared to their adult counterparts) outside the scope of service. Young PWUD are also in need of services, and restricted access might expose them to more risky behaviours than they would face inside a DCR, as well as obstruct them from accessing other services available through the DCR. Further specific age restrictions (e.g., 21 or 26 years) were not specifically mentioned by most stakeholders, noting that people of any age can use drugs; duration of (problematic) drug use was deemed far more important than biological age of potential clients.

Route of drug administration

Relatedly, most participants (PWUD and local professionals) found that there should be no exclusion based on specific type of illicit substance (e.g., heroin or amphetamines), nor on administration route (injecting, inhaling or smoking). Regarding the latter, however, many of the interviewees stated that *injecting* use should comprise the main focus of a DCR—especially when policy choices should have to

be made due to budgetary reasons—since PWID are deemed a particular "high risk, high need" population. However, the provision of a non-injecting option alongside services for PWID may not only serve the needs of non-PWID, but may also help promote transitions away from IDU (Bridge, 2010). Consistent with prior research (Watson *et al.*, 2013), PWUD in the focus groups had a strong preference for a DCR which allows both injecting and smoking within the same facility, though with some sort of spatial separation between the two—which is fairly common in DCRs throughout Europe (EMCDDA, 2017). This separation is largely based on different highs and comfort regarding exposure to different methods of drug administration.

Local residency

Another subpopulation of PWUD that is frequently excluded or dissuaded from attending DCRs based on operating rules are non-local residents. This perspective was reflected in local stakeholders' views. A reason for excluding non-local residents was especially to avoid a 'honeypot' effect of PWUD from neighbouring cities without a DCR. Similarly, primarily to avoid attracting more drug users to the vicinity of the DCR, many Swiss and Dutch DCRs do not admit PWUD who are not resident in the local area (Schatz & Nougier, 2012). However, an important downside of applying this eligibility criterion is that it excludes non-local residents who may benefit from such a service, and vulnerable groups such as illegal immigrants and refugees. Some stakeholders stated that such a residency criterion may not be necessary since PWUD will not travel long distances to the DCR, and given the intake interview at first visit. Other admission criteria adopted in several countries include homelessness and not being enrolled in an OST programme. These criteria were not endorsed by any of the groups of respondents; on the contrary.

Summary

Operational DCR models vary between countries—some having more lenient eligibility criteria (e.g., in Germany and Australia) and others being more targeted and restrictive (e.g. in the Netherlands and Switzerland). In this way, local policy makers have been able to determine whether they prioritise throughput and coverage or high need. Such policy choices may bear on concerns about 'honeypot' effects and will certainly relate to the general impact of DCRs. From our study we can conclude that, in order to maintain a low-threshold nature, DCRs should avoid a plethora of admission criteria and conditions, in order to reach as many potential clients as possible. However, two criteria for exclusion were frequently mentioned by professional stakeholders across cities: minors (< 18 years) and non-local residents (especially in Ghent and Antwerp). Interviewees did stress the importance of flexibility when applying admission criteria and regulations, for example with intoxicated clients, pregnant women, and first-time injecting drug users. For these high-risk groups of PWUD, special considerations

and protocols should be in place (BCCSU, 2017). These subgroups of PWUD should not be *a priori* denied access to a DCR, since provision of such service results in a hygienic and safe drug consumption (other than public use), and may provide opportunities for appropriate information, education and access to auxiliary services.

Recommendation 5: A DCR should clearly define its target group and related admission criteria

The target group of DCRs should encompass high-risk and hard-to-reach PWUD. A DCR should find a balance between maintaining its low-threshold nature (to maximize utilization and minimize barriers), while delineating clear eligibility criteria for the target population (e.g., individuals aged 18 and over and local residents). Special considerations should be given to high-risk, vulnerable groups of PWUD including intoxicated clients, pregnant women, first-time injectors. Ideally, DCRs should provide the possibility for both injecting and non-injecting drug use within the same facility, with some form of physical separation.

Location

Determining a suitable location of a DCR is important in order to have good prospects of being effective. Factors that lead (local) stakeholders to consider introducing a DCR, such as high levels of public drug use and associated nuisance or a high prevalence of drug-related health emergencies, may point to the general locality in which the service should be situated. DCRs have been established near open drug scenes and in areas where there is a long-standing drug market. Proximity to the place where people purchase drugs has been identified as an important factor in the use of DCRs (Hedrich, 2004). Yet, it should be noted that efforts to relocate drug scenes/drug-using populations by providing DCRs in other areas away from drug markets may not be successful and just result in poor service utilisation (Hunt, 2008). During the interviews, different opinions arose within and between cities where to best locate a DCR. For some, DCRs would be best situated in a centralized location (e.g., Ghent and Liège); having a centrally located facility, proximate to other services, would increase the likelihood of PWUD using those services. On the other hand, such a centralization option may also lead to a concentration of services in one area and thereby neglecting other neighbourhoods. Therefore, others advocate DCRs to be located in specific areas, away from central neighbourhoods, which may have the advantage of geographically spreading services and de-stigmatizing specific areas. However, DCRs may be less accessible for clients when located too far from central neighbourhoods or other services (Bardwell *et al.*, 2017). All in all, wherever the specific geographic location in a specific city, the main consideration expressed by PWUD and professionals alike was that a DCR should be easily

accessible, irrespective of (de)centralization. If a DCR is located too far, or difficult to reach, a segment of the target population will not be reached. For instance, some studies (Petrar *et al.*, 2007) indicate that PWUD are generally not willing to travel great distances to use a DCR—meaning that the location and accessibility of the DCR is an important factor to consider. This was confirmed by PWUD in our focus groups, and mainly related to the intensity of withdrawal symptoms that may influence PWUD's willingness to travel to a DCR. Travelling presents extra hassles as well as transportation costs, which is often described as a barrier.

Recommendation 6: The location of a DCR should be easily accessible for its target population

A location and neighbourhood should be carefully selected when implementing a DCR. Wherever its specific geographic location in a specific city, a main consideration should be that the facility is easily accessible for clients, irrespective of (de)centralization, in order to sufficiently reach the target group.

DCR integration: models and services

Every single professional stakeholder advocated that a DCR should be part of an integrated local drug strategy, that is, a DCR as one option in a continuum of services for PWUD that encompasses not only drug consumption, but also (psycho)social and medical services and support mechanisms. Indeed, the available evidence suggests that these facilities should be part of a comprehensive drug policy in order to adequately and effectively respond to drug-related harms that acknowledges public and individual health objectives (EMCDDA, 2010, 2017; Kennedy *et al.*, 2017).

Recommendation 7: A DCR should be part of a comprehensive, integrated drug strategy

A DCR should be an integrated part of a comprehensive local, regional and national drug strategy, included in a wider range of health, treatment and social services, to reach and fulfil a diverse range of individual and community needs that arise from illicit drug use.

However, in contrast, opinions within each of the five Belgian cities were rather mixed whether a DCR should be *physically* integrated within an existing organisation, or integrated within a network of services mainly through referrals. On the one hand, (a majority of) local professionals throughout Belgium advocate a physical integration within an existing service; most frequently proposed were low-threshold (harm reduction) services (such as MSOC/MASS, Transit, CASS), and, to a lesser extent,

hospitals. In general, an integrated DCR (i.e., the most common model in Europe) has several advantages compared to its stand-alone counterpart. For example, integrated service models are often perceived as best practice because clients can access a range of services under one roof; compared to stand-alone services, integrated facilities would seem likely to have an in-built advantage in promoting engagement with other health and welfare services, which may lower the threshold (both in time and distance) for use of such services as they are directly available; thereby helping to prevent loss to care, to decrease barriers in access to care, and to ensure continuity of care. Indeed, studies indicate that low-threshold programmes offered at DCRs effectively attracts higher-risk PWUD and helps to connect these individuals to health care and substance use treatment services (Kimber *et al.*, 2008; Toth *et al.*, 2016; Wood *et al.*, 2006b; Wood *et al.*, 2007). During the interviews, local professionals clearly emphasized such advantages.

Furthermore, according to these stakeholders, a major advantage of the integrated option is that it allows sharing of resources (and expertise), such as the premises and staff. Opportunities for staff to rotate between services (the DCR and other projects), increasing their knowledge and skills and also reducing any risk of burn-out is considered another advantage of an integrated DCR (Hunt, 2008). As a result, such a DCR will cost less to set up and run, whereas a specialised DCR would be more expensive due to rental costs of a building and starting a programme from scratch. Local low-threshold facilities (e.g., MSOC/MASS, Transit, CASS) were commonly cited as suitable organisations for such a partnership. However, a major caveat would be the mixing of DCR clients and other PWUD coming to the organisation for reasons other than drug consumption. Indeed, according to several of the interviewees, while this integration may work well for active PWUD, the impact on people enrolled in OST programme from these centres may be less helpful. Each day they have to manage picking up their methadone/buprenorphine in the immediate vicinity of the DCR. This situation may be more challenging for those in a detoxification centre, as they have to undertake their detoxification while they can be confronted with (illicit) drug use in the same building. The integration of services for active PWUD and those enrolled in OST inevitably triggers clients who are trying to stay away from illicit drug use, which provides a risk of relapse. More generally, one challenge to the physical integration of a DCR into an existing organisation is that other service users might not want to be around (or associated with) PWUD. Therefore, in the scenario of a physical integration in a low-threshold facility, stakeholders clearly emphasized the need for a spatial/physical separation of the DCR and other areas within the same building (for OST dispersion and consultations), for example by means of a different entrance. Indeed, it is important to clearly demarcate spaces where drug use can take place within the larger facility and where it cannot, so that clients who are not using the DCR (i.e., may be trying to reduce or avoid illegal drug use) can easily avoid these areas. In this regard, one alternative option is to integrate a DCR within a hospital. The first known embedded DCR to operate in a hospital is at the

Lariboisière Hospital in Paris, which opened in October 2016. The advantages of integrating a DCR in a hospital context (with a separate entrance) are similar to those of integrating it in low-threshold services (MSOC/MASS), without mixing a heterogeneous population of PWUD who are coming to the specific service for reasons other than drug consumption. PWID have shown willingness to access a DCR in a hospital (McNeil *et al.*, 2016; Ti *et al.*, 2015), and may thus be a feasible option. Importantly, organisations seeking to implement integrated DCR will need to consider how the service fits within and complements other services provided by that (low-threshold) agency.

On the other hand, partly for the above-mentioned reasons, some professional stakeholders explicitly advocated the idea of a stand-alone facility—still partnered with other local agencies, but not physically integrated. The main reason for advocating such a specialised model was that a DCR should focus on its core business—drug consumption—because 'flooding' a DCR with auxiliary services and programmes would install a barrier for hard-to-reach drug users. Indeed, while services in the stand-alone model are much more restricted, the advantage is that those PWUD who come into these facilities all have the same goal. The range of other auxiliary services is still available (elsewhere), and PWUD can be informed (or already know) that services like counselling or detoxification are provided by another local organisation (Schäffer, Stöver, & Weichert, 2014). Incorporating (social, medical, or drug treatment) services within a DCR may potentially raise the threshold for individuals who are merely interested in drug consumption. Indeed, it has been suggested that a stand-alone DCR may be more effective in reaching clients who actively avoid or do not seek health care services, if they perceive the facility as a place to safely use their drugs, rather than as a health care facility *per se*. The main advantage of a stand-alone facility—though integrated within a network of local services to improve access to additional services and referrals—was that this option may significantly lower the threshold due to the exclusive focus on drug consumption, and thus reach a specific segment of PWUD who are not (yet) reached by other local agencies. Still, several services were deemed essential in a stand-alone facility, such as NSP, wound care, and (for some) drug testing. These services were also endorsed by PWUD in the focus groups. A minority of professional stakeholders spontaneously cited the inclusion of a take-home naloxone programme in the DCR as an important strategy. Overall, proponents of a stand-alone facility advocate that, in addition to the core services provided in the DCRs, clients may be referred to more extensive support services if desirable and necessary.

The latter option—a specialised, stand-alone DCR—was overwhelmingly preferred by PWUD during the focus groups in each city. PWUD consistently advocated a rather clinical operationalization of a DCR in their city, which should specifically focus on drug consumption. Though they were opposed to the idea that a DCR was too much embedded within a service model, they clearly stated that some possibilities to pass clients on to other care and support services should be present. Moreover, PWUD (similar to professional stakeholders advocating a stand-alone facility) stated that such auxiliary (social,

welfare, medical, and drug-related) services and support should be provided through referrals rather than delivered on-site. This resonates with the primary objective of a DCR as perceived by PWUD: to be able to consume their drugs in a safe and hygienic environment (cf. supra). An important argument posited by professionals to work through referrals rather than on-site delivery was that most services already exist and that implementing them on-site as well would be financially inefficient since it would create overlap of services within the same city.

Overall, the choice between providing services based on a specialised or integrated model is one of the main choices to be made when determining what form of service might be provided. Each of the DCR models has their advantages and disadvantages. Because a single DCR model cannot fit all needs, the choice of a particular model needs to reflect the nature of the local context, needs of PWUD, as well as interests of the wider local community. When implementing a DCR, stakeholders will have to decide which of these models might fit best with their drug service system. Next to this, the budgetary implications will most likely influence the final choice.

Recommendation 8: The optimal DCR model is one integrated within a continuum of care

Existing low-threshold facilities (e.g., MSOC/MASS, Transit, CASS) already working with PWUD appear promising locations for setting up a DCR; such organisations will need to consider how such a facility may fit within and complement other services provided by the agency. The decision whether or not to physically embed a DCR within an existing local organisation should balance between the advantages of such integration, while maintaining a low-threshold nature for both DCR clients and individuals who are coming to the specific service for reasons other than drug consumption. Irrespective of physical embedment, integration and close linkages with existing local organisations are imperative in order to ensure that a DCR provides access to health and social services and referrals, but does not duplicate what is already available at the local level.

Staff

In accordance with (and reliant on) the specific DCR model and services provided within, policy makers will need to consider the type of staff involved in running a DCR. Across cities and respondent groups (professionals and PWUD), two types of staff were consistently cited as essential within a DCR.

First and foremost, *medical staff* was spontaneously mentioned by respondents, which is in keeping with the above-mentioned focus on health promotion as a goal through providing a safe and hygienic environment to use drugs. Nurses, and for some *psychiatric* nurses more specifically, were

deemed the most essential staff in DCRs across cities. Indeed, given the health challenges experienced by PWUD accessing DCRs, and the need for emergency overdose response, it is ideal if staffing models include a supervising (psychiatric) nurse (BCCSU, 2017), especially trained to provide interventions such as safer injection education. Although desirable, the actual presence of physicians was mostly not deemed necessary in the DCR, particularly given their high cost of employment. For 'basic' medical care (wound care) and intervention in case of an overdose, nurses were deemed more than suitable; a physician thus should not be physically present at the DCR. Rather, though not physically nor permanently present on-site, a physician linked to the facility (on-call during opening hours) was however thought to be necessary with regard to responsibility/liability.

Social staff (mostly cited as educators and social workers by participants) is a second important category of personnel that should be present in a DCR, according to the participants. In addition to a medical focus provided by nurses, social staff are able to assist clients with different aspects of referral to a variety of social and welfare agencies (including those who specialise in substance use treatment and support services).

Stakeholders held mixed views concerning the need to hire *security personnel* in the DCR. On the one hand, some stated that this would not be necessary, especially when a DCR is integrated in an existing low-threshold facility. Regular staff may take up security issues; some argue that the presence of security personnel might increase the threshold and could provoke undesirable behaviour from DCR clients. Being located in the proximity of a police station would be a more desirable alternative. On the other hand, in a specialised DCR, security personnel was deemed necessary since no support from the wider facility is available, and (specifically trained) security personnel around the DCR may furthermore reassure the neighbourhood.

Last, individuals identified as *peers* (i.e., people who formerly used or currently use illicit drugs) also play important roles in the planning and operation of DCRs worldwide, which was (rather strongly) acknowledged by professional stakeholders during the interviews. More specifically, they noted that the particular value of peers is to relate to DCR clients given their shared experiences, as well as their ability to make clients feel comfortable and welcome. This was supported during some of the focus groups. A previous feasibility study (Kerr *et al.*, 2003) has also shown that PWUD value the inclusion of peers within DCRs, and feel that their inclusion in the injecting room would be an asset. Taken together, many argued that peers should be considered for involvement in DCR operations where possible. Examples are involvement of DCR clients in the establishment of the services on offer, or employment of (former) drug users. However, several concerns were highlighted by respondents, such as the challenge to expose active users to an environment in which drugs are consumed regularly.

Recommendation 9: A multidisciplinary team of staff should be present in a DCR

A DCR needs to provide a sufficient number of trained staff. At minimum, a team of (psychiatric) nurses and social workers should be permanently present in the facility in order to provide a multidisciplinary approach. A physician may be on-call during opening hours, yet not necessarily physically present on-site. Where possible, involvement of peer workers in daily DCR operations should be considered.

Furthermore, the successful operation of a DCR is contingent on the establishment of relevant policies and procedures. At minimum, these should include: documentation procedures; referral pathways; procedures for contacting police in the event of aggression or safety related issues; and code of conduct/rights and responsibilities for clients and staff. A specific overdose response protocol is required for identifying overdose or other medical emergencies and determining when to intervene. Special efforts—by means of (continued) staff training and education—are needed to ensure that staff are trained to provide trauma-informed and culturally safe care, amongst others. A framework in cases when staff are exposed to ethically conflicting situations should be elaborated.

Recommendation 10: Clear procedural protocols should be outlined

An effective operation of a DCR requires a minimum set of policies and procedures, known by all staff, and consistent with those procedures adopted in corresponding community drug services.

House rules, contract and registration

Worldwide, DCRs operate under clear eligibility criteria, and there are explicit rules and responsibilities which clients are expected to adhere to. For professionals, the most essential house rules to establish in a DCR are: no aggression and violence, prohibition of dealing and sharing drugs, and no alcohol consumption on the premises. The main reason provided by stakeholders for alcohol prohibition is to reduce violence and drug use risks. These basic rules, which apply in most countries, were also clearly supported by the views of PWUD during the focus groups. Similarly, both professionals and PWUD endorsed the fact that a facility should apply a time limit policy in consumption areas, but not necessarily in the resting area where clients may go after drug consumption. Overall, a time limit of circa 30 minutes was proposed, which largely resonates with international practices (Woods, 2014), however, while maintaining a certain individual flexibility. The main reason stated for a time limit is to allow as many users as possible into the DCR, and prevent use of the facility as a for substitute shelter

(especially applicable to stand-alone DCRs), and waiting times. Indeed, most international facilities have to deal with queues, so to keep the DCR accessible to all and adhere to their objective to reduce public drug use, a set time limit is utilised. Relatedly, similar to waiting times, limited days/hours of operation poses an important barrier for PWUD to access the DCR (Petrar *et al.*, 2007; Small *et al.*, 2011). When asking what days and hours a DCR should be operational, a spontaneous first reaction of most participants was that 24/7 access would be ideal. They however acknowledged that this would be unrealistic for budgetary reasons. Estimates of opening hours ranged widely, but most expressed the idea that a DCR (1) should be open on later hours (not, for example, at 8 am), and (2) that specific hours of operation should be adjusted and complemented to other local harm reduction programmes. Even if there are more than one DCR in the same city, this should be guaranteed in order to provide an opening span on city-level as broad as possible (as is the case, for example, in Frankfurt).

Recommendation 11: A DCR should have clearly established house rules

It is essential that clear policies concerning service users' conduct are established. These are explained to anyone using the service, and clients agree to abide by these rules of conduct. Policies should include clearly specified sanctions that are applicable if policies are violated. Rules should be proportionate and need to balance the obligation to manage a safe environment with the desire to operate a service that is as inclusive as possible vis-à-vis a marginalised population.

Recommendation 12: A DCR's capacity and opening hours should meet local needs

The impact of DCRs is tied to their ability to reach sufficient proportions of high-risk PWUD. Therefore, as with its geographical location, the capacity and opening hours of a DCR should respond to the local needs of the individuals who will be using the service in that community.

A majority of stakeholders in all cities further expressed the need to 'formalize' the house rules in some sort of a contract (a declaration of agreement with house rules) when a potential client first arrives at the facility. This is a common practice in European DCR. A code of conduct on which DCR use is conditional—and corresponding sanctions—should be explained and agreed (by contract). Local professionals in the interviews stated that this would provide some ground to exert a time-out or suspension as a sanction in case house rules are violated, but equally to assure clients' rights—a two-way contract. One important example was that a contract may safeguard the non-distribution of DCR clients' personal information. This tends to be basic information such as the date and frequency of

visiting, and often including details on the substance the visitor is using. Furthermore, clients often have to undergo an entry interview upon their first visit or a one-time registration survey at intake—during which the 'terms of use' document is signed by both parties. This may include the registration of personal information such as day of birth or name. Later, while most facilities worldwide allow access to clients on an anonymous basis, about one out of three DCRs require their clients to present with a non-anonymous identification. For most PWUD in the focus groups, a non-anonymous registration at intake would not pose a barrier for using the service, however, with the clear understanding and assurance that these data will not be shared with police or other agencies outside of the DCR—hence the two-way contract. After initial registration (thus for each subsequent DCR visit), while confidential codes for identification were more readily supported than showing identification, many PWUD prefer to enter and leave a DCR anonymously. Indeed, in order to attract the target population without raising fears about confidentiality, and to make the service as low threshold as possible, all clients of the DCR should ideally remain anonymous.

Professionals state that intake and subsequent registrations would be of great value, given the data this could generate (e.g., types of illicit drugs used, frequency of use, number of unique clients) for informing drug policy, as well as for evaluation purposes. Despite its advantages, some stakeholders cited several barriers for adequate registration. These especially include lack of ID for refugees or illegal immigrants, and distrust among PWUD. Stakeholders endorsed policies that protect the anonymity and privacy of DCR clients; a clear system is required for identifying returning clients and linking them to their assessment information. Overall, a possible solution, like in Frankfurt, may include a one-time, non-anonymous registration at intake where afterwards a unique identification code is given to each clients for subsequent visits (Stöver & Förster, 2017). This unique code is linked with the data of the respective user, anonymized, and may be useful for statistical analysis and to work out a care plan in dialogue with the client (EMCDDA, 2000). Ideally, the registration system should be integrated within existing ones—at the least being compatible with already adopted systems in order to prevent a fragmentation of registrations.

The information to be gathered for (new) clients should balance the need for relevant information that underpins care and evaluation, while avoiding collecting too much information that assessment becomes a deterrent to service utilisation. These collected data should be protected under medical confidentiality, and a clear framework (an intelligence-sharing protocol) for what can(not) be shared and how information can be used should be developed and agreed. Use of operational procedures, protocols, and policies is a crucial aspect for protecting personally identifying information, privacy of DCR users, and confidentiality of the collected data (Hunt, 2008; Semaan *et al.*, 2011)

Recommendation 13: Client registration should safeguard confidentiality and anonymity

Assessment and registration of service users should be considered in order to determine eligibility of potential DCR clients. One must balance the need for relevant information, while avoiding collecting so much that assessment becomes a deterrent to service utilisation. Policy and programme measures should be in place to ensure the privacy of people using the service and data collection should be protected by professional secrecy.

3. The implementation process

Multi-agency task force

Options regarding the implementation process and evaluation were topics that did not arise in focus groups with PWUD. According to professional stakeholders, the planning and development of a DCR in Belgium should be facilitated by extensive roundtable consultation with all relevant stakeholders, including but not limited to local authorities, social and healthcare service providers, police and law enforcement officers (in respect to the latter group, see also RECOMMENDATION 4) as this is equally the case for NSP (Strike *et al.*, 2006). In this view, a local multi-agency task force should be installed—with representatives from all relevant sectors—in which all professional stakeholders are engaged in the consultation, planning, and implementation process.

Recommendation 14: A multi-agency, local task force with relevant professionals should be installed

All relevant stakeholders should be engaged in the development of DCR options from early planning stages onward. Ideally, a multi-agency partnership is established in the form of a steering committee or local task force overseeing the consultation and implementation process.

"Nothing about us without us"—User involvement

Decision-makers in cities contemplating DCR implementation should carefully consider the opinions and preferences of potential clients regarding DCR design and operational preferences to ensure that facilities will attract, retain, and engage PWUD (Petrar *et al.*, 2007; Small *et al.*, 2011; Watson *et al.*, 2013). Including their perspectives in DCR implementation research—and policy development more generally—is vital to maximize the uptake of DCRs and increase future utilization (Luchenski *et al.*, 2018; Ti, Tzemis, & Buxton, 2012), because of the nuanced descriptions they can provide about their

drug-using practices and environments (Bayoumi & Strike, 2012). In order to ensure adequate engagement of the target population and assessment of need, PWUD should be involved in the planning and implementation of a DCR (for example through a representative from an advocacy group of PWUD being present during meetings), but equally once the DCR is operational (BCCSU, 2017). For example, in Australia, some of the operational rules were pre-tested with DCR potential clients, to examine deterrent effects. User involvement—in all its forms—is essential to ensure equity, acceptability and relevance of (DCR) services and should be a standard practice. Peer worker programmes are an acceptable and effective method to involve service users. Indeed, a Canadian feasibility study has shown that PWUD value the inclusion of peers within DCRs, and feel that their inclusion would be an asset (Kerr *et al.*, 2003).

Recommendation 15: Local PWUD should be involved in the planning and implementation phases

Decision-makers in cities contemplating DCR implementation should carefully consider the opinions and preferences of potential clients regarding DCR design and operational preferences to ensure that DCRs will attract, retain, and engage PWUD.

Community consultation and communication

Public opinion is an important factor in decision-making regarding the implementation of public health programmes, and for DCRs more specifically (Hyshka *et al.*, 2013). Despite evidence on the contrary, negative connotations associated with DCRs may persist. Such perceptions are often unfounded, as several studies in different countries have suggested that, though DCRs are often met with mixed public opinion prior to introduction, the attitudes of local residents and businesses tend to become more positive over time (Firestone-Cruz *et al.*, 2007; Salmon *et al.*, 2010; Strike *et al.*, 2014; Thein *et al.*, 2005). Community engagement is thus imperative if DCRs are to be successful. During the interviews, indeed, stakeholders strongly favoured involving residents and businesses during the whole process of implementation. In addition, in order to reduce opposition of a specific neighborhood, stakeholders propose to always communicate transparently, to organize DCR visits, and a 'hotline' for questions and concerns. A possible option is to set up a community advisory committee during the planning stage to be proactive in addressing any community concerns (Perks *et al.*, 2013). Such community consultations are a way of educating the community about the importance of this strategy, as well as a place to disseminate the evidence surrounding the benefits of DCRs. Recently, an operational guidance was published aimed to support policy makers with the consultation and engagement process related to implementation of a DCR, based on experiences of the *Dr. Peter Centre*

in Vancouver (BCCSU, 2017). Similarly, prior experiences with establishing OST, relevant to DCRs, could serve as a guidance for building public support and increasing acceptance. The *Pivot Legal Society* developed a toolkit for addressing NIMBY-concerns in the community (Pivot, 2011). Collectively, these documents should be adopted as a guidance for key stakeholder consultation as well as a broader local community consultation when (thinking about) the implementation of a DCR. For example, prior to opening a DCR to clients, the operating agency may consider organising an 'open house' and inviting the local community, media, elected officials and interested members of the public. Seeing how the DCR is set up and how it will operate may help to satisfy curiosity as well as alleviate any concerns about how the program will work (Perks *et al.*, 2013). Overall, given the controversial nature of DCRs and often limited public knowledge of these services, providing information and open communication about the facility and its operations should be promoted in order to reduce community resistance and ensure successful integration in the community.

Recommendation 16: Clear communication with community stakeholders is key

As with other harm reduction interventions, consultation with local residents, businesses and other community stakeholders prior to DCR implementation is essential to minimise community resistance. Transparency and open communication between all parties are fundamental in this process.

Ongoing transparency and involvement of relevant stakeholders after implementation

A DCR must work collaboratively with all relevant stakeholders, including PWUD, partnering agencies, community residents and other neighbours to promote open communication about the service and its operations in order to ensure successful integration in the community. Stakeholders in the interviews not only stressed the importance of community consultation in the early process of DCR planning and implementation, but equally ongoing communication once implemented. According to Hedrich and colleagues (2010), DCRs, more so than other public health services, rely on acceptance by PWUD, communities, health and social service workers, law enforcement and politicians to be implemented *and sustained over time*. As such, ongoing assessment of public opinion is necessary to inform public health policy regarding this issue. Maintaining good relationships with local communities, businesses, and other stakeholders is imperative for the successful operation of DCRs. A DCR—and its steering committee—should ensure ongoing liaison with all local stakeholders, and adjust operations where needed. Again, transparency and good communication are essential.

Recommendation 17: Ongoing liaison with local stakeholders should be assured once implemented

In order to ensure continuity of a DCR, and adapt its operations if deemed necessary, ongoing dialogue with all local stakeholders involved should be a prerequisite.

4. MONITORING AND EVALUATION

According to stakeholders, it is crucial to evaluate the (cost-)effectiveness and impact of these facilities carefully, and build the evidence base that justifies their implementation (especially given the fact that DCRs remain controversial measures in the drug policy framework). Without evaluating the impact of services that are first introduced, no judgement can be made about their effectiveness, their value for money and whether they are a valuable addition to existing services. Detailed process and outcome evaluations would need to be conducted. Importantly, detailed data before DCRs were to commence (a 'baseline' measure), and comparative data from sites where DCRs were not to be introduced, would need to be collected. An advisory board, ideally including an international expert of DCRs (e.g., France or Canada), should be assembled to design the evaluation protocol for the DCR (pilot). Such evaluation should be conducted by an independent organisation (external to facility operations) with expertise in the area of drug policy—such as a university—in consultation with all relevant stakeholders, including DCR clients, service providers, and local residents and businesses. Sufficient funds for a comprehensive evaluation should be included when the costs of a DCR are calculated. As a scientific pilot programme, the Vancouver team developed a rigorous methodology to conduct an external 3-year evaluation of the DCR's impacts (Wood *et al.*, 2004a; Wood *et al.*, 2004b; Wood *et al.*, 2006a). Such a design could be adopted in a Belgian setting—however, adapted to the specific local context and locally determined objectives. With regard to the latter, (clearly defined and measurable) evaluation indicators should echo initial DCR aims. However, it should be kept in mind that the goals and aims of a facility may change over time, in accordance with funding and staffing ratios, as well as changes in the needs of the client population, local service networks, and local drug scene (BCCSU, 2017).

Recommendation 18: A rigorous scientific evaluation of a (pilot) DCR is as an essential component

A DCR should be subjected to detailed process and outcome evaluations by an external organisation, in consultation with all relevant stakeholders. A well-defined, methodologically sound evaluation plan with clear objectives should be established before implementation.

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