Innovation, Mutual Learning & Empowerment

A pilot training initiative on community-based Drug Consumption Rooms in Europe

Correlation
European Harm Reduction Network

European Network of Drug Consumption Rooms

Title
Innovation, mutual learning and empowerment. A pilot training initiative on community-based Drug Consumption Rooms in Europe.

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We thank the teams Podané Ruce, ŠENT and Stigma and especially Barbara Janíková, Katja Krajnc and Luka Mrak for co-organizing the DCR Trainings; the Municipality of Brno for their support in implementing the training activities and all of the participants for attending the training and their contributions during the sessions.

Editor
Graham Shaw

Recommended citation
Perez Gayo, R. & Rogialli, A. (2023). Innovation, Mutual Learning & Empowerment. A pilot training initiative on community-based drug consumption rooms. Amsterdam, Correlation - European Harm Reduction Network.

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This Publication has been co-funded by the European Union. Views and opinions expressed are, however, those of the author(s) only and do not necessarily reflect those of the European Union or HaDEA; neither the European Union nor the granting authority can be held responsible for them.

This project has been made possible with the provision of a financial grant from Gilead Science Europe Ltd.

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Co-funded by
the European Union

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Acronyms

BKEF	Budapest Drug Council, Hungary
C-EHRN	Correlation - European Harm Reduction Network
CND	Commission on Narcotic Drugs
COVID	Coronavirus Disease
CS	Civil Society
CSFD	Civil Society Forum on Drugs
CSI	Civil Society Involvement
CSO	Civil Society Organisation
DCR	Drug Consumption Room
DM	Decision Maker
EC	European Commission
EU	European Union
FGD	Focus Group Discussion
HCV	Hepatitis C Virus
HSE	Health Service Executive, Ireland
KCKT	Civil Drug Coordination Board, Hungary
KEF	Local council drug coordination forum, Hungary
KETHEA	Therapy Centre for Dependent Individuals, Greece
KKB	Drug Coordination Committee, Hungary
KT	Drug Council, Hungary
MAT	Hungarian Society on Addictions
MP	Member of Parliament
MSIF	Medically Supervised Injecting Facility
NDI	National Drug Prevention Institute, Hungary
NOC	National Oversight Committee, Ireland
NSP	Needle and Syringe Programme
OKANA	Organisation Against Drugs, Greece
RRF	Rights Reporter Foundation
SIG	Strategic Implementation Group, Ireland
THL	Institute for Health and Welfare, Finland

1. INTRODUCTION

For more than 30 years, Drug Consumption Rooms (DCRs) have been implemented in Western countries. DCRs typically aim to reduce overdose-related morbidity and mortality, prevent the spread of infectious diseases and provide people who use drugs with access to a broad range of medical and social support services. As a frontline service, DCRs are also often among the first sites where insights into new drug use patterns arise, and they, therefore, play an essential role in the early identification of new and emerging health and drug trends. In addition, DCRs may have the objective of reducing drug use in public and in improving public amenities.

A substantial body of practical experience and research evidence has accumulated to support the effectiveness of DCRs in achieving public health and safety. However, while some countries seamlessly integrate DCRs into their continuum of care for people who use drugs, the scale and breadth of their global implementation varies significantly.

From a legal standpoint, international conventions afford flexibility for establishing DCRs, contingent upon national legislation recognizing them as part of a public health strategy. However, the operational success of DCRs in many countries hinges on adjustments to legislative, judicial and administrative frameworks, alongside grappling with political, cultural, economic and ethical hurdles, as well as public opinion debates. Consequently, considerable efforts are dedicated to navigating the intricate politics surrounding drug use, necessitating negotiations for legislative transformation, institutional restructuring, and particular principles governing social life.

Beyond cultural, ideological or political shifts, the implementation of DCRs reveals a nuanced landscape where practical considerations and negotiations often receive insufficient attention despite their equal complexity. These considerations involve, amongst others, the strategic designing of care support services, the development of supportive environments and day-to-day operations, encompassing the articulation and enhancement of procedural protocols to effectively respond to the unique context, needs, preferences and values of the served communities.

These challenges become particularly pronounced when establishing a DCR for the first time in regions with high drug-related fatalities or limited resources. Moreover, the process of establishing and operating a DCR is ongoing, subject to periodic evaluations of efficacy and legitimacy, to ensure continued optional functionality and societal acceptance.

In 2023, in an effort to assist care professionals in Europe contemplating the establishment or improvement of DCRs - including community-based and community-led organisations, programme managers, policy makers, researchers, and other related stakeholders - C-EHRN and the European Network of DCRs (ENDCR) conceptualized and developed an on-site training programme. This programme was piloted in two locations, Ljubljana, in cooperation with the NGOs STIMGA and ŠENT, and Brno, in cooperation with PODANÉ RUCE.

The following report presents an overview of the methodology employed in the development of the training programme, along with a summary of the background, context and outcomes of each pilot training.

2. BACKGROUND

2.1. GENERAL GOAL

The overall goal of the training programme is to increase the competencies of social and healthcare workers to actively contribute to the effective planning, establishment and operation of DCRs in Europe, ultimately enhancing their local public health, safety and community well-being.

2.2. SPECIFIC GOALS

Enhance Understanding of DCRs

✦ Develop a comprehensive understanding of the principles, objectives and evidence-based practices associated with DCRs.

✦ Upscale the implementation of current best practice DCR and harm reduction models, strategies and practices.

Strengthen Networking & Collaboration

✦ Foster effective network and collaboration skills among social and healthcare workers involved in DCR initiatives.

✦ Develop strategies to engage with local communities, law enforcement, policymakers and other relevant stakeholders to build a supportive network for the successful planning, establishment and operation of DCRs.

Optimise Operational Logistics

✦ Gain practical insights into the day-to-day operational aspects of running a DCR, including facility management, staffing and outreach efforts.

✦ Develop skills to address logistical challenges, such as legal and regulatory compliance, resource allocation and crisis management within the context of DCRs.

Advance Data Collection, Monitoring and Evaluation Competencies

✦ Improve proficiency in data collection methods and ensure accurate and ethical monitoring of DCR activities.

✦ Enhance skills in utilizing data for evidence-based decision-making, programme evaluation and continuous improvement of DCR services.

✦ Explore current best practices for measuring the impact of DCRs on public health indicators, safety outcomes and community well-being, promoting a culture of accountability and transparency.

2.3. METHODOLOGY

To ensure responsiveness to the specific contexts of local communities and that the training participants contribute to the learning process, a participatory and collaborative approach is emphasised throughout the training development and implementation methodology. Grounded in the latest insights from the field and informed by the dynamic needs of local stakeholders, the training programme integrates a literature and best practice review, needs assessment, tailored curriculum development and an evaluation process.

Literature & Best Practice Review

To establish a solid foundation, in 2022, C-EHRN conducted an extensive selection and synthesis of current scientific research, guidelines, methods and tools about crucial areas in designing, implementing and operating a DCR [1]

Recognising the pivotal roles of DCR care workers and community members, C-EHRN actively engaged members of the ENDCR in this process. Through a series of workshops, participants actively contributed to identifying and integrating the latest developments in the field. The workshops served not only as a platform for knowledge exchange, but also as a means to foster collaborative relationships.
The insights gathered from the literature review and the workshops were integrated into a publication that subsequently underwent a thorough review by experts in the field.

This multifaceted approach, combining literature synthesis, stakeholder engagement and expert review, ensures the development of a general theoretical and practical framework to enhance the efficacy, relevance and practical application of the DCR Training Programme.

Needs Assessment Consultation

In developing the DCR Training Programmes, a crucial step involved conducting a Needs Assessment Consultation with each participating organisation. This consultation served as a vital orientation to understand the diverse range of locally relevant cultural, political, and legislative environments, as well as the unique needs, values, preferences, and resource access within each community.

Through these structured dialogues with local stakeholders, these consultations enabled the tailoring of the training content to address the distinctive requirements of each organisation. The inclusive and collaborative nature of these consultations ensures that the training programmes are evidence-based and responsive to the specific contexts and needs of the communities served.

Development of Training Materials

The subsequent step in the DCR Training Programme involves the development of training materials. This process integrated and translated insights from the literature, best practice reviews, and the comprehensive needs assessment into a dynamic context-specific training curriculum and modules.

The development phase placed a particular emphasis on crafting training materials that are not only informative but also culturally sensitive, relevant, and engaging. The materials include presentations, case studies, and interactive exercises designed to foster both theoretical understanding and the acquisition of practical skills among participants. This approach enhances the effectiveness of the training, facilitating a

more meaningful and impactful learning experience for all participants.

Feedback & Training Evaluation

In addition to the pre-training assessment conducted to establish a baseline and expectations of participants, the training approach incorporates ongoing feedback moments throughout the training sessions. These regular assessments are designed to gauge participant comprehension, level of engagement, and overall satisfaction with the training experience.

After completing the training programme, a comprehensive post-training evaluation is undertaken. This evaluation uses qualitative and quantitative measures to measure the programme's effectiveness. The post-training evaluation serves as a valuable tool to identify specific areas for improvement in the programme, ensuring the continuous refinement and enhancement of the training content and delivery.

Training Follow-up

In the post-training phase, there is a commitment to providing participants with comprehensive follow-up support. Each participant receives a package of materials that includes the training materials for reference, a detailed report highlighting the main points of discussion that emerged during the training, and a compilation of action points generated by participants during the sessions.

A dedicated follow-up session is scheduled to ensure sustained learning and address emerging issues. This session aims to reinforce key concepts, guide applying newly acquired skills in real-world scenarios, and offer a platform for continued dialogue and support.

3. TRAINING: SLOVENIA

2.1. Background

On the 28th & 29th of September, 2023, C-EHRN and the ENDCR piloted the first iteration of its DCR Training Programme in Slovenia in cooperation with two local organisations in the process of implementing a DCR: NGO STIGMA (Ljubljana) & NGO ŠENT (Nova Gorica).

Stigma[1] is a harm reduction organisation that operates two drop-in centres in Ljubljana. They provide access to free sterile injection equipment, counselling and other social support. Stigma also runs a mobile needle exchange programme in Ljubljana and other cities in Slovenia and a programme, 'Safe House' ('Varna hiša'), for people who use drugs who are exposed to (domestic) violence.

ŠENT[2] is a non-profit, non-governmental humanitarian organisation that aims to support people who deal with mental health challenges and their relatives, working within a harm reduction and social inclusion framework. Some of the key activities of ŠENT include psychosocial rehabilitation and counselling; support for job training and in securing employment; day centres and shelters; and providing sterile needles and other harm reduction paraphernalia to people who use drugs through a mobile programme.

2.2. Context

The trajectory toward establishing a DCR in Slovenia spans a considerable period, with the first initiatives dating back to the 1990s, followed by different community-led and community-based attempts to implement a DCR in Ljubljana during the 2000s.

Noteworthy progress emerged in 2012 when legislative amendments, advocated by the NGO Stigma since 2008, introduced a significant shift. The amendment to the criminal law allowed for the provision of a treatment programme or a controlled space for drug use, contingent upon adherence to approved conditions. This legal shift laid the groundwork for groundbreaking harm reduction efforts and paved the way for the country's first DCR in Ljubljana.

The momentum gained further traction in 2015 with the initiation of a DCR pilot project. Spearheaded by Stigma and financed by the Ministry of Health, the project aimed to provide a safe environment for people who use drugs. However, the project encountered an array of bureaucratic hurdles and financial constraints, leading to the premature closure of the project before its planned opening. The intricacies of the project included navigating the approval process of the National Medical Ethics Committee which, despite eventual endorsement, raised concerns about indirect cooperation in illegal activities. Additionally, challenges emerged in identifying an appropriate agency to provide the required service supervision, as mandated by the Criminal Code.

[1] link to website
[2] link to website

After almost two decades of advocacy and legal transformation efforts, at the end of 2023, Stigma and ŠENT are in the advanced stages of preparation, leading to the opening of the first DCRs in the country. While ŠENT is currently renovating its Nova Gorica facility to accommodate supervised injection, inhalation and snorting of subtances, Stigma has established a dedicated DCR for snorting within one of its two drop-in centres. Other routes of consumption are planned to be introduced at a later stage.

Two factors shape the strategic decision by Stigma: firstly, the lack of sufficient space to integrate supervised consumption services in their city centre drop-in facility, where it would be most needed; and secondly, the fact that snorting drugs is a visible phenomenon in public spaces close to the existing facilities.

Despite advancements, the establishment of both DCRs still faces numerous challenges. In the case of Ljubljana, bureaucratic delays persist, primarily related to forming a group of experts tasked with providing necessary supervision as required by the Criminal Code. In addition, both organisations need guidance with specific DCR operational and technical matters. These include, among others, staffing requirements, the design of procedural policies and protocols, and the implementation of data collection and evaluation strategies.

2.3. Training Participants

The training in Ljubljana brought together several local and national stakeholders from diverse sectors, fostering cooperation. Alongside staff from the two organisations, Stigma and ŠENT, representatives from other NGOs that work in the field of social inclusion, the National Ministry of Health, the National Institute of Public Health, the Municipality of Nova Gorica and the Psychiatric Clinic of Ljubljana, took part in the training.

2.4. Training Modules

DCR Models

The session introduced the main models of care and operational implementation across DCRs worldwide, emphasizing their adaptability to different community needs. In addition to theoretical and historical underpinnings, the session incorporated relevant case studies, showcasing successful DCR implementation. The selection of case studies aimed to support the practical application of the presenting models, offering tangible examples of how DCRs have been customized to address specific community challenges.

As such, this session served as a foundation for subsequent discussions through the training, helping participants understand the flexibility inherent in DCR design and operation and inspiring them to think creatively about tailoring these models to suit their specific needs and context.

Stakeholder Cooperation

Among the themes that emerged during the assessment consultation, the need for improved cooperation among local and national key actors has been framed as vital. Although the implementation of a DCR might be initiated by one agency, successful initiatives require developing and maintaining complex cooperation structures between a diverse array of local, regional and national stakeholders.

At the same time, implementing a person-centred and community-based/led model of care demands a shift in power distribution among stakeholders as to ensure meaningful and equitable involvement in co-production processes.

As a means to trigger and support challenging conversations about stakeholder roles, distribution, relationships and structures, in this session, participants were invited to engage in a tailored hands-on mapping exercise. Using visual representations, the different stakeholders attending the training had an opportunity to develop a common understanding of their current situation and to imagine new possibilities while acknowledging or attending to specific context-related constraints or conditions.

Service Design: Model of Service & Operational Protocols

In this session, participants delved into the principles and methods that underpin the choice of a particular DCR model. They also learnt how this model informs every aspect of its operation, from staff training to client service, and how it aligns with broader harm reduction goals. Participants had the practical opportunity to design and/or improve their guiding principles and approaches to service delivery.

Afterwards, attendees were introduced to the critical operational elements underpinning a DCR's functioning. By the end of the sessions, participants clearly understood the day-to-day procedures and responsibilities and tools and models of good practice to design and implement their own.

DCR Monitoring & Evaluation

There is a lack of publications or guides on performing project monitoring and evaluations in the context of DCRs. In this session, participants had access to a structured overview of types of evaluation, relevant best practices and current applications. These include, among others, key performance indicators and monitoring and evaluation methodologies to support the improvement of their services to understand the effects of the programme in the communities they serve and the effectiveness of services in achieving their ultimate goals.

2.5. Training Outcomes & Impact

The sessions and exercises prompted discussion, highlighted strengths or issues to resolve, and inspired DCR implementation. Some key discussion points included the following:

Service Accessibility

✦ Stigma is a low-threshold service that does not require identification or registration at intake. It only provides clients with an alphanumeric code to access the needle exchange programme; ideally, they would not want to collect further data.

✦ ŠENT plans to have an intake protocol, including questions about the substances they plan to use, administrative route and quantity. This plan was developed in conversation with the local police, for which the collection of this data is required to operate the DCR.

✦ Participants discussed the matter of whether to allow people who are already under the influence of drugs/alcohol into the DCR or not. While some felt it would not be appropriate, others underlined that those clients would otherwise use in a less safe environment.

✦ As for the issue of age restrictions to access the DCR, staff from the NGOs sometimes meet minors who inject drugs, for whom a DCR would be an important facility. A possibility to offer support to this group without running into legal hindrances might be to offer sterile supplies to minors but not access to the DCR.

Staffing Models | Social or Health Approach

✦ According to Slovenian law, consumption in a DCR has to happen "under medical supervision", an unclear phrasing that NGOs have had trouble understanding, even in cooperation with legal experts. According to the Ministry of Health, this legislation implies the necessity of a nurse to be present in a DCR, while local NGOs suggest that first aid is something trained social workers can perform.

✦ It was pointed out that, due to discrimination, many people who use drugs in Slovenia might refrain from accessing medical services: hiring a nurse would then improve access to healthcare by offering clients some basic medical assistance.

✦ Some participants stressed the importance of having a DCR that does not have a medicalized appearance, which would be the case if a nurse were to be present.

✦ In addition, employing a nurse requires a larger budget, which poses more challenges in the context of limited funding. NGO representatives also highlighted the difficulties they face in finding medical staff that are willing to work in a DCR.

Other Legal Challenges

✦ In Nova Gorica, Šent plans to incorporate a smoking room in their facilities. This is important as, opposite to the situation in Ljubljana, more people in the area of Nova Gorica smoke rather than inject. Therefore, they are defining how to install a ventilation system, also in conversation with other ENDCR members, and they are considering an outdoor smoking room.

✦ National laws that forbid smoking (tobacco) inside of buildings (due to a recent legislative change, even with a ventilation system in place) might be an obstacle towards the establishment of a smoking room. There could be, however, possibilities of exceptions for smoking substances that are not tobacco.

Staff Responsibilities

✦ The discussion also touched on the issue of which staff would legally be allowed to support people who use the room. For instance, are they allowed to administer life-saving medication?

✦ Naloxone, for instance, can be obtained in Slovenia as a medication for home use from one's doctor upon payment and self-declaration as a person who uses drugs. At the time of the training, the staff of the NGOs would not be allowed to obtain or administer Naloxone in a DCR. With the support of the Psychiatric Clinic of Ljubljana, dedicated training could be offered to DCR staff, following which they would be legally allowed to administer Naloxone to clients.

2.6. Next Steps

The discussion that took place during the training sessions resulted in the proposal of:

✦ **Improving & updating a working group that would gather the main actors involved in developing DCRs in Ljubljana**. The group would organize regular internal meetings and consultations with neighbors, local businesses, and relevant institutions.

✦ **Improving & updating a working group gathering the main actors involved in developing DCRs in Slovenia**. The group would organize and hold regular meetings; prepare a shared database of relevant legislation with the support of legal scholars; define DCR protocols; organize consultations with neighbors, local businesses, and relevant institutions; and design self-assessment surveys to monitor the impact of the DCRs.

3. TRAINING: CZECHIA

3.1. Background

On November 30th and December 1st, 2023, C-EHRN and the ENDCR launched the second pilot of the DCR Training Programme in Brno, Czech Republic, in collaboration with the local organisation, Podané Ruce, which has recently opened the first DCR in the city.

Podané ruce[3] provides comprehensive support and professional services to people who use drugs across the Czech Republic. Alongside the newly opened mobile DCR, their services include needle exchange, treatment for drug dependence, mental health support, programmes for youth and prison-specific programmes. At the centre of their work are the principles of harm reduction, and they strive towards providing more high-quality social and health services.

3.2. Context

The mobile DCR in Brno opened in September 2023. In the immediate proximity of the DCR, the organisation runs a well-established outreach needle exchange programme.

At the time of the training, the DCR is accessible for one person at a time, with the possibility of giving access to two or three people in the future. To be able to use the DCR, one must be 18+ years old and already be a client of the outreach programme. There is also a requirement to briefly answer questions on the substances they plan to use and sign a 'terms of use' contract. The DCR allows for injection only and is open from Monday to Friday for two hours per day, which will be expanded at the beginning of the new year. When accessing the outreach programme, clients are provided with a code; however, the organisation also uses nicknames for those that prefer not to have a code associated with them.

The Brno DCR operates in an area with a significant presence of people from the Roma community, and staff have noticed limitations in adequately reaching this community. The training, therefore, included moments where participants could discuss strategies to fill this service gap.

3.3. Training Participants

The Training in Brno was attended by staff of the mobile DCR and of the outreach needle exchange service and other members of the organisation Podané ruce. Additionally, representatives from the municipality of Brno and the Addictology faculty of Prague were present during the sessions.

[3] link to website

3.4. Training Modules

DCR Models

Mirroring the DCR Training Programme in Slovenia, the first session was to provide participants with a comprehensive understanding of the various models of DCR globally, specifically emphasizing their adaptability to different community needs. Building on the introductory phase, the session moved to practical aspects of mobile DCR design. Most DCRs described in the literature are located at a fixed site, and finding guidance on mobile models is hard.

Aiming to support the further development of the mobile DCR in Brno, the second part of the session emphasized considerations on outreach strategies, accessibility of mobile services, and specific models of cooperation and integration of services.

Person-centred Models of Care

One of the goals of the DCR in Brno is to improve the negative health outcomes of Romani people and other excluded communities. Financial constraints, not being able to reach health care, and having problems to get through the complexity of regular care systems are some of the most critical problems; in addition, the absence of trust between care providers and Romani people in care-giving processes.

Aiming to support Podane Ruce in improving and further implementing a person-centred, trauma-informed and culturally safe DCR service, participants were invited to engage in a tailored hands-on mapping exercise in this session. By using visual narrative timelines depicting the multidimensional relationship between Podane Ruce DCR services and the communities they serve, participants in the training had the opportunity to integrate and analyse diverse components of the DCR user's experiences and identify directions for change and improvement of the service care pathways.

As a means to trigger and support challenging conversations about stakeholder roles, distribution, relationships and structure, in this session the participants were invited to engage with a tailored hands-on mapping exercise. By using visual representations, the different stakeholders attending the training had an opportunity to develop a common understanding of their current situation and, furthermore, imagine new possibilities, while acknowledging or attending to their specific context-related constraints and conditions.

Operational Frameworks

The session allowed participants to present and discuss their experiences in designing and implementing operational guidelines and service rules in their DCR. To support the discussion, related examples of protocols and implementation experiences in other European DCRs were provided, including house rules [such as split-and-sharing], admission criteria and health protocols.

The session also provided an overview of current approaches to human resources in European DCRs. This includes common staffing models, required competencies and skills, and strategies for establishing supportive environments for staff.

3.5. Training Outcomes & Impact

The sessions and exercises prompted discussion, highlighted strengths or issues to resolve, and provided inspiration for DCR implementation. Some key discussion points include the following:

Building Trust & Engaging Communities

The different training sessions, discussions, and exchanges centred on identifying strategies for building and maintaining trust between the DCR service and its users. As a recently implemented service, significant energies are dedicated to fostering trustworthy communication and information sharing and enhancing the social inclusion of local marginalised communities. To support the development of such strategies, participants in the training dedicated attention to identify the factors that currently impact access to the service, including:

✦ In general, individuals and communities are more likely to open up, disclose information, accept care and recommend the services if they trust a healthcare professional. As a newly implemented service, the DCR staff perceive that the local communities are not yet sufficiently familiar with their presence and service.

✦ Grounded in person-centred care models, DCR staff members agree on the importance of incorporating local communities' lived and living experiences to support culturally relevant care services, help address power imbalances and foster engagement.

✦ The injection room of the mobile DCR in Brno has been installed inside a former ambulance. DCR staff members identified the need for further vehicle adaptations. Some clients describe it as too sterile and medical, leading to an association with (medical) authorities and previous negative experiences connected to a medical establishment.

Service Accessibility

✦Training participants identify barriers that Romani communities experience in access to care. These include language issues or lack of cultural competence.

✦ The rule that only one person can visit the DCR at a time could represent a barrier for clients to access the service, as many might rather be accompanied by or accompany someone else.

✦ This is especially true in the case of women who practice peer-assisted injection with their partners more often than men, a practice which is not allowed in the DCR.

✦ As people in the DCR area are often in groups, it is difficult for staff to establish 1:1 contact. In the perception of the Training's participants, people who use drugs (or families/groups where multiple people use drugs) in the area can be resistant to being open about their drug use with other members of their communities for fear of being stigmatised. Fear of being seen visiting the DCR could represent a barrier to access.

Capacity Building

Participants in the training highlighted the importance of continuous training to develop their competencies further to improve the quality of the DCR service and community well-being outcomes. Additionally, participants highlighted the following training modules as fundamental requirements for DCR staff in their service:

✦ **Safer injection practices**
Safer injection training aims at building the skills of individuals already experienced in drug use and harm reduction who wish to address the specific needs of counselling to improve injection techniques and other health outcomes, such as the prevention of communicable diseases. It discusses the differences and preferences for needle length and gauge, as well as needle safety, vein care, the management of common soft tissue infections and supportive tips for finding veins.

✦ **Cultural safety**
In general terms, cultural safety training aims to build personal awareness and emphasize person-centred care for marginalised individuals and communities. Cultural safety involves understanding histories, needs, power imbalances and the influence of care workers' beliefs and values on service delivery. As such, it requires that the care provider prioritises the individual narrative, builds partnerships with the individual to reflect upon and transform existing power imbalances involved in caregiving.

✦ **Conflict management, de-escalation strategies & talking to the police**
Usually, this typology of training presents a combination of frameworks, strategies and techniques to reduce the risk of harm in crisis and conflict situations. Topics range from conflict prevention, de-escalation, and management and resolution of self-care strategies. Strategies may include violence and aggression prevention, communication techniques, emotional awareness, persuasion and cooperation, mediation approaches, or redirecting negative behaviour.

3.6 Next Steps

Alongside their well-established harm reduction services, implementing a DCR in Brno by Podané Ruce represents a significant step towards ensuring equitable access to care for marginalised communities and better health outcomes. During the training session, participants highlighted several follow-up actions to increase their capacity to deliver more effective person-centred care:

✦ **Increase cooperation with local Romani organisations**, as well as to implement strategies to increase the inclusion of lived/living experiences in the DCR service, such as peer-to-peer programmes or health-mediator initiatives.

✦ **Implement anti-rumour strategies** to prevent the further discrimination of marginalised communities, improve coexistence and harness the potential of diversity by triggering a change in perceptions, attitudes and behaviours among the general population of Brno and specific target groups.

✦ Develop and implement **continuous training programmes and capacity-building activities** to support staff to improve or acquire new competencies.