Alma Mater Studiorum
Università di Bologna

SCUOLA DI ECONOMIA MANAGEMENT E STATISTICA
-Sede di Forlì-

Corso di Laurea Magistrale in
Management dell'economia sociale
(Classe LM-77 – Scienze Economico-Aziendali)

TESI DI LAUREA
In
Bilancio e Sostenibilità

Measuring the social return on investment. A case study of Drug Consumption Rooms (DCRs) in Amsterdam.

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Anno Accademico 2018/2019
Febbraio 2020

«When I talk to addicted people, whether they are addicted
to alcohol, drugs, gambling, Internet use, sex, or anything else,
I encounter human beings
who really do not have a viable social or cultural life.

Maybe our fragmented, mobile, ever-changing modern society
has produced social and cultural isolation in very large numbers of people,
even though their cages are invisible!»

Bruce K. Alexander

Introduction

«Every day our actions and activities create and destroy value; they change the world around us. Although the value we create goes far beyond what can be captured in financial terms, this is, for the most part, the only type of value that is measured and accounted for. As a result, things that can be bought and sold take on a greater significance and many important things get left out»[1]. This sentence, extrapolated from the Social Value UK Guide to SROI, gives an idea of the challenging objective pursued through the calculation of the Social Return on Investment (SROI). The concept of value is wide and it includes social, economic and environmental aspects that the SROI aims to measure by providing a useful framework to account this broader concept of value.

This thesis relies on the SROI in order to establish the social impact of a particular kind of facility in Amsterdam called Drug Consumption Room, which is a safe space where (homeless) people struggling with a drug addiction can use their drugs in a hygienic and supervised environment. The user room is a harm reduction intervention with different impact areas mostly relate to the health of the People Who Use Drugs (PWUD) and the reduction of the public nuisance.

The goal of this thesis is threefold: to evaluate the social impact created by a Drug Consumption Room (DCR) in Amsterdam by using the Social Return on Investment (SROI) tool; to explain the whole process of creation of value; to identify new possible evaluation tools in order to facilitate a future evaluation of social impact.

The final work is the result of three work phases:

1. Pre-assessment: study of the tools (SROI and SROI Value Map) needed for the evaluation of the DCR social impact and consequent filling of the early stages of the Value Map by referring to the literature on the topic;
2. Fieldwork: three-months work inside the facility by exploring the different services (drop-in, user room) and collecting data and information through expert meetings, focus groups, interviews and informal conversations with the stakeholders involved.

[1] The SROI Network (2012), "A Guide to Social Return on Investment"

This phase leads to modify the Value Map in order to better represent reality;

3. Final assessment: phase that includes the assemblage of all the collected materials and the integration of the case study into the broader topic of Harm Reduction policies and interventions.

This thesis work eventually demonstrates, in view of limitations in terms of time and resources, an overall positive social impact of the user room managed by *De Regenboog Groep* in Amsterdam and identifies some evaluation tools in order to improve the material required for the conduction of a social impact analysis.

The thesis is structured in three chapters. The first chapter aims to provide a picture of harm reduction as one of the four pillars of the drug policies by explaining the history and the implementation. Besides, the second part of the chapter addresses the Italian experience with *Take Home Naloxone* (THN) programs, which is a model for the other countries. The final part of the chapter provides a comparison between Italy and the Netherlands concerning the harm reduction interventions. This chapter is useful to have a background of the approach behind the Drug Consumption Room, which represents the subject of the social impact evaluation.

The second chapter describes what the DCRs are, the history and the different models, the goals and the target, the structure, the approach and eventually the impact. In summary, this chapter aims to provide a full analysis of the DCRs' topic. The final paragraph is an introduction to the DCR managed by *De Regenboog Groep* that is subject of analysis of the evaluation of social impact presented in the third chapter.

The third chapter is the thesis' core: it shows systematically all the stages that lead to the establishment of the social impact and the SROI ratio calculation. In this chapter, thanks to a tool called Value Map, the entire logical framework of the creation of value is rebuilt. The analysis carried out in this chapter demonstrates an overall positive social impact of the DCR and suggests new evaluation tools.

Finally yet importantly, the appendix collects all the focus groups and interviews carried out during my internship in the facility in order to add qualitative information to the analysis and to gather useful information for the Value Map.

List of abbreviations

DCR → Drug Consumption Room

EMCDDA → European Monitoring Centre for Drugs and Drug Addiction

HepC → Hepatitis C

HIV → Human Immunodeficiency Virus

MMT → Methadone Maintenance Treatment

NSP → Needle Syringe Program

PWID → People Who Inject Drugs

PWUD → People Who Use Drugs

SROI → Social Return on Investment

THN → Take Home Naloxone

Chapter I

Harm Reduction strategies, an overview

1.1 Harm Reduction and the four pillars of drug policies

Nowadays it does not exist a universally accepted definition of harm reduction. According to "Harm reduction international", this concept is referred to «policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support»[2].

Harm reduction is one of the four pillars of drug policies together with prevention, treatment and enforcement approach. Implemented in Europe in the 1990s for the first time, the four pillars are common in many cities such as Geneva, Zurich and Frankfurt in Europe and Sydney outside Europe. Prevention is the most cost-effective and long-running way to reduce the harm related to drug use. It includes a list of strategies and interventions that aim to prevent and inhibit a dangerous consumption of alcohol, tobacco and drugs through education in early childhood and adolescence. The effectiveness of prevention approach is linked with the large impact of childhood experiences, both positive and negative, on lifelong health and opportunities. These experiences create a huge variety of far reaching outcomes on the future of people and the adverse childhood experiences are particularly associated with risky health behaviors, chronic health conditions, low life potential, and early death. Different strategies are included in the prevention approach. According to the "Wellington Guelph Drug Strategy", prevention interventions concern: «reducing individual, family, neighborhood and community harm from substance use by addressing risk factors and enhancing protective factors; delaying the onset of first substance use; reducing the incidence (rate of new cases over a period of time) and prevalence

[2] https://www.hri.global/what-is-harm-reduction

(number of current cases at one time in a population) of problematic substance use and substance dependence and providing education regarding substance issues, resiliency, and the social determinants of health»[3]. Some examples of the prevention model are the development of policies regarding selling and accessing substances and the offer of family or individual mentorship programs to build resilience. The benefits associated with the prevention policies are for example the reduction of the costs to the society and the harm at an individual and aggregate level. In prevention strategies, the commitment and the collaboration among social sectors should be high in order to achieve the desired results but, eventually, this kind of policies will have the best impact in reducing harm from substance use.

The treatment pillar encompasses interventions and strategies designed to support the needs of individuals experiencing substance-related issues in a long-term care framework. This pillar includes a broad range of services with different duration and intensity and it enables to encourage people who use drugs to make healthier decisions about their lives. The goals of this pillar concern: «improving the physical, emotional, mental, and spiritual health of people who use or have used substance; improving the quality of life of families, neighborhoods, and communities affected by substance use; reducing the barriers that prevent people from becoming engaged in care; increasing the number of people who access treatment; expanding treatment programs; and building community capacity to provide addiction services- working with FHTs, physicians, pharmacists»[4]. In order to reach these goals the treatment approach provides trauma-informed models of care, advocate for supportive housing services for drug-addicted people, offers a peer-based support services and build capacity within multiple sectors. Some examples of treatment policy are for example counselling and self-help programs.

The enforcement or community safety pillar aims to reduce crimes and community harm related to the drug use in public spaces and to guarantee public order. The implementation of this pillar implies a solid partnership among police, justice and social-

[3] http://wgdrugstrategy.ca/get-informed/4-pillar-drug-strategies/prevention/
[4] http://hklndrugstrategy.ca/four-pillars/treatment/

health service providers and the provision of support in recovery for people who have accomplished criminal action associated to drug use. According to this framework, the community safety approach tries to achieve goals of: «addressing the criminal behavior that most affects the safety of community members; increasing community safety; ensuring access to addictions supports in the court system; developing effective pathways to support community members with substance use issues transitioning out of the justice system; promoting alternative healing and recovery options for court-ordered programming (supporting individuals whose addiction has resulted in criminal activities); exploring evidence-based strategies to address social justice and enforcement efforts in addressing substance use and those struggling with addictions; encouraging working partnerships between police, justice, and social/health service providers to address shared challenges»[5]. A broad range of policies to reduce the harm associated with criminalization of illicit drugs would be available following a decriminalization model of policy that still represents a controversial issue in drug policy debate.

The last pillar is the harm reduction approach consisting in reduce the harm arising from the sale and the use of legal and illegal substances to individuals and communities. It provides a health-centered approach to the topic by focusing on the physical and emotional harms caused by substance use. Furthermore, harm reduction, it also could be considered as a movement for social justice built on respect for the rights of PWUD (People Who Use Drugs) and on the reject for every kind of discrimination or stigmatization towards this hard-to-reach part of the population. According to the "Harm reduction coalition", this pillar follows a set of fundamental principles: it includes firstly the acceptance that licit and illicit drugs exist, and that there is a way to minimize the harmful effects instead of ignoring or condemning them. Furthermore, following this approach, it is also important to consider drug use as a complex phenomenon and to understand that some ways of using drugs are safer than others. The harm reduction pillar believes that the quality of individuals or

[5] http://hklndrugstrategy.ca/four-pillars/justice-and-enforcement/

communities life does not depend necessarily on the cessation of drug use and it makes a call for a non-judgmental and non-coercive provision of services to PWUD. This approach ensures also that PWUD are involved in the process of creation of programs and services, seeks to empower users to share information and support each other and tries to do not minimalize the danger related to licit and illicit use of drugs. Briefly, the harm reduction approach encompasses the respect of the rights of people who use drugs, a commitment to evidence and social justice, a collaboration with PWUD and the avoidance of stigma. Following these principles, a harm reduction approach aims to achieve different goals. First, it tries to keep people alive and to encourage positive, both small and incremental, changes in their lives without coercion. Second, it aims to reduce the harms of drug policy by trying to improve drug laws in a way that they are not deleterious for PWUD and the communities. Many policies around the world are still encouraging the criminalization of people who use drugs and the denial of life-saving medical care services. Third, the harm reduction pillar seeks to offer a valid alternative to approaches that want to prevent or end drug use by reaching the PWUD that do not want to stop using substances.

1.2 History of harm reduction: USA and Europe

This paragraph aims to retrace the main developments in the history of Harm Reduction (HR) by considering American and European history on the topic. The history of drug policies and harm reduction in the United States is interesting for many reasons: for example, in the USA started for the first time the so-called War on Drugs and in the USA were developed some important methods for treating individuals with disorders related to the drug consumption, such as methadone and buprenorphine for opiate use disorder. However, the harm reduction policies implementation was complicated in the US because of political resistances due to a historical demonization of drugs.

The most common illegal drugs currently used in our times have been consumed for thousands of years for medical and spiritual purposes. A prohibition approach to drugs began officially in 1971 in the United States because of President Richard Nixon who declared that the drug abuse was the “public enemy number one”. The war on drugs

implied a series of interventions designed to ban the drug trade and it started in her early stages before the Richard Nixon declaration. The first anti-opium laws date back to the 1870s and they were addressed to Chinese immigrants; the first anti-cocaine laws in the early 1900s in South America and the first anti-marijuana laws in the 1910s and 1920s in the Midwest and Southwest. Moralistic intolerance of intoxication combined with the stigmatization of minority groups has led to a demonization of psychoactive drugs. Subsequently, in 1971 Richard Nixon increased federal funding for drug-control agencies and drug-treatment efforts and increasing penalties, enforcement and incarceration for drug offenders. Two years later, the *Drug Enforcement Agency* was established and three offices were combined in order to better control drug abuse at a federal level: the O*ffice for Drug Abuse Law Enforcement*, the *Bureau of Narcotics and Dangerous Drugs* and the *Office of Narcotics Intelligence*. Later on, between 1973 and 1977, eleven states decriminalized marijuana possession and during Jimmy Carter presidency (1977) a campaign platform including marijuana decriminalization was inaugurated and in the same year the *Senate Judiciary Committee* decided to decriminalized possession for up to one marijuana gram for personal use. Nevertheless, the sea change was not long-lasting and other proposals to decriminalize marijuana were abandoned. During Ronald Reagan presidency, started in 1981, the War on Drugs became stricter and focalized on criminal punishment that led to an increase in incarcerations for nonviolent drug offenses. Specifically, the number of people incarcerated for nonviolent drug laws offenses increases from 50.000 in 1980 to over 400.000 by 1997[6]. Nancy Reagan, the wife of the president, who gave birth to the anti-drug campaign "Just Say No", also played a crucial role. The campaign was highly-publicized and representative of an effort to educate schoolchildren on the dangers of drug use. The extension of the War on Drugs was also guided by the crack epidemic, appeared in the early 1980s, that causes a significant increase in the use of crack cocaine due to its affordability. This

[6] http://www.drugpolicy.org/issues/brief-history-drug-war

kind of highly addictive drug had bad effects within African American communities by causing increase of addictions, deaths and drug-related crimes.

The United States Congress passed the *Anti-Drugs Abuse Act* (1986), which envisaged the allocation of 1.7 billion dollars to the War on Drugs and the approbation of some mandatory minimum prison sentences for drug offenses. During Bill Clinton presidency, the War on Drugs did not stop and the President rejected to end the ban on funding for syringe access programs. Something started to change in 1987 when Arnold Trebach and Kevin Zeese gave birth to a foundation described as the loyal opposition to the War on Drugs: the "*Drug Policy Foundation*". In the late 1980s, a consistent number of activists, scholars and policymakers adopted a vision against the prohibition approach in relation to drugs. At the drawn of the New Millennium, the politics has slowly shifted towards more sensible drug policy. According to the historical background, it was not until the late 1980s that syringe exchange programs appeared from both state and local level. Although the discovery of acquired immunodeficiency syndrome (AIDS) dates back to 1981, the political context made difficult to implement any programs oriented to a harm reduction approach. Furthermore, during that time the crack cocaine epidemic increased the demonization phenomenon of psychoactive drugs. Before harm reduction programs became part of the drug policy, the main idea was to carry out some pilot experiments, evaluate them and to make a decision concerning the possibility of implementation of that kind of intervention. Therefore, in 1988 a pilot program was proposed and subsequently adopted, even if it faced strong opposition. The project results showed positive outcomes in getting People Who Use Drugs into a long-term substance use treatment but they were not able to demonstrate the effect of the program on unsafe injection and HIV transmission. The program, considered as a failure, was stopped a year later the beginning. Other syringe exchange experiments were conducted afterwards in Tacoma, Washington and New Haven: all of them, funded by private foundations, were more successful than the one in 1988. Specifically, the pilot program from New Haven evaluated the reduction in HIV transmission thanks to a mathematical model based on the observation of the level of HIV antibody over the time in the syringes returned from the exchange. Although those

projects provide evidence of effectiveness, the opposition to the syringe exchange programs was still strong and it added a provision to prohibit the use of federal funds to finance syringe exchange programs until research showed that the programs are safe and effective. At the same time, the main problem was that the federal government was refusing to support financially researches on that kind of programs. That is the reason why a good amount of private foundations supported the research in this field especially during the early to mid-1990s when the number of HIV and AIDS cases increased and more syringe exchange program were implemented. During this period, the research on this topic accelerates and accumulates by leading to the provision of a great amount of policy statements and scientific literature reviews. Even if the researches demonstrated the effectiveness and the safety of the syringe exchanges programs the political opposition continued to be strong. However, since 2002 the United States has been facing a heroin epidemic correlated with an increase in the number of overdose deaths especially in suburban and rural areas that has led to a legalization of syringe exchange in some states such as Indiana and other neighboring states. Nevertheless, the federal funds could not be used to cover the expenses for needles and syringes but they could be used for all the expenses left such as staff costs or rent. The consequence is that many programs in the United States are still underfunded even if the cost of the needles and syringes is low in comparison to the other expenses. In conclusion, the effectiveness of syringe exchange programs in reducing HIV transmission is widely demonstrated, even if the researches collected were not enough to convince state and local governments to support financially the implementation of syringe exchange programs in a proper way.

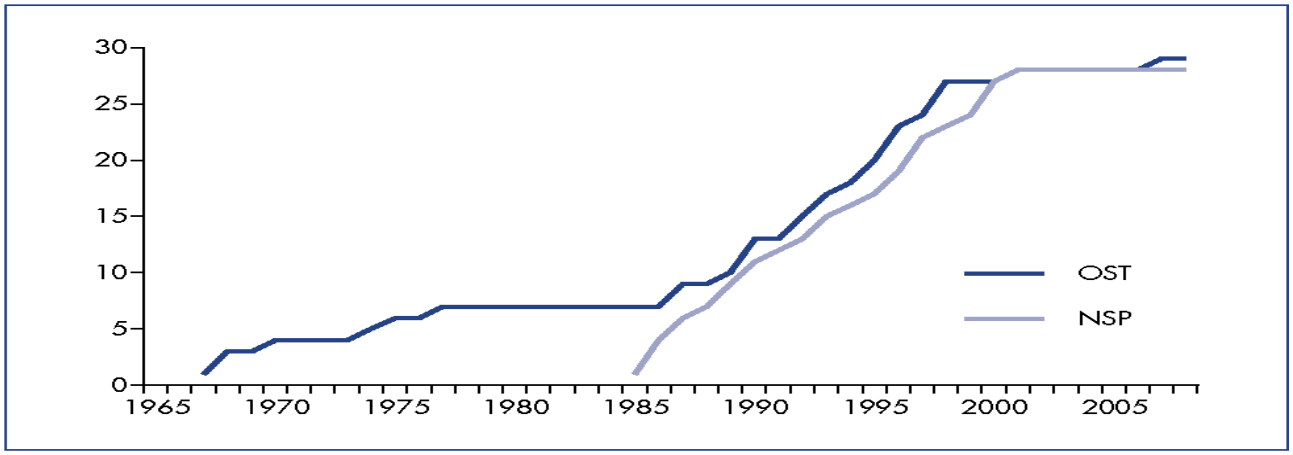
However, besides the development of syringe exchange programs, also research on drug addiction treatment evolved over the years. For example, after German scientists discovered that methadone during the World War II, the Americans started to control the medication and by the 1950s American doctors were already using methadone to treat the addiction without knowing what would have been the best use of this medication. Only in 1960s Vincent Dole won a *New York City Health*

Research Council Grant to study heroin addiction treatments and he developed the modern methadone protocol of treatment. Nowadays, approximately half million people are attending methadone maintenance treatment programs.

Moving forward to Europe, the harm reduction appeared for the first time in the late 1960s and 1970s in the western European countries but it became more and more popular only in the mid-1980s when the HIV and AIDS emergence arose. During that period, the number of People Who Use Drugs affected by drug-related diseases increased in many cities around Europe. According to the EMCDDA data, in 1985 when the antibody tests were introduced, it turned out that there was a high rate of infection among People Who Inject Drug (PWID) in Europe: Edinburgh (51 %), Milan (60 %), Bari (76 %), Bilbao (50 %), Paris (64 %), Toulouse (64 %), Geneva (52 %) and Innsbruck (44 %)[7]. Europe was facing a public health emergency, the solutions found to face the problem were different across Europe and they were implemented at local level, driven by local health authorities and civil society. In 1984 in the Netherlands, began the first formal Needle and Syringe Exchange Program (NSP) thanks to drug user organizations who decided to provide sterile injecting equipment to their peers and to counter Hepatitis B transmission. HIV and AIDS epidemic leads policy makers to deal with more awareness the topic of drug policies clarifying their aim and identifying their objectives and priorities. Therefore, in 1986 also the United Kingdom started to implement Needle and Syringe Exchange Programs (NSPs) and similar projects were also developed in the same period in Denmark, Malta, Spain and Sweden. At the beginning of the 2000s, NSPs operated in 28 countries. The graphic below from EMCDDA shows the increase of NSPs

[7] EMCDDA (2010), "Harm reduction evidences, impacts and challenges"

and opioid substitution treatments (OST) in the European countries:



Note: The data represent the official introduction of OST, and the availability of publicly funded NSPs.
Source: Reitox national focal points.

The data shed light on a change across Europe in the methods to deal with drug consumption related problems: from a detoxification approach to the health management of people who use drugs. Consequently, the drug treatment services became more and more user friendly and based on a collaborative approach. Moreover, the Methadone Maintenance Treatment (MMT) appeared for the first time in Sweden in the 1960s and later soon in the Netherlands, United Kingdom and Denmark. The MMT is a treatment based the long-term prescription of methadone as a substitution of the opioid and it provides also counseling, case management and other psychosocial services. In the 1990s, after the mid-1980s HIV and AIDS epidemic, the MMT increased all around Europe and harm reduction became further and further part of drug national policies.

Nevertheless, only in 2000 the European Union gave birth for the first time to a drug strategy with an associated action plan for the following four years. The plan presented six recommended targets for the EU members including the reduction over five years of the incidence of drug-related health damage and the number of drug-related deaths. Another important document from the European Union popped up in 2003 when the *Council of European Union* adopted a recommendation on the prevention and reduction of health-related harm associated with drug dependence (COM 2003/488/EC). According to this recommendation «Member States should, in

order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction»[8]. The recommendation includes a range of activities that the Member States should implement:

1. To provide information and counselling to drug users in order to promote risk reduction and to facilitate their access to appropriate services;

2. To inform communities and families and to enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

3. To include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods. Outreach work is a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

4. To encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

5. To promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

6. To provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation, taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

7. To establish measures to prevent diversion of substitution substances while ensuring appropriate, access to treatment;

[8] Council of the European Union, Council Recommendation of 18 June 2003, COM 2003/488/EC. Recommendation 2003/488 - Prevention and reduction of health-related harm associated with drug dependence

8. To consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

9. To promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical action;

10. To provide where appropriate, access to distribution of condoms and injection materials, and also to programs and points for their exchange;

11. To ensure that emergency services are trained and equipped to deal with overdoses;

12. To promote appropriate integration between health, including mental health, and social care, and specialized approaches in risk reduction;

13. To support training leading to a recognized qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence[9].

This document represents a milestone in the European drug policy. Thereafter others drug action plans were adopted, such as the 2009-2012 plan that also aimed to reduce the demand for drugs and the health and social consequences of drug using by improving the coverage, quality and effectiveness of service of prevention, treatment and harm reduction. In short, even if there are many differences among European countries in the extent and the nature of harm reduction, Europe remains one of the most supportive regions in regard to harm reduction policies and practices.

1.3 Harm reduction implementation

According to the EMCDDA definition of harm reduction, it «encompasses interventions, programs and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies»[10]. Harm reduction provides

[9] https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32003H0488

[10] EMCDDA (2010), "Harm reduction evidences, impacts and challenges"

a wide range of practical responses and interventions to handle drug use related problems by reducing the risks. The different types of interventions could be divided in two major categories: mainstream interventions, such as Opioid Substitution Therapy (OST) and Needle Syringe Exchange Programs (NSP); and highly targeted interventions, such as Drug Consumption Rooms (DCR), Heroin Assisted Treatment (HAT), peer naloxone-distribution or interventions in nightlife settings. This paragraph aims to provide a framework of the main harm reduction interventions following the mentioned categories of the EMCDDA.

The EMCDDA envisages harm reduction as a combined intervention that encompasses a package of activities such as the simultaneous implementation of needle and syringe programs, opioid substitution therapy, counselling services and drug consumption rooms.

The Opioid Substitution Therapy (OST) is a type of evidence-based harm reduction intervention that gives to people addicted to fast-active opioids, such as heroin, the possibility to replace the illicit drugs with slow-active medicines, most typically methadone and buprenorphine. Substitution treatment, often combined with psychosocial interventions, is the most common treatment for opioid dependence. The evidences of effectiveness show that OST reduces HIV risk behaviors and harms related with the injection of opioids, such as abscesses, septicemia, and endocarditis. Therefore, OST is enabling people to reduce injecting drug use and so to decrease the harm of HIV infection. According to MacArthur Georgie, methadone maintenance therapy has been associated with a 54% reduction in the risk of HIV infection among people who inject drugs (PWID)[11]. Thanks to the OST, People Who Use Drugs (PWUD) have the possibility to get in contact and to access to other health and social services through their attendance to the OST programs. Researches on this topic show how the impact of opioid substitution therapies on the long-term health of PWUD is more substantial for people who remain on OST for at least one year. Nevertheless, the retention rates are still low in many countries and an evidence review demonstrates that the OST programs have an average of one-year retention rate around 50% in low and middle-income countries[12]. There are many ways in

[11] MacArthur GJ et al, (2012) "Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis", BMJ

[12] Feelemyer, J et al., (2014) "Retention of participants in medication-assisted programs in low- and middle-income countries: an international systematic review"

which opioid substitution therapies are delivered: through primary care, specialist clinics, pharmacies or "take home" OST. The possibility to have access to the OST directly from the primary care is important to increase the accessibility of this kind of service. Even if not every healthcare facility is able to provide this harm reduction intervention, delivering OST in primary care remain crucial also because it can lead to some collateral benefits such as the reduction of the fear of social stigma that people could feel by accessing to a specific harm reduction or HIV service. Moreover, providing OST in specialist clinics is also positive as far as it put together in the same facility a wide range of harm reduction and other targeted health and psychosocial services.

However, one of the most common form of service delivery is represented by the pharmacies. PWUD seem satisfied by this possibility because it is generally more flexible and accessible than the others. The major barrier for the pharmacies have been identified with the high dispensing fees that hinder some people to access to the OST provided by pharmacies. The last way to deliver the OST is called "Take home" or "Take away" OST: it enables PWUD to consume doses of methadone or buprenorphine at home without any supervision. It is generally granted only to people who have been adhering to OST for already few months. The lack of trust between service providers and PWID is the major barrier to this kind of service.

According to a research of Harm Reduction International[13], the number of countries in which the opioid substitution therapy is available has increased since 2016 from 80 to 86 but it remains still not available or prohibited by law in some countries such as Russia. Moreover, when OST is available, methadone is definitely the most common prescribed substance. The graphic below shows the geographic distribution of OST facilities and shows the entry barrier in Asia, Middle East, North America and Western Europe. The explanations are multiples such as the scarcity of approved prescribers, the lack of specialized and accessible services for women and migrants or the stigma towards PWUD.

[13] Harm Reduction International (2018), "The Global State of Harm Reduction: 6th edition"

The infographic shows that in a certain number of countries OST is available also in prison. It represents one of the three treatment approaches used in European Union prisons with regard to PWUD. The first approach is a low-intensity drug treatment, which is a short terms program including counselling, psychoeducation, crisis intervention, motivational programs, Cognitive Behavioral Therapy (CBT) or short-term treatment in outpatient settings. The second includes a medium or high-intensity drug-free treatment, which is a treatment delivered in residential settings in inpatient wards. The third treatment group is about a medium or long-term opioid substitution treatment: thanks to this program, people who use heroin or other opioids can stabilize their addiction. In this case, the continuity of the treatment is essential if they are supposed to remain drug free post release.

According to the EMCDDA updated information (2019)[14], the clients of the opioid substitution therapy (OST) are about 654.000 in Europe: 75% are men and 25% are women. On average, people who resort to the OST are between 40 and 44 years old. The percentages related to the treatment duration are: 13% of the population resorts to OST for less than 1 year; 14% between 1 and 2 years; 17% between 2 and 5 years of treatment; 28% between 5 and 10 years and 29% more than 10 years.

[14] European Monitoring Centre for Drugs and Drug Addiction (2019), "European Drug Report 2019: Trends and Developments, Publications Office of the European Union", Luxembourg

A new problematic issue has to be handle about opioids: new high-potency synthetic opioids. They are new psychoactive substances causing deaths and intoxications around Europe currently representing a big challenge to drug policies models and nowadays the harm reduction response to this topic is limited.

Beside the opioid substitution therapy, the second mainstream type of initiative among harm reduction interventions is the Needle and Syringe Program (NSP) that includes the provision of clean needles and syringe to People Who Inject Drugs (PWID). The main objective of the program is to reduce the risk of diseases transmission, such as HIV and other blood borne viruses like hepatitis B or C, caused by the sharing of injecting equipment. Besides, another goal is the reduction of Injecting Risk Behaviors (IRB). Usually many NSPs provide also other equipment to prepare drugs such as filters, mixing containers and sterile water. The global coverage of NSPs is still inadequate because the majority of the countries who provide NSPs keep on providing less than 200 clean needles per person per year that is the recommended minimum amount of needles per person per year determined by the World Health Organization (WHO). Since his introduction, the NSP has been related to some positives health outcomes: for example, studies in the 1990s reported a reduction in the incidence of HIV, HBV and HCV infections, a decline in needle sharing among HIV positive and negative individuals, in syringe reuse and an increased rate of drug treatment program attendance. Furthermore, around 20% of AIDS cases and upwards of 55% of hepatitis C cases are related to injection drug use and that is also a reason why NSPs are an important tool to fight against the diseases transmission[15]. In addition, these kind of programs are not only useful to reduce HIV and Hepatitis infections, but they are also cost-effective. For example, the Center for *Diseases Control and Prevention* reported in 2005 that NSPs «are cost effective. At an average cost of $0.97 per syringe distributed, SEPs can save money in all injection drug user populations where the annual HIV seroincidence exceeds 2.1 per 100 person years. The cost [to prevent one] HIV infection by SEPs has been

[15] https://harmreduction.org/wp-content/uploads/2012/01/CostEffectivenessofSyringeExchangePrograms.pdf

calculated at $4,000 to $12,000, considerably less than the estimated $190,000 (listed in 1997 dollars) medical costs of treating a person infected with HIV»[16]. Even if the cost-effectiveness of NSPs has been proved, there is a lack of political support and funding: even in Europe, that is the most supportive region in terms of harm reduction policies. In Italy because of a huge reduction in funding the number of NSP sites fall from 106 in 2012 to 66 in 2015[17]. According to the civil society organizations in Italy this negative trend will continue so long as the "*Livelli Essenziali di Assistenza*"(LEA) will not implemented in this direction. In a more general level, international donor funding for HIV is in decline, especially in countries where harm reduction interventions are more needed.

NSPs are delivered in different ways. The fixed sites are, for example, one of the delivery strategies: they are usually located in areas with a high rate of injecting drug use and they encompass drop-in centers, pharmacies or specialized voluntary counselling and testing centers. One of the positive aspects of the fixed sites is the possibility to offer additional services, like counselling, in an easier way. On the other hand, mobile programs also exist and they operate in vans or busses by providing needles and syringes through a door or a window. Sometimes they work together with fixed sites by attracting the harder-to-reach populations that fixed sites maybe do not catch. Outreach programs, usually combined with fixed or mobile sites, represent another delivery strategy. They actually are an effective way to reach people who normally avoid harm reduction services for different reasons. Moreover, some countries, such as the Netherlands, Italy and Germany, use syringe vending machines besides other NSPs. These machines are usually located outside fixed sites or in places in which needles and syringes are hard to access and the majority of them is open 24 hours a day, 7 days a week. The machines are important most of all to reach the most marginalized people among drug users. Lastly, pharmacies are also a way to deliver NSPs: some of them just sell needles and syringes directly to people, others exchange harm reduction kits with vouchers. However, pharmacies are not really effective in

[16] https://www.cdc.gov/hiv/risk/idu.html
[17] Harm Reduction International (2018), "The Global State of Harm Reduction: 6th edition"

resource poor settings and they rarely offer also educational or additional healthcare services.

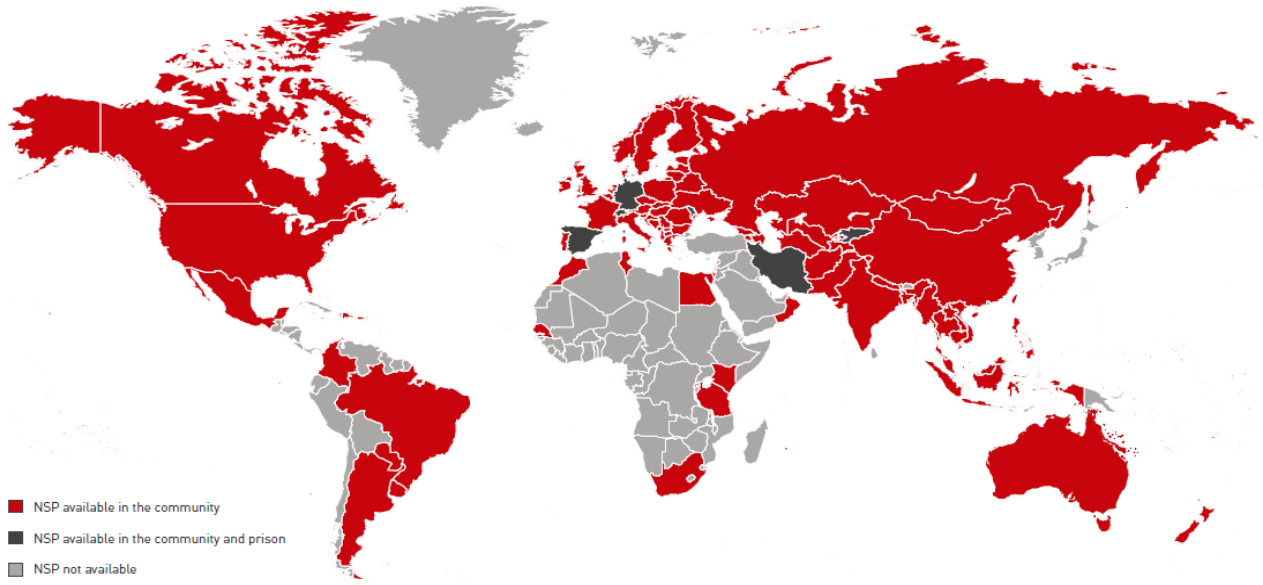
In general, the *Global State of Harm Reduction* records a decline in the number of countries that are implementing NSPs nowadays: from 90 in 2016 to 86 in 2018[18]. This phenomenon is related to the reduction of services in Latin American countries in which some civil society organizations reported that there is not anymore a significant part of population who inject drugs. On the other hand, in Eurasia 10 of the 27 countries have increased the number of NSPs in operations. Nevertheless, according to a report from the *Eurasian Harm Reduction Network*, among PWID, 10% is able to access to NSPs in Eastern Europe and 33% in Central Asia[19]. Some of the reasons are restrictive opening hours, poor quality equipment, stigma and discrimination. Stigma and discrimination are worldwide reasons to reject the access to NSPs mostly for specific groups, such as women who use drugs, homosexuals, homeless people, migrants and indigenous peoples.

However, the major barrier to NSPs implementation worldwide is the criminalization of injecting drug use. In 2018, for example, 93 countries in which NSPs could have been useful did not implement them because of punitive drug policies and, on the other hand, some countries such as Bulgaria, Laos and Philippines closed their NSPs by carrying out punitive policies. Nevertheless, there are countries in which policies are shifting in the other direction: for example, Myanmar decriminalized the possession of needles and syringes in 2015. The criminalization of the possession of the injecting equipment is in fact dangerous because it could be related to unsafe injecting practices and it has been associated with an increase in HIV infections among female sex workers who inject drugs.

The following graphic shows the availability of NSPs around the globe by specifying the countries in which that services are available in community; in community and prison or if they are not available.

[18] Harm Reduction International (2018), "The Global State of Harm Reduction: 6th edition"

[19] Eurasian Harm Reduction Network (2013) "Quitting While Not Ahead: The Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe and Central Asia"

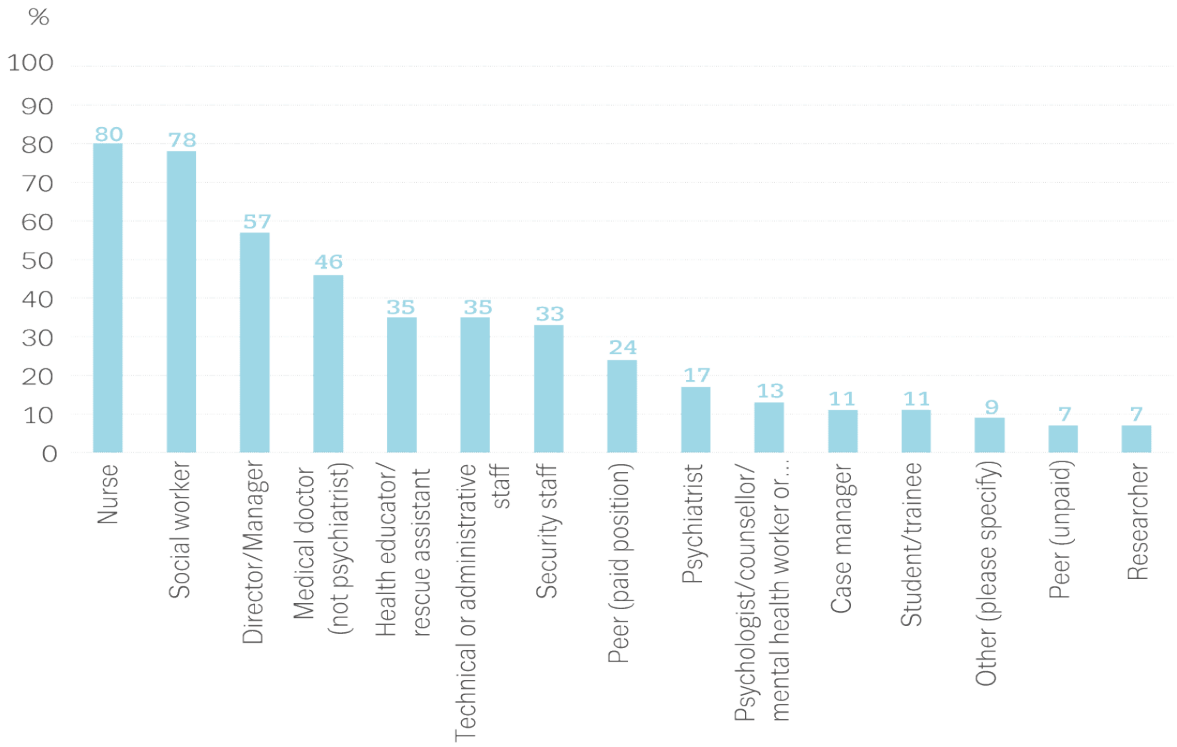


Against this background, a final consideration could be that even if the positive impact of NSPs in preventing HIV and improve the health of PWID is widely documented, the provision of this kind of services remains inadequate.

Besides the mainstream interventions (OST and NSPs), there are the highly targeted interventions such as Drug Consumption Rooms (DCRs), Heroin Assisted Treatments (HATs), peer naloxone distribution and the interventions in nightlife settings. The Drug Consumption Rooms (DCRs) are a particular kind of facility, subject of the next chapters of this work. They are a specific type of facilities in which people who use drugs can use them under the supervision of a trained staff. According to the EMCDDA definition, they actually are «professionally supervised healthcare facilities where drug users can consume drugs in safer conditions»[20]. In the 1980s, the epidemic of heroin use and drug injecting leads to a spread of HIV and AIDS among drug users. This is the reason why a wide range of responses appeared, such as outreach, peer education, health promotion, NSPs and OST. Drug Consumption Rooms represent a controversial solution to the problem: they started to have a space in the national policies only around 1990s when harm reduction as a policy began to be accepted in Europe. The first DCR was opened in Berne (Switzerland) in 1986 and, subsequently, in Germany, the Netherlands, Spain,

[20] EMCDDA (2018), "Drug Consumption Rooms: an overview of provision and evidences"

Norway, Luxemburg, Denmark, Greece and France. DCRs achieve different objectives. For example, they aim to reduce the risks of disease transmission due to an unhygienic use of the injecting equipment. Thanks to the DCRs PWUD have access to hygienic injecting equipment that give them the possibility to inject in a safe way by preventing the risks of contracting a drug use related disease such as HIV or Hepatitis C. Another crucial point is the prevention of overdose related deaths that is realized thanks to the supervision of a trained staff that is always ready to take action in case of overdose of clients. Besides, these facilities are also important in their function of a bridge between marginalized (homeless) addicts and health and social services. The clients of the DCR are usually high-risk drug users and hard-to-reach individuals that can get in contact with social workers and the health system by attending the supervised injecting sites. Furthermore, DCRs have an impact also in terms of public order and reduction of the public nuisance by reducing the drug use in public spaces and, subsequently, the presence of discarded needles and other drug use related problems. DCRs typically provide sterile injection equipment to drug users, counselling services, emergency care, primary medical care and referral to social healthcare and addiction treatment services. To make it possible, DCRs are composed by a team that includes a wide range of different professional groups as we can see in the following infographic from Belackova et al. (2017):



The effectiveness of DCRs in relation to some of their goals is proved: for example, researches on this issue demonstrated that these facilities are able to reach and stay in contact with marginalized people and that they lead to a general improvement of the hygienic condition of clients. They also have a proved positive impact on public order and they reduce risk behaviors such as syringe sharing among clients that could lead to diseases (HIV, Hepatitis C) transmission. It is still unclear and hard to estimate what is the real impact of DCRs on the reduction of the risk of HIV and Hepatitis C incidence among the wider population of injecting drug users. The estimation of this particular outcome is not so easy to carry out because of coverage and methodological problems. A clear effect could be instead recognized in terms of an increase in detoxification and drug dependence treatment and a general positive impact on the communities where DCRs are operating[21].

Nowadays, DCRs became an integrated part of harm reduction policy interventions in many European countries and they are also involved in the current political discussion because of the emergence of a new stimulant injection that is increasing health-related risks for PWID.

[21] EMCDDA (2018), "Drug Consumption Rooms: an overview of provision and evidences"

Another high-targeted harm reduction intervention is the Heroin Assisted Treatment (HAT), which encompasses the prescription of heroin for some addict users usually consumed in clinics under medical supervision. The history of the HAT began in the early 1990s when a group of both clinical and academic experts from Switzerland went to England looking for a treatment for heroin users to solve a Swiss emergence in terms of spread in the number of young people who were injecting heroin with a consequent increase in the risks of HIV transmission. When this group of experts from Switzerland visited a clinic in the north in which smokable and injectable heroin was prescribed, they decided to change the way in which heroin was delivered by maintaining the advantages and avoiding the disadvantages. They conceptualized a model based on the delivery of heroin inside medical supervised sites with a target composed by the most treatment-resistant heroin addicts in the community. The British model was implemented through "take home" prescriptions and the addicts did not consume the heroin inside the clinic under a medical supervision as in the Swiss model. The first pilot HAT clinic was eventually open in 1994 in Switzerland and a study to evaluate this kind of treatment was defined. The results of this study showed the positive benefits related to the HAT and that is why the World Health Organization (WHO) organized an international committee to discuss about this study by confirming the results. However, the committee underlined a big lack on this study related to the absence of a control group. Therefore, randomized controlled trials were subsequently implemented in different countries such as Germany, the Netherlands, Spain, United Kingdom and Canada. The RCTs showed the positive effect of HAT in reducing illicit heroin use and criminal activity and in improving the health condition of heroin users. The studies gave evidences of effectiveness of the treatment but they were not the only element that influenced the spread of the HAT: another important point was related to the historical context and especially to the pressure exerted by medical professionals and political considerations. Thanks to the prescribed supply of heroin, the HAT can offer a substance free from contaminants and adulterants used with clean injecting equipment that is used in a supervised and hygienic environment. In this way, HAT

clinics are able to prevent overdose and HIV infection and they provide access to counselling, social and healthcare treatments by improving the wellbeing of PWID. Reviews showed also that the HAT helps people to stabilize or, in some cases, to reduce the consumption of drugs and to increase the uptake of other treatments. Furthermore, the EMCDDA demonstrated the cost-effectiveness of the HAT by showing that the high cost of the treatment per client is more than balanced by the positive outcomes and savings in terms of health, public order and other services[22]. The coverage of this kind of intervention is smaller in comparison to the harm reduction interventions analyzed before (NSP, OST and DCR). The countries that have implemented the HAT are eight: Canada, Germany, the Netherlands, Spain, Switzerland, Denmark, Belgium and United Kingdom. Nowadays, the HAT is available in 58 clinics across these countries and four of them offer HAT as part of the standard treatment system.

Another type of harm reduction high-targeted intervention is naloxone distribution. Technically, naloxone is «a competitive opioid antagonist that can rapidly reverse the respiratory depression induced by heroin and other opioids. It competes for space at the μ2 opioid receptors, temporarily removing opioids from the receptors and preventing opioids from re-attaching to the receptors. Therefore, it may be used as an antagonist drug to reverse opioid effects and opioid-related overdose»[23]. Naloxone has not effect on non-opioid overdoses and it is not a source of addiction. Naloxone's history began in 1960s when it was discovered and patented. In 1971, the *US Food and Drug Administration* approved the naloxone as a solution for intravenous, intramuscular and subcutaneous injection. Since the nasal administration was the best way to facilitate the naloxone treatment in case of emergency, in France was created a naloxone spray in 2016 that was approved one year later from the European Commission for EU-wide marketing and that has been introduced in some European countries. Take-home naloxone (THN) program is an intervention that aim to make the naloxone available in places where overdose might happen more likely. If before the naloxone was available

[22] EMCDDA (2012), "EMCDDA report presents latest evidence on heroin-assisted treatment for hard-to-treat opioid users"

[23] http://www.emcdda.europa.eu/topics/naloxone

only to the emergency personnel, thanks to the take-home naloxone programs, it is available also to opioid-using peers, family members and other trained laypeople. The THN programs train on overdose risk and management people that are potential responders to an overdose. The target group of the training projects is composed by people who use opioids and the potential bystander at an overdose such as healthcare providers, staff members in facilities for homeless people and police and prison officers. The first community-based naloxone projects were implemented in the 1990s, during the overdose deaths epidemics, in both United States and Europe and then they developed quickly in many countries. Thanks to THN projects, naloxone was distributed as a part of a rescue kit at community-based health services to people who use opioids and other potential overdose bystanders. The coverage of this particular kind of harm reduction intervention refers to Europe, Australia, North America and Central Asia and includes 11 European countries. Italy had a crucial role in the spread of THN initiatives: pioneer doctors in drugs services from Italy, Germany and United Kingdom started training projects for non-medical personnel about opioid overdose management with naloxone. In 1990 in Italy, naloxone was removed from a list of prescription-only emergency medications and one year later began an experimental distribution of naloxone by doctors at public drug services in Piemonte and Lazio regions. Since then naloxone provision continues to extend to Italian cities such as Rome, Naples. In 1996, the Ministry of Health officially reclassifies naloxone as an over-the-counter medicine. Italy represents a model in terms of THN programs to prevent opioid overdose deaths. Unlike Italy, in the majority of the European countries THN programmes implementation has always been hampered by legal barriers that required the medical prescription to get the naloxone in pharmacies.

The last highly targeted intervention of Harm Reduction is the intervention in nightlife settings. This kind of intervention have a different target in comparison to the other analyzed practices: people who consume psychoactive substances with the intention of “having fun” are the target of the intervention. The alcohol and drug consumption in nightlife settings could lead to health and social problems such as health harms, aggressive behavior and violence, driving under the influence of alcohol

and drugs or problems related to drug dealing and public nuisance. According to the EMCDDA, many strategies could be implemented following the harm reduction approach to deal with the problem:

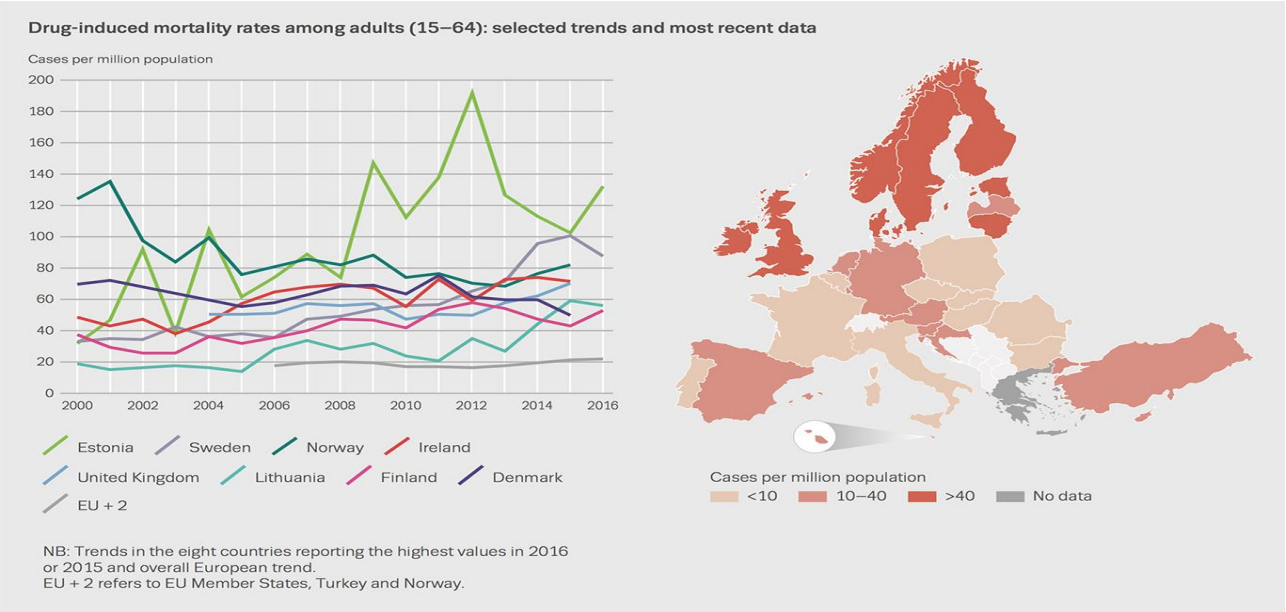
- Prevention or harm reduction information material can be provided to young people in recreational settings. Peer educators disseminating this type of information may be seen as more credible. These activities can be supported by websites and apps providing more detailed information on drugs, alcohol and related harms, and tips on avoiding them. However, the evidence for behavioral change effects from these interventions is scarce.
- Environmental strategies have a better evidence base. This approach includes measures that target factors that promote excessive consumption (e.g. discounted drinks, loud music and poor serving practices) or that create safer spaces and venues (e.g. by reducing crowding, providing chill-out rooms and free water, serving food, enforcing rules on behavior and access).
- Drug-checking services (sometimes called pill testing) enable individual drug users to have their synthetic drugs chemically analyzed, providing information on the content of the samples as well as advice, and, in some cases, counselling or brief interventions. The effectiveness of this approach in changing behavior is not clear, but it may provide a valuable opportunity for engaging drug users and for drug monitoring purposes[24]. Specifically, the number of drug-checking services available in Europe is growing. The intervention could be carried out in different ways such as off-site testing centers and on-site testing at festivals and in nightclubs.

The paragraph shows that the range of harm reduction interventions is broad. However, the distinction between mainstream and highly targeted interventions, provided by the EMCDDA, is useful to clarify the main differences between the interventions.

1.4 Take Home Naloxone programs, a focus on the Italian model

[24] http://www.emcdda.europa.eu/best-practice/briefings/nightlife-festival-and-other-recreational-settings_en

A research conducted in 2016 by *Forum Droghe*[25] gave an important contribution to the evaluation and the information provision of naloxone distribution in Italy. The scientific literature on this topic is narrowed even if the Italian experience of naloxone distribution could be considered as a model for the other countries. According to EMCDDA data, the Italian background in terms of number of opiates users shows a downward trend going from a rate of 7.7% (range 7.4-8.0) estimated in 1996 (corresponding to 299.000 persons), to 8.1 (range 7.8-8.3) in 2004 (approximately 312.000), to 5.2 (range 4.5-5.7) for the last estimate available (approximately 203.000 people) relative to 2014[26]. Nevertheless, always according to the EMCDDA, Italy is still among the first five countries with the highest rate of problematic users around Europe and, referring to the opiate users, another crucial issue is related to the increase, in modern times, of the number of young people who use opiates. Furthermore, drug related deaths are not high in comparison to the other European countries as it is shown in the following infographic from the EMCDDA:



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[25] Forum Droghe is an association both of individuals and various organizations involved in the reform of drug policies, harm reduction in particular. Forum Droghe also promotes research about the evaluation of the impact of drug legislation on the prison and justice systems.

[26] EMCDDA Statistical Bulletin, years 2004-2015

[27] infographics\infographic-drug-induced-mortality-rates-among-adults-15–64-selected-trends-and-most-recent-data_en.htm

According to national data from the Central Directorate for Antidrug Services (DCSA) of the Ministry of interior, drug-related deaths in Italy had a peak in 1999 and they decreased and stabilized afterwards during 2004-07. The majority of drug-related deaths are induced by opioids. At regional level, the drug related deaths distribution in Italy shows that the higher number of this kind of deaths occurred respectively in Emilia Romagna, Campania, Lazio, Toscana and Piemonte[28].

The Italian drug treatment system is composed by two complementary sub-systems: the SerDs (public drug addiction service units) and social rehabilitation facilities. These systems are implemented on regional basis by third-sector organizations and they operate in synergy with the public system. However, due to this regional autonomy, the operative and organizational models of this specific kind of services are different from a region to another and the result is a fundamental heterogeneity in services implementation among regions.

Take Home Naloxone programs in Italy are carried out by low-threshold facilities encompassed in the harm reduction network. Harm Reduction developed in Italy in the 1990s in the context of the HIV epidemics among drug addicts. Nowadays, harm reduction programs are more extensive in the North and in the Centre of Italy than in the South and they are usually based in big cities. They are delivered in different ways: through fixed sites (drop-in centers and reception units), mobile units, outreach programs and dispensing machines of needles and syringes. Thanks to the low-threshold facilities training programs, PWUD and probable overdose bystanders become more aware about the procedures to follow in case of opioid related overdose. According to *Forum Droghe* research on THN in Italy, the prevention project implemented by the low-threshold facilities includes:

- individual counselling on safer use;
- distribution of informative materials;
- support and the dynamics of peer support between clients;
- formation of groups for safer use and for emergency interventions;

[28] Forum Droghe (2016), "Preventing opioid overdose deaths. A research on the Italian naloxone distribution model"

- collection and diffusion of information and an eventual warning system on drug quality based on client information;
- placement of naloxone vials in places where PWUDs frequent;
- direct first aid interventions by health and non-health staff.

Spotlight - The role of SerDs in Italy

SerDs are part of the national health system and, nowadays, there are 638 public addiction service unites operating in Italy. Thanks to this widespread network they represent one of the most important pillars in terms of drug addiction interventions. SerDs mainly carry out outpatient treatments and they provide integrated treatments and reintegration programmes. For example, they cover an important role for the provision of treatments of substitute medicines such as methadone and buprenorphine (OST).

Anyway, referring to THN programmes, SerDs are not promoters of this kind of intervention that is exclusively implemented in low-threshold services of Harm Reduction. The narrowed role of SerDs in the naloxone distribution restricts the power of spreading of THN programmes all around Italy.

Moving forward to the Take Home Naloxone programs in Italy, it is important to underline that the naloxone became an over-the-counter drug in 1996 even though the first interventions realized with the naloxone date back to 1991 when some SerDs allowed their doctors to distribute naloxone in order to deal with the high number of overdose cases among opioid users. In Italy the naloxone is an over-the-counter drug, which means that can be bought in pharmacies without a medical prescription and it is available to every citizen. It is considered as a life-saving drug and that is why all the pharmacies are obliged to always have naloxone in stock. Nevertheless, the pharmacies do not play a crucial role in the naloxone distribution: PWUD rarely go to the pharmacy because, on the one hand, they are not aware of the availability of the naloxone as an over-the-counter drug and, on the other hand, they often feel ashamed to show up in pharmacies. Due to the fact that PWUD do not feel comfortable to buy the naloxone in pharmacies, doctors and health workers start distributing it to users and communities around them.

The research conducted by *Forum Droghe* (2016) shows that 57 units among the

Harm Reduction providers distribute naloxone[29] and that the coverage is unequal between the North and the South of Italy. The majority of the services who provide naloxone are in Lombardia (10), Piemonte (7), Emilia-Romagna (9) and Lazio (12).

1.5 Harm Reduction, a comparison between Italy and the Netherlands

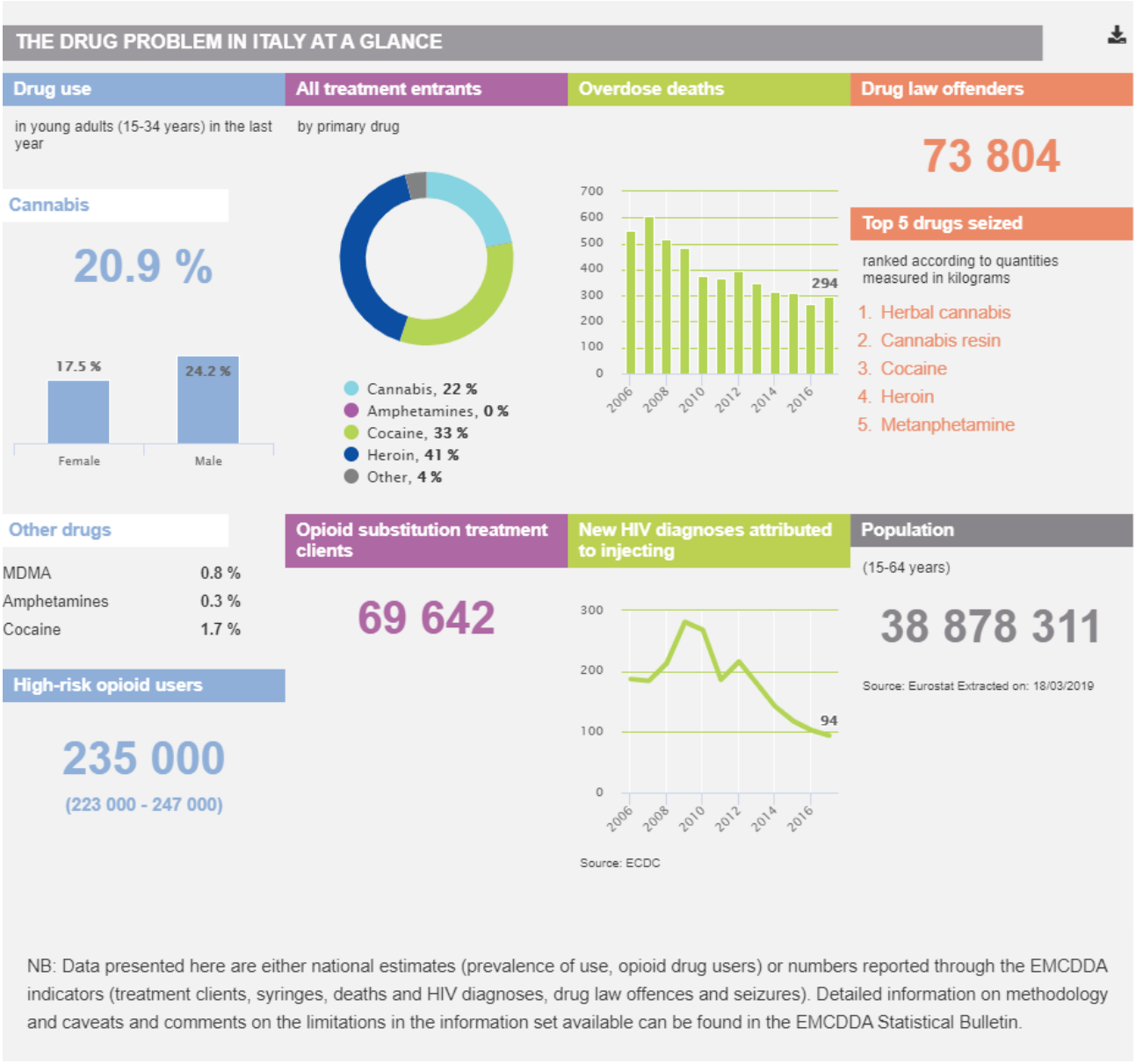
The Italian and the Dutch experience in terms of drug policies and Harm Reduction is different from many points of views: the gap could be partially explained also through the differences in the cultural setting.

In Italy the national policy on drugs refers to a document called the "*Italian National Action Plan on Drugs*" launched in 2010 for the first time and still in force. The plan is mostly focused on illicit drug use and it is structured around two pillars: demand and supply reduction. In order to reduce the demand the plan provides for prevention, treatment, rehabilitation and reintegration interventions. On the other hand, the supply would be reduced through evaluation and monitoring activities, legislation and juvenile justice. The implementation of the plan is supported by other elements:

1. individual regional/autonomous provinces plans;
2. technical and scientific implementation guidelines;
3. the Project Plan, which sets out the different national projects carried out under the Action Plan;
4. the 2014 National Action Plan for the Prevention of the Distribution of New Psychoactive Substances and Demand on the Internet.

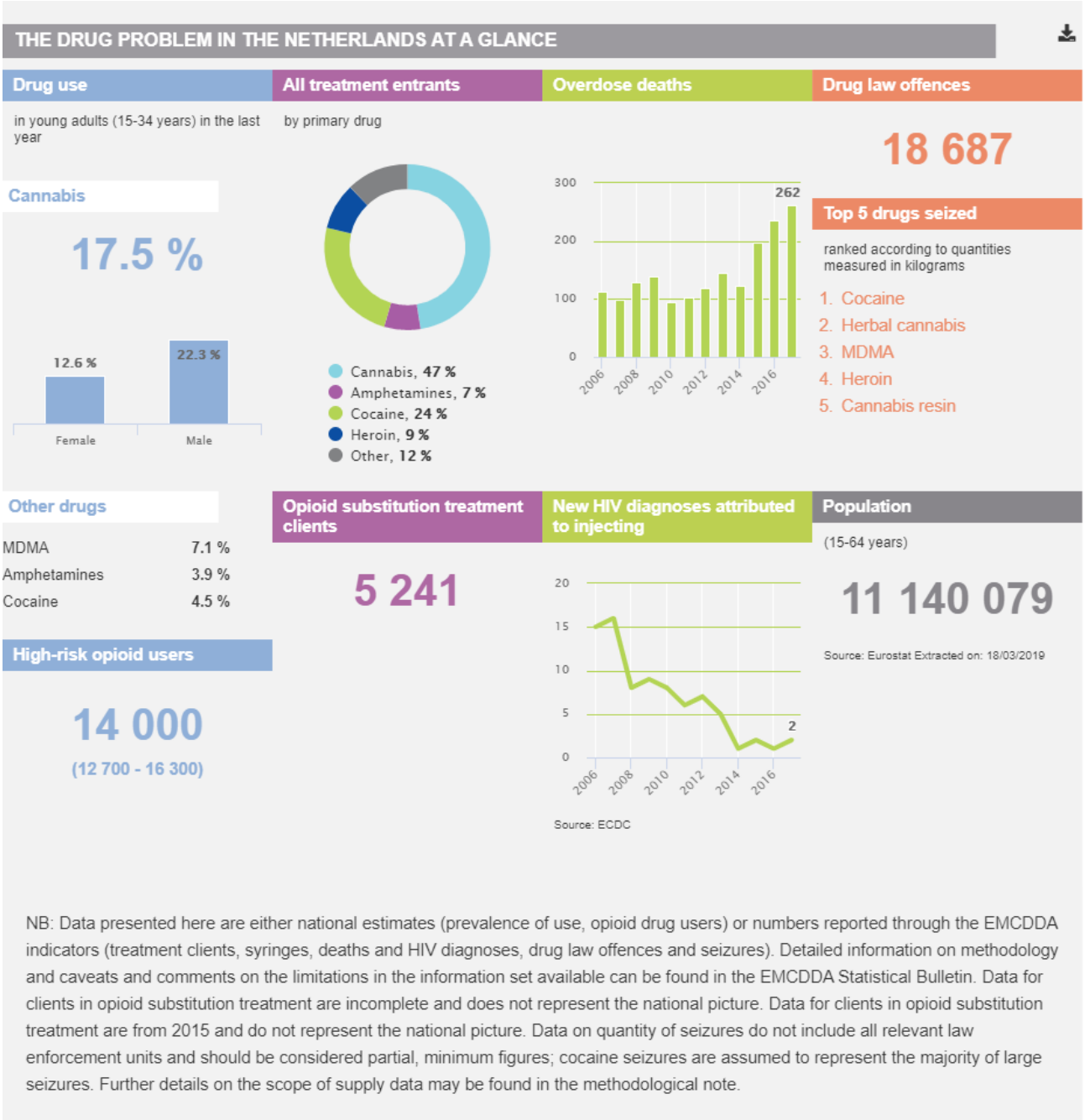
The EMCDDA provides an overview of the drug problem in Italy:

[29] CNCA- Forum Droghe (2016), Harm Reduction and Limitation of Risks in DPA



Moving forward to the Netherlands, the country presents a pragmatic approach based on four major policy objectives: to prevent drug use and treat and rehabilitate drug users; to reduce harm to users; to diminish public nuisance caused by drug users; and to combat the production and trafficking of drugs. The Dutch policy makes a distinction between soft and hard drugs and it discourages the drug use so far as it causes health and social damages. A glaring example of different policy on drugs between the Netherlands and Italy is represented by the Dutch cannabis policy, carried out through a series of policy letters over the years. The “coffee shop” policy allows the cannabis to be sold inside these particular kind of shops by following some

rules: no advertising, no sale of hard drugs, no public nuisance in and around the coffee shop, no admittance of or sale to minors, no sale of large quantities per transaction (maximum 5 g) and a maximum in-store stock for sale of 500 g. From 2013 another rule is in force: admittance to coffee shops and sales are limited to residents of the Netherlands, although local adjustments in the implementation of this criterion are allowed. The EMCDDA provides an overview of the drug problem in the Netherlands:



In these political frameworks, both Italy and the Netherlands provide a range of services and interventions related to the harm reduction approach.

The history of harm reduction in Italy started in the 90s with the HIV epidemics among injecting heroin users. The crisis concerned the whole Europe and in Italy the government had to find a solution to deal with the HIV spread. Harm reduction interventions were set up to face the epidemics in Italy: outreach programs, low-threshold centers, the provision of clean injecting equipment and drug treatments. This approach was consolidate afterwards in 1999 with a state-regional agreement that included the harm reduction among the services provided by the public system with regard to the drug addiction. Another recent important step was done with the decree of the President of the Council of Ministers of 12 January 2017 that includes the harm reduction among the Essential Level of Healthcare (Livelli Essenziali di Assistenza, LEA). However, even if the harm reduction is officially included among the LEA, the "Italian National Plan on Drugs" (2010) does not incorporate the harm reduction principles and the consequence is that not all the regions have implemented harm reduction policies by generating a huge differentiation among the Italian regions[30]. Harm reduction services are more common in the North and the Center of Italy and they are usually located in big cities. Different harm reduction projects are provided heterogeneously from both public drug dependency service units (Ser.Ds) and accredited private social and health organizations. The different services are delivered through mobile units, drop-in centers, reception units and outreach programs, and by public and private outpatient treatment services and the naloxone is provided, often combined with individual counseling, in the majority of the harm reduction units. Referring to the harm reduction intervention in Italy, the country provides needle and syringe programs (NSP) and take-home naloxone programs (THN) and does not provide drug consumption rooms (DCR) and heroin-assisted treatment (HAT).

[30] https://www.fuoriluogo.it/mappamondo/dove-sono-finti-i-livelli-essenziali-della-riduzione-del-danno/#.Xgd8TkdKjIU

On the other hand, the harm reduction approach is consolidated in the Dutch drug policy: the country provides all the range of interventions except for take-home naloxone programs, which is the milestone of the harm reduction in Italy. Harm reduction services, both for users of traditional drugs and for recreational users, are available all over the country. These services are delivered through low-threshold facilities and centers for social addiction care. An important part of the outreach work is managed by low-threshold services in outpatient care facilities. The history of harm reduction in the Netherlands began in the 1970s when a huge problem related to the heroin spread was growing all around Europe. The approach used by the Dutch politicians aims to not consider the drug users as criminals but as people who need help: through an Harm Reduction response to the problem, the Dutch policy tried to reduce drug-induced deaths and drug-related infectious diseases, as well as at prevent drug-related emergencies. In 2016, a hepatitis plan was launched and it includes: the offer of hepatitis B virus and HCV testing to PWUDs and the provision to the addiction care institution of the role of establishing and maintaining contacts with this high-risk group of users.

Compared to the Netherlands, in Italy the harm reduction approach is not widespread in a capillary way all over the country and does not include all kind of possible interventions. In fact, as we have seen in the previous paragraph, even if Italy is considered as a pioneer in Take-Home Naloxone programs, only 57 services are providing the THN and the coverage is concentrated in the regions of the North. Besides that, Italy also has a lack of Drug Consumption Rooms and drug checking services because of political choices oriented to not include these interventions in the Italian harm reduction implementation. Drug consumption rooms appeared in Switzerland in 1986 and they quickly spread all around Europe and their effectiveness was proved over the years. Drug checking services likewise are known as valid prevention tools that can provide users information about the chemical composition of the acquired dose. Nevertheless, in 2009 the Italian *Drug Addiction Departement* (DPA) defined a policy strategy hesitant about harm reduction by excluding Drug Consumption Rooms, Heroin-Assisted Treatment and drug checking services from the Italian range of HR

interventions. This choice has implications in terms of effectiveness of the harm reduction intervention in Italy because this kind of policy is more powerful and successful if included into an integrated system of harm reduction services.

Chapter II

Drug consumption rooms, a harm reduction response to drug use

2.1 DCRs, history and different models

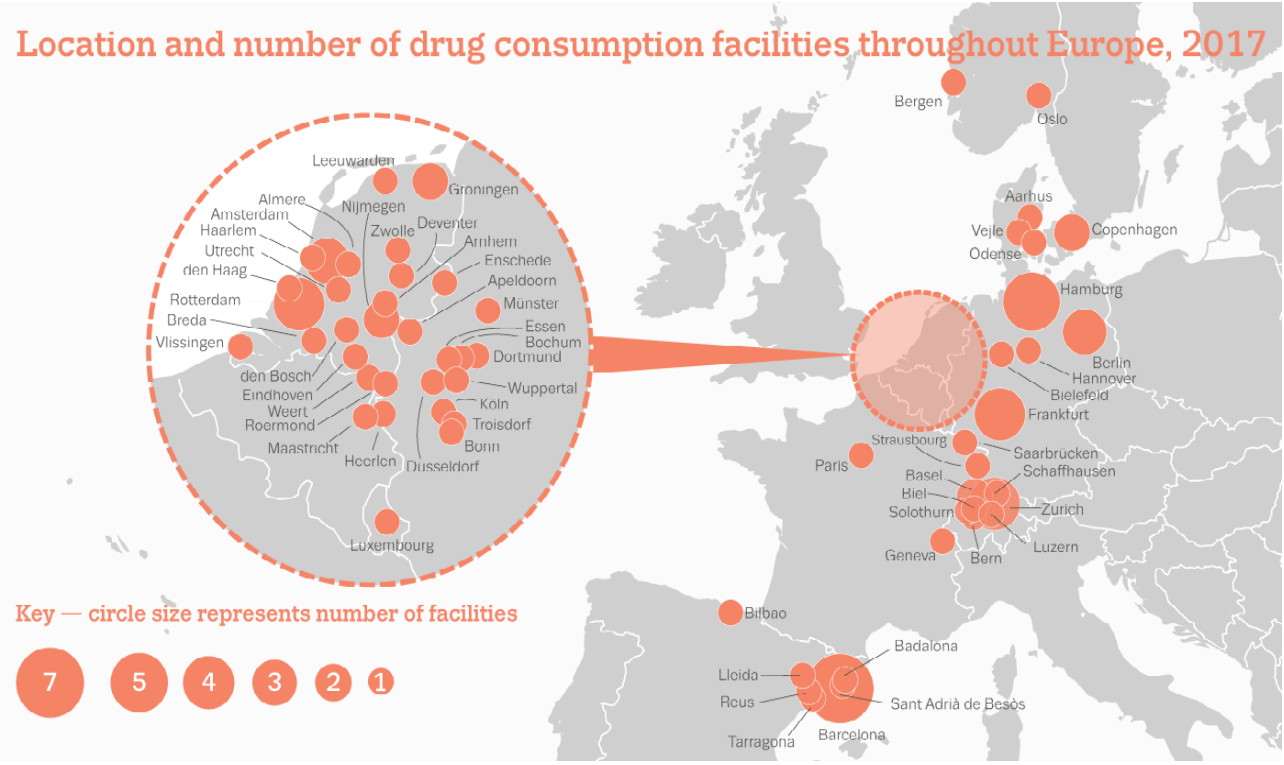
Drug consumption rooms, also called safer injecting facilities, are locations in which people who use drugs can use them under the supervision of a trained staff. More specifically, they «are facilities where (homeless) people struggling with a drug addiction can use their drug in a hygienic and quiet environment, with social workers present in the background»[31]. In the first place, Drug Consumption Rooms (DCRs) are useful to get in contact with hard-to-reach population and to provide them a safe environment to consume drugs.

A kind of experimental drug consumption room initiatives appeared for the first time in the Netherlands from the 1970s ("*the Prinsenhof*" and the "*HUK*" in Amsterdam) and ten years later in Switzerland ("*Fixerraum-experiment*" at the AJZ in Zurich) but they had a short life, closed by the agencies themselves or by the police intervention. The approach of those kind of facilities was different from the one of the modern DCRs because they did not focus on the supervision on drug use or on the provision of hygienic equipment and they found many problems related to the maintenance of a safe environment. On the other hand, the first drug consumption room, in accordance with the modern conception, was created in Bern (Switzerland) in 1986 during a period affected by an increase of deaths due to drug consumption all over Europe and an harm reduction approach to the issue began to arise. They emerged in particular local contexts such as neighborhoods with drug injecting problems in streets or near railway stations.

[31] Standard of Care Opiate Addiction (2017)

Specifically in the Netherlands, in 1990, a religious institution began allowing the use of drugs in her facilities, but only from 1994 regular consumption rooms appeared. The first one that opened in 1994 was in Maastricht. Concerning the legal context, an important step that contributed to the feasibility of those facilities was made in 1996 when the College van Procureur-generaal defined some guidelines that «clarified that the possession of drugs in consumption rooms is tolerated, provided the facilities fit into the local drug policy framework defined by the local triumvirate of mayor, police and public prosecutor»[32].

Nowadays the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) records 78 official drug consumption rooms in seven countries in Europe: the Netherlands, Germany, Denmark, Spain, Norway, France and Luxembourg. Moreover, other DCRs operate in Switzerland, Canada, Australia, Mexico and Ireland.



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[32] Dagmar Hedrich (2004) "European report on drug consumption rooms"

[33] Belackova V., Salmon A.M. (2017), "Overview of international literature – supervised injecting facilities and drug consumption rooms"

The drug consumption rooms have been a transposition of their major objectives over the years. According to a research[34] from *Trimbos-Instituut*, they had a clear shift in their goals and, if in 2003 the majority of the DCRs had as a main objective the nuisance control, in 2018 DCRs are more interested in nuisance control combined to health promotion. Therefore, the modern DCRs aim primarily to reduce the risk of disease transmission by providing sterile injecting equipment like needles and syringes, to prevent overdose deaths related to the abuse of drugs and to connect drug-addicted people to addiction treatments and to other health and social services. On the back burner, what DCRs also want to achieve is the reduction of public order problems related to the consumption of drugs in public places that implies for example the presence of discarded needles along the streets. Typically, DCRs achieve those goals by providing safe tools to inject, offering counseling services to the beneficiaries, providing a rapid intervention in case of crisis or in the event of overdose and assuring the access to primary medical care if needed.

Nevertheless not all the DCRs are the same, there are different models and configurations of them. Specifically, Hedrich D. identifies three kind of DCRs: integrated, specialized and mobile. The integrated model is the most common among all the drug consumption rooms: this specific type of DCR includes the presence of several services provided such as testing for blood borne virus, drop in center, access to employment program, provision of food, showers and clothes. The strength of integrated DCRs model is the capacity to put together many services in a single place.

On the other hand, the specialized model offers a tiny variety of services strictly related to the drug consumption such as advices on health and drug consumption related risks. Their functioning is quite simple: the clients who fulfill the admission criteria receive a sterile equipment and they are allowed to go inside the facility when a place is free, consume drugs, clean and leave the area.

Finally, the mobile model exists only in Berlin, Barcelona and Copenhagen and it provides services for a less broad range of beneficiaries compared to the other models.

[34] Anouk de Gee, Daan van der Gouwe, Sara Woods, Cedric Charvet, Agnes van der Poel (update 2018), "Drug consumption rooms in the Netherlands"

These facilities are flexibles in a geographical way but they present some problems in cost-benefits terms because mobile DCRs «have lower throughput but still require similar levels of staffing to the fixed-site DCRs in the same cities. As such the cost per client is inevitably higher»[35]. The function of mobile DCRs is to support and to be complementary to the fixed site.

Moreover, the paper from the *European Harm Reduction Network* "Drug consumption rooms in Europe. Models, best practice and challenges" underlines the risks related to the most common model of integrated drug consumption rooms. Even if the possibility to have in a single place a broad range of services is attractive for the clients, it could be difficult for people who are in a detoxification program to be in contact with people who are still drug users and who consume drugs in the same facility in which they are. The integrated DCRs could create an unhealthy interaction that can lead to a relapse. The specialized model avoid this problem by providing only a safe space for drug consumption, strictly related services and by focusing on the referral to other services for detoxification, access to employment services and so forth.

2.2 DCRs, main objectives and target

Drug consumption rooms have many objectives and, as we have already seen shortly in the previous paragraph, they had a shift in their goals over the years. According to the EMCDDA they «primarily aim to reduce the acute risks of disease transmission through unhygienic injecting, prevent drug related overdose deaths and connect high-risk drug users with addiction treatment and other health and social services»[36]. The public order objective is not included from EMCDDA into the list of the main important goals of DCRs even if it is the main reason for which DCRs were born. The majority of the DCRs have arisen as a solution for health and public order problems related to the diffusion of the drug market in 1970s. Those facilities are

[35] Harm reduction network (2014), "Drug consumption rooms in Europe. Models, best practice and challenges", Amsterdam

[36] Belackova V., Salmon A.M. (2017) "Overview of international literature – supervised injecting facilities and drug consumption rooms"

useful to avoid the presence of discarded needles in public places and other problems related to the drug consumption in public spaces. Every DCR has a role in the control of public nuisance but, over time, that goal has been merged with the health promotion objective. Nevertheless, the balance between the objectives is also related to the country. In the Netherlands, for example, the majority of the DCRs has been created thanks to neighborhood and police initiatives with the clear objective of reduction of public nuisance. The rest came from the initiative of social or drug services in cooperation with drug users' interest groups that have as a main goal the prevention of the health of that part of the population. Moreover, when we talk about health promotion goals we are including several aspects with different timing of implementation: «they aim to provide safe and hygienic drug consumption opportunities (immediate objective), to reduce mortality and morbidity among the target population (medium-term objective) and to stabilize and promote the health of their clients (long-term objective)»[37]. There are multiple ways in which DCRs achieve all of those goals: they supervise the consumption and make sure that the house rules are respected, they give advices to the clients analyzing their personal situation, they provide help in case of emergencies like overdose crisis, they provide primary medical care services, safe needles and in some case lots of complementary services such as night shelter, counselling, case management, provision of food, clothes, showers.

In short, the DCRs have three main objectives: reduce harms associated with illicit drug use, connect people who use drugs (PWUD) with treatment and health service and reduce public order and safety problems associated with illicit drug use. Another crucial aspect is the capacity of DCRs of establishing a contact with hard-to-reach population and the effort to assure them a possibility for survival and social inclusion. First, DCRs have to attract clients and try to find a way in which they would continue to attend the facilities regularly. According to the EMCDDA report on drug consumption rooms (2004) the clients of these facilities have a specific profile: «the typical user of consumption rooms is older than 30 and has a history of problem drug use – mainly of heroin and/or

[37] EMCDDA (2004), "European report on drug consumption rooms"

cocaine – going back 10 or more years. Clients under 20 and recent drug users with a history of problem drug use of only one or two years' duration are uncommon, while the number of registered clients in their 40s, 50s and even 60s has increased». More specifically, a paper written by Potier C. analyses 14 articles on DCRs' client profile and she discovered that «the majority of SIS users were male, ranging from 30 to 35 years of age with frequent housing insecurity and unemployment and with a previous history of incarceration. Resorting to prostitution was identified in 10–39% of users. The most frequent drugs used were, in descending order, heroin, cocaine, opiates, amphetamines, and their derivatives»[38]. In general terms, the target is characterized by marginalized people who are mostly homeless, not in good health conditions and that are looking for health care, food and hygienic facilities for drug consumption. Moreover, there are some admission criteria that people who wants to have access to the facility have to fulfill. First, it is clear that those kind of rooms are not available for PWUD just in an experimental or intermittent way. Apart from that, the barriers for the access are not the same all over Europe and Germany is the country with the strictest criteria, such as the exclusion of people who are under OST. In general, the more common admission criteria are: clients must be at least 18 years old, they have to live not too far away from the DCR and they have to be sober and not intoxicated.

Focusing on the Netherlands, the admission criteria are on average 6,5 and it is possible to find DCRs with only two of them and others with twelve. Analyzing the criteria all over the years, it is clear that the shift on main DCRs' goals is reflected on the variation of the criteria all over the time: in 2001 the 67% of DCRs in the Netherlands had "having caused public nuisance" as an admission requirement, in comparison with the 2018 in which only the 33% of the Dutch organizations are preserving that condition according to a *Trimbos-Instituut* research. Moreover, according to the same research, in 2018 the most frequent admission criteria were "signing of contract (statement of agreement with house rules)", "minimum age (range 18-26 years)", "registered as a client with the managing organization" and

[38] "Potier et al. (2015), "Supervised injection services: What has been demonstrated? A systematic literature review"

"being homeless". The following table shows the list of admission criteria registered by the *Trimbos-Instituut* in different years among a group of DCRs in the Netherlands:

Table 3. DCR admission criteria.

	2001 N=15	2003 N=30	2010 N =30	2018 N=24
Signing of contract (statement of agreement with house rules)	40%	-	67%	88%
Minimum age (range 18-26 years)	47%	80%	90%	79%
Registered as a client with the managing organisation	60%	67%	67%	68%
Being homeless	60%	77%	43%	63%
In possession of drugs while entering the DCR	33%	-	53%	58%
Registered in the municipality	27%	63%	70%	54%
Registered as a client of the local organisation	47%	50%	37%	46%
Residing legally in the Netherlands	-	-	-	46%
In possession of a valid ID	-	-	-	38%
Having caused public nuisance	67%	47%	40%	33%
Residing in the vicinity of the DCR	20%	-	20%	21%
Signing of a disclaimer	40%	-	20%	21%
Poor physical and mental condition	47%	47%	17%	17%
TB-control	-	-	23%	4%
Known to police	-	27%	13%	4%
Other:				
Nurse's or doctor's referral	-	-	-	13%

- = unknown: not asked or not reported

Blue = top-3 criteria in that year

In the European context, it is also possible to find a particular kind of DCRs with a specific target: women who use drugs. The first facility of that type appeared in Germany, in Hamburg, and it is called RAGAZZA. Some considerations on customer satisfaction have been extracted from that DCR: «80% of RAGAZZA's clients reported that they feel more comfortable and safe among women. In addition, the atmosphere in a woman-only space is more relaxed than is a mixed-gender service. 90% of respondents said that they could speak more openly about their problems and they trusted staff more readily, which made it easier to accept offers of help»[39]. The percentage of women who attend normal DCRs varies between 10% and 25%.

[39] Harm reduction network (2014), "Drug consumption rooms in Europe. Models, best practice and challenges", Amsterdam

2.3 DCRs, how do they operate?

In the previous paragraphs we identified three different DCR models (integrated, specialized and mobile) which operate following different approaches. However, the general service model for a supervised DCR has four main components: assessment and intake, a supervised consumption area, other services area and referral. Every component has some specific objectives.

The activities linked to the "assessment and intake" are: the determination of the eligibility for using the service, the control of official access criteria, the provision of information on consumption rooms functioning, about risk avoidance, the provision of hygienic equipment, getting information on drugs to be used and the determination of individual needs.

The main objectives of the "supervised consumption area" are: the insurance of lower risk, the supervision of the consumption and the assurance of compliance to the house rules, the provision of tailor-made safer use advice, of emergency care in case of overdoses and other adverse reactions, of a space for drug use protected from public view, the prevention of loitering in the vicinity of the facility.

The "other services" area includes the objectives of monitoring the effects of drug consumption among clients who have left the consumption area, of provision of primary medical care services, drinks, food, clothes, showers, crisis interventions, needle and syringe program and further services such as shelter, counselling or case management.

Finally, the "referral" encompasses objectives of provision of information about treatment options, of motivation of clients to seek further treatment and of referring clients to further services like detoxification, substitution treatment, accommodation, social welfare or medical care. The majority of the DCRs in Europe provide auxiliary services like coffee, tea, use of a phone, showers and clothes. According to a survey carried out on 62 DCRs in seven European countries, those facilities provide on average seven place for supervised injection, four for smoking or inhaling and «over half of the facilities provide the service on a daily basis, opening on average for eight hours a day. The number of visitors varied widely – between 20

and 400 – with six of the 33 facilities catering for more than 200 clients a day»[40]. In general, the DCRs' staff is not allowed to help clients with the injections and some basic hygiene conditions and safety procedures are required. The DCR facilities could be really different amongst them: sometimes they have a living room atmosphere and sometimes they look like an hospital. However, in the majority of the structures the procedure is quite similar: the staff carries out a visual check to the drugs and verifies the physical condition of the client to be sure that he is not intoxicated.

Focusing on the Netherlands, according to a research[41] conducted on 24 DCRs in that country, among the facilities analyzed in 19 of them drug injected is allowed, in 13 snorting is allowed and in all of them smoking is allowed. Moreover, «the number of DCR visitors per day that smoke varies from 2-10 (n=10 DCRs), to 11-20 (n=5), to 21-35 (n=4), based on data of 20 DCRs. The number of DCR visitors per day that inject varies from 0 (n=6 DCRs), to 1-2 (n=8), to 6-8 (n=2), based on data from 16 DCRs. Categories that were most mentioned in 2018 are 2-10 smokers and 0-2 injectors per day». Concerning the opening hours, the majority of DCRs in the Netherlands are opened every day even if the number of opening hours varies between 3 and 24 hours a day. On average, they are open 10.6 hours a day. Focusing on the provision of services, the research shows how the clients have access to the basic services in almost all the facilities. Moreover, in 2018, between 67% and 96% of DCRs offer care, treatments and daytime activities. According to the same research, two thirds of the facilities provides health education and one fifth of them offers STD and infectious diseases testing and treatment. The 88% of the DCRs provides also work and re-integration projects according to the objective of social inclusion. In conclusion, the research shows that over the years a comprehensive set of services has developed according to the objectives expansion over time. The "sweeper function", which means getting homeless people off the streets, has become less and less important in comparison with the need to offer them a safe place to stay and medical and social assistance.

[40] Woods S. (2014), "Organisational overview of drug consumption rooms in Europe"

[41] Anouk de Gee, Daan van der Gouwe, Sara Woods, Cedric Charvet, Agnes van der Poel (update 2018), "Drug consumption rooms in the Netherlands"

2.4 Rat park experiment, a different approach towards drug addiction

The "Rat Park experiment" was conducted by the American psychologist Bruce K. Alexander in the late '70s and it has shown that drug addiction is not only related to drugs themselves but it is also strictly connected with the environmental conditions (setting) in which drugs are consumed. The previous researches conducted in this field had led to a completely different kind of considerations and had justified for many years a policy approach known as "War on Drugs". The experiments on drug addiction carried out during the '60s were led from a group of experimental psychologists by using skinner or standard boxes for rats. The skinner boxes are small cages in which the rat could get pellets of food one by one and the standard box is a small cage in which the rats are isolated and they can only see people that give them food and water.

During these experiments, the rat was alone in the cage with two different bottles inside the box: one filled with water and the other one filled with water plus heroin or cocaine. The result of the experiment is that the rat will choose repetitively to drink the water from the bottle with drugs until he will eventually overdose and die. The rat experiment was considered as a proof that drugs are irreversibly addictive and it was used from the mass media to provide more support to the "War on Drugs", a prohibition approach to drugs that began officially in 1971 in the United States when the president Richard Nixon declared the drug abuse as the "public enemy number one". In the first place, the psychologist Bruce K. Alexander agreed with the conclusions of the experiment but then, at a later time, he started to highlight some controversial points that brought him to reassess it. First, he underlined that rats in nature are «highly social, sexual, and industrious creatures»[42] and putting one of them in a cage, isolated, would bring him to madness and of course to rely on mind-numbed drugs. The same would happen putting a human being into an equivalent solitary confinement. Second, in the experiment, the rat is located inside a cage in which there is nothing else to do instead of drink and eat: this context is far away

[42] https://www.brucekalexander.com/articles-speeches/rat-park/148-addiction-the-view-from-rat-park

from the one in which humans usually are. Third, «rats are rats. How can we possibly reach conclusions about complex, perhaps spiritual experiences like human addiction and recovery by studying rats? Aren't we more complex and soulful than rats, even if we have similar social needs? »[43].

These considerations have led Bruce K. Alexander and a small group of his colleagues, composed by Robert Coambs, Patricia Hadaway and Barry Beyerstein, to develop a new space for rats in which carry out a new experiment: the "Rat Park". They built a big plywood box filled up with things that rats like (running wheels, platforms for climbing, etc.) and with male and female rats. Several experiment were ran by comparing the drug consumption of isolated rats in standard cages and the rats in the "Rat Park". The experiments showed that the rats in the "Rat Park" (called "social rats") did not consume hardly any morphine solution. On the other hand, the isolated rats (called "caged rats") were consuming huge quantities of it. The new results proved that the drug consumption of the rats was not related to the irresistibility of the morphine but to the isolation's condition.

The "Rat Park experiment" attracted the attention of the local mass media and of the local university of Vancouver. Nevertheless, the experiments did not bring a universal reconsideration concerning the causes of drug addiction as Bruce K. Alexander expected. Thanks to these experiments and other evidences, the interesting consideration is that the drugs become irresistible only when the context for a normal social experience is destroyed. Another example considered by Bruce K. Alexander refers to the native tribal groups from Western Canada colonized by the English empire. Once they were colonized the alcoholism became universal among the native people and also the drug consumption dramatically increased. Even if the English in a first moment explained the phenomenon by talking about genetic vulnerability, this story appeared not so credible and reliable. On the other hand, a parallel could be done with the "Rat Park experiment" and an explanation could be that people are attracted by drugs/alcohol especially when they are socially and culturally isolated/"caged". In this regard, Bruce K. Alexander

[43] https://www.brucekalexander.com/articles-speeches/rat-park/148-addiction-the-view-from-rat-park

declared: «when I talk to addicted people, whether they are addicted to alcohol, drugs, gambling, Internet use, sex, or anything else, I encounter human beings who really do not have a viable social or cultural life. They use their addictions as a way of coping with their dislocation: as an escape, a pain killer, or a kind of substitute for a full life. More and more psychologists and psychiatrists are reporting similar observations. Maybe our fragmented, mobile, ever-changing modern society has produced social and cultural isolation in very large numbers of people, even though their cages are invisible! »[44]. In conclusion, Bruce K. Alexander's thought towards drug addiction leads to a consideration: the addiction is not only an individual issue but also a social problem that arises when the society is fragmented and leads people feel isolated and caged. Addiction is a form of adaptation and it cannot be treated by using punitive measures as the policy did during the so-called "War on Drugs".

2.5 Impact of DCRs

The impact of DCRs is hard to evaluate for different reasons such as the limited coverage of the target population or methodological related issues. However, there are some evidences of effectiveness that demonstrate the benefits of those facilities in the reduction of public nuisance problems, in the improvements in safe and hygienic drug use and in the access to health and social services for marginalized people. On the other hand, there are no evidences regarding the correlation between the development of DCRs and the increase in the use of drugs or frequency of injecting and the increase in local drug-related crimes.

Furthermore, the ability of DCRs to reach the target population has been demonstrated in different studies that have showed a match between the target group (drug users who are at high risk of HIV infection and overdose) and the people that actually attend those facilities. Some of them are affected from some drug-related diseases (53% suffers from HCV and 5.9% from HIV[45]) and the majority has regular contacts with the local drug help system and uses low-threshold agencies. The

[44] https://brucekalexander.com/articles-speeches/rat-park/148-addiction-the-view-from-rat-park
[45] Hedrich D. et al. (2010), "Drug consumption facilities in Europe and beyond"

consequences related to the DCRs' ability to reach the target population are the improvement in clients' hygiene and the benefits in public order. Moreover, the impact of DCRs on the reduction of HIV transmission is hard to evaluate but evidences have shown that these facilities reduce the injecting risk behavior, such as syringe sharing, by providing hygienic injecting equipment to the users and increasing their awareness concerning the risks connected to the unhygienic injection. The reduction of these kind of behaviors is related to the reduction of the risk of HIV transmission and also overdose death. The estimation problems are related to the limited coverage of the target population and to methodological problems in isolating the impact of the DCRs from other interventions.

Evaluation studies have shown a positive impact of the DCRs. In addition, another important aspect related to the impact of the DCRs in the communities is the relationship with the neighborhood. In order to avoid the community resistance towards the harm reduction intervention it is essential to have contacts with the neighborhood in which the DCR is located. The community has to accept the presence of the facility in the quartier in order to minimize discontent among the neighbors by reminding them relevant positive results of the facility such as the decrease in public injecting and the number of syringes discarded on the street. On this matter, a research on the effect of a DCR in Sydney on drug-related property crime and violent crime in its local area demonstrated that there are not evidences which show a correlation between the presence of the facility and the increase or decrease in thefts or robberies around it. A similar study was carried out in Vancouver and it led to the same considerations about the lack of connection between the DCR and the amount of crimes.

In conclusion, the impact of the DCRs is surely related to an improvement in safe and hygienic drug use, to an easiest access to health and social services for marginalised people and to a reduction of the public nuisance. No evidence are provided in terms of an increase in use or frequency of the drug consumption related to these facilities and also in terms of an increase in local drug-related crimes.

2.6 DCR, AMOC as a case study for a social impact evaluation

AMOC is one of the eight locations of *De Regenboog Groep* in Amsterdam in which European homeless people and PWUD can find a wide range of services according to their needs. In order to better explain AMOC's structure it would be useful to have an imagine of the building because every floor is intended to have a different function. Therefore, the underground floor is the night shelter in which 10 beds are provided: every day homeless people come to AMOC and some of them ask for a spot in the night shelter. Once the staff collects all the requests the social workers write down a daily list of people that can sleep in the facility that day depending on the clients conditions (for example if on client is sick he has priority). The first floor is occupied by the drop-in in which clients follow some steps during the opening hours of the week:

1. They come inside the facility and they show up at the office to be registered in the system from the staff. Once they are registered they can also ask to have a shower or change clothes, for a spot in the night shelter, to talk with the social worker and to be added to the computer list;
2. They received papers to have coffee and bread for breakfast. They can grab the breakfast and stay in the common room with all the others;
3. At 1:00 they can have lunch and then, for the people who need, also a curriculum vitae service is provided;
4. They can stay inside the common room until 17 and then only the people who are in the night shelter list will come back for dinner and to sleep.

The Drug Consumption Room is located on the second floor of the building and the PWUD who are attending the room has to be registered in the system before going inside. Once they are in the system, they can stay in the room and use drugs under the supervision of the trained staff. The DCR looks like a living room with colored chairs, a sofa, tables and a space in which they can charge their phone. The staff provide them all the material they need (spoons, alcohol pads, needles, filters and so forth).

The social workers offices and *Correlation - European Harm Reduction Network* office are located on the third floor of the building. The social workers have to manage clients situations, they have meetings with clients every day and they try to help them with all their needs (find a job, psychological help and so forth). *Correlation EHRN* instead is a network hosted by *De Regenboog Groep* that represents a center of expertise in the field of drug use, harm reduction and social inclusion by merging into the network practice, research and policy.

Since the thesis work is focalized on the Drug Consumption Rooms issue and it considers AMOC DCR as a case study for the social impact evaluation it would be useful to explain more about this specific part of the facility. The Drug Consumption Room in AMOC was opened on February 1998 by Jikkie Van Der Giessen during an historical period in which the municipal Council of Amsterdam agreed to carry out a set of interventions designed to give a package of care to long-term drug addicts to improve their living conditions and public order. The social services started to select and approach possible interested parties in this project and some interested clients also applied on their own initiative. Thanks to a meeting between the neighborhood police officer, the potential clients and the (future) AMOC staff members, a contract was signed between the clients and AMOC. Many things are changed during the years: the size of the user room increased and also the number of clients (from 4 in the beginning to 60 nowadays); the nationalities of the clients are increased (initially was only for German users); the use of drugs is also different (from an heroin base target group, the consumption shifted radically to cocaine use). Nowadays, the target group of the DCR can be identified as long-term hard drug users who mostly use heroin and cocaine. Some clients use illegal methadone or alcohol, hashish, psychotropic medication and other psychotropic substances (mushrooms, LSD, ecstasy, etc.) in addition of their main drug. There are some criteria that the client has to fulfil to be allowed to attend the user room:

1. The minimum age is 18 years old;
2. The client has to be European. In case of non-European client the decision to open a contract in the users room has to be taken by the direction, the social worker of the client and the staff of the users room;

3. The mental health and cognitive capacity of the client is taken in consideration in order to understand if he/she is able to comply with the contract's rules of the user room;
4. The number of clients has to be in accordance with the capacity of the user room.

Moreover, the clients are usually homeless or they have a place to stay such as a crack house or a tent that is not considered as a legal housing.

The procedure to stipulate a contract with a new client is composed by different steps. First of all the client has an intake with the social worker who is asking him/her a set of basic questions (an example of intake form is available in the next page). Once the client had the first meeting with the social worker, the staff team verifies with the social worker that the given information are correct and different decisions could be taken concerning a new contract:

1. Positive decision: the client can sign his/her contract without specific limitation;
2. Negative decision: the staff refuses to open a new contract (or ask for complement to the demand) for different reason: if the potential client is not belonging to the target group of AMOC, if there are other possibilities for the potential client to use hard drugs in another facility, if the potential client is a recreational user or a beginner;
3. Waiting list: for example if the team estimate that complementary information are necessary or that it is might be counter indications to offer a contract.

If the client is accepted, the staff gives him/her an official form to the client and send him to the GGD tuberculosis department to pass a tuberculosis test. The client has to show the test results afterwards. During the last step the staff reads the contract to the client and answer to all the question from him/her and eventually he/she signs the contract. An explanation of how the room works and what are the available materials is given to the client and also his/her abilities to inject properly, hygienically, safely and with no stress are verified from the staff. The first month of the contract is a "proof period", the contract is re-evaluated after two and four weeks at the users room team meeting until the end of the first month. However, all the contracts are re-evaluated on a regular basis.

INTAKE FORM USERS ROOM 2011

BASIC INFORMATION

Date of the request = ……../……../…….
Name of the client = ……
Date of Birth =……../……../……. Nationality = ……

Name of the social worker = ……

Last TBC date = ……../……../…….
Did this client had a contract before in Amoc = NO – YES (when = ……../……./…….)
Did this client had a contract in any other Users Room = NO – YES (where = ……)

Can the client understand = english dutch else = ……

LIVING INFORMATION

Living situation = street squat boat friends house else

How long of homelessness = ……(months/years)

How long in the streets of Amsterdam = ……(months/years)

USING INFORMATION

How many years / months of use = ……(years / months)

What kind of use = smoking injecting sniffing else

Drug of choice = cocaine heroine methadone hash/weed speed amphetamine else = ……

Other drugs of choice = tablets (specify = ……)

According to the contract, the only rule that is in force nowadays is that the people have to act in accordance to three important principles: safety, hygiene and stress free. All the behaviors inside the room have to be consistent with safety, hygiene and stress free criteria in order to maintain the space as a nice livable environment.

It is important to underline that AMOC is dealing with a difficult target group composed by European citizens that, driven by poor economic circumstances, decide to leave their country and come in Amsterdam. The majority come to the Dutch city hoping to find a job but all of them soon find out that is not as easy as they thought. The reality is that without a job, a wage, a house and a health insurance the Dutch government cannot provide them any kind of benefits. In this context, AMOC provides a specific range of care facilities for this vulnerable group of foreign nationals.

The third chapter of this work is focalized on the evaluation of the social impact produced by the Drug Consumption Room run by AMOC. The goals are to evaluate the social value created by this activity; to understand the whole process of creation of social value and the identification of new evaluation tools.

Chapter III

Social Return on Investment of AMOC DCR

3.1 SROI, definition and methodology

Nowadays, the concept of "value" is wide and it includes social, economic and environmental aspects that should be considered in order to improve organization activities by analyzing social, environmental and economic costs and benefits. The Social Return on Investment (SROI) is an analytical tool used to measure and account this broad concept of value. The SROI is a ratio of the net present value of benefits to the net present value of the investment, which means that for example a ratio of 2:1 indicates that an investment of 1 € delivers 2 € in social value. It compares the value created by the intervention to the investment carried out to achieve the impact.

Moreover, the SROI calculation includes the definition of a "Theory of Change" able to retrace the story of how change is being created by the activity. It gives more than just financial information by including in the analysis quantitative and qualitative aspects. That is the reason why the SROI analysis should not be narrowed to a number but it should be considered as a framework able to explore the social impact created by the organization. The SROI analysis is declinable in different ways: it can consider the social value generated by an entire organization or just focus on one aspect of the organization's work. It could be an internal exercise or a research conducted by external researchers.

The SROI analysis can be evaluative or forecast:

- Evaluative, which is conducted retrospectively and based on actual outcomes that have already taken place;
- Forecast, which predicts how much social value will be created if the activities meet their intended outcomes[46].

[46] http://www.socialvalueuk.org/app/uploads/2016/03/The%20Guide%20to%20Social%20Return%20on%20Investment%202015.pdf

The analysis presented in this chapter is forecast and it aims to predict the potential value created by one of the Drug Consumption Rooms managed by *De Regenboog Groep* in Amsterdam.

The SROI is based on seven principles that should be followed in order to conduct the analysis in a right way:

1. Involve stakeholders;
2. Understand what changes;
3. Value the things that matter;
4. Only include what is material;
5. Do not over-claim;
6. Be transparent;
7. Verify the result.

The first principle concerns the stakeholders' involvement, which regards the inclusion of the stakeholders in the evaluation process: some stakeholders play a central role in the analysis. It is important to carefully identify and involve them. The second principle is about exploring and reporting the process of creation of change by providing evidence and by considering positive, negative, intended and unexpected changes. The "Theory of Change" provides a logical framework that enables the analyst to understand how the organization is making the difference through its activity. The third principle refers to the importance of considering the outcomes with their relative weight according to the stakeholders' perception. The fourth principles suggests a selection among the information and evidence that should be included in the analysis in order to give a true and fair picture. The fifth principle invites to not over-claim the value of what it is actually created from the organization itself by considering what would have happened without the intervention (counterfactual) and the contribution of other organizations in the creation of value. The sixth principle suggests to declare and make clear how stakeholders, outcomes, indicators have been identified and selected. The last principle eventually suggests involving an independent third party in order to verify the results.

The SROI analysis includes different stages aiming to evaluate the social value by retracing the full story of how it has been created (Figure I – SROI phases).

[47] Figure I – SROI phases

[47] APM (2016), "Social Return on Investment: A powerful tool for the realization of benefits"

The SROI analysis is useful for a wide range of purposes: it can be used as a tool for strategic planning and improving, for communicating impact and attracting investment and/or for making investment decisions. Focusing on a Drug Consumption Room (DCR) in Amsterdam, this thesis work is using the SROI in order to achieve the following goals: to evaluate the social impact created by using the Social Return on Investment (SROI) tool; to explain the whole process of creation of value; to identify new possible evaluation tools in order to facilitate a future evaluation of social impact. The spotlight below provides insights about how the analysis has been conducted in order to achieve the mentioned goals.

Spotlight – Development of the case study analysis

The analysis presented in this chapter is the results of three different work phases:

- Pre-assessment: study of the tools (SROI and SROI Value Map) needed for the evaluation of the DCR social impact and consequent filling of the early stages of the Value Map by referring to the literature on the topic;
- Field work: three-months work inside the facility by exploring the different services (drop-in, user room) and collecting data and information through expert meetings, focus groups, interviews and informal conversations with the stakeholders involved. This phase leads to modify the Value Map in order to better represent the reality;
- Final assessment: phase that includes the assemblage of all the collected materials and the integration of the case study into the broader topic of Harm Reduction policies and interventions.

In the following paragraphs I describe, step by step, every phases of the SROI analysis by following the structure of the Value Map.

3.2 Value map, scope definition and stakeholders' identification

The first stage of the analysis refers to the definition of the scope. It is useful to define the boundary of what is being considered in order to have a clear idea of what it should be taken into account and what should not. The definition of the scope is

the result of a negotiation between what is feasible to measure and what the evaluator would like to improve and communicate.

The image below (Figure II – Scope) is extrapolated from the Value Map that I used to conduct the analysis and shows what are the elements provided in order to define the scope. The Value Map is indeed a logical framework that makes clear how the activity creates change by considering the cause-and-effect chain of inputs, outputs, outcomes and impacts.

Scope				
Organisation	De Regenboog Groep - AMOC			
Objectives	to attract high-marginalized drug users and support them through an integrated system of services			
Scope	Activity	AMOC is one of the 8 locations of De Regenboog Groep that deal with a specific target: marginalized people from foreign countries. This location provides a range of care services, addressed to the target group, including the possibility to use drugs inside a supervised room called Drug Consumption Room. The AMOC Drug Consumption Room is the object of this analysis.	Goals - how the activity leads to the desired impact	The DCR leads to the desired impact by giving to marginalized drug users the possibility to use illicit drugs inside a supervised facility that can be considered as a safe environment.
	Contract / Funding / Part of org	The DCR is managed by AMOC that is part of the non-profit organization De Regenboog Groep, based in Amsterdam.	What decisions will be influenced by this analysis?	This analysis is part of a Master thesis project that aims to evaluate the social value created by this supervised facility (DCR). One of its goals concerns also the identification of new possible evaluation tools for the organization.

Figure II - Scope

First, the map requires identifying the organization subject of the analysis: in this case it is AMOC, a location from *De Regenboog Groep*. *De Regenboog Groep* is a non-profit organization, based in Amsterdam, that provides support to people who live in social poverty conditions through voluntary buddies, walk-in-centers, social workers, reintegration projects and so forth. The mission of the organization is the following one: «We stimulate the development of people living in (social) poverty, encouraging them

to actively take part in society. We believe that every human life is valuable and every human is worthwhile caring for. Whether they became isolated because of mental health or addiction related issues, live on the street or have financial debts: *De Regenboog Groep* stimulates people in poor social situations to take back the lead and create a fulfilling and socially active life for themselves. Our volunteers and workforce are united in their concern with the empowerment of people in (social) poverty. We are all human»[48].

AMOC is one of the eight locations (walk-in-centers) of *De Regenboog Groep* for homeless people. However, AMOC is different from the other locations for many aspects and the main one is related to the target group: AMOC is helping European citizens that, driven by the poor economic circumstances in their native countries, end up in Amsterdam in a homelessness situation. The most common situation concerns people who come in the Netherlands hoping to find a job in the country ending up in a harsh reality without a job, an income and a place to stay. Since they are not Dutch citizens, they are not entitled to benefits, care or housing and this situation makes their living condition more difficult to change. Sometimes they do not speak any other language except for their native one. AMOC is trying to help this vulnerable group of people by giving them a shelter in the walk-in-center and providing them with other complementary services in order to make their life easier in Amsterdam or by helping them to go back to their country of origin. Inside AMOC it is possible to find a Drug Consumption Room used by the people from this target group who are also drug addicted. The main objective of the AMOC DCR, as I reported in the scope definition, could be described as "to attract high-risk marginalized drug users and to support them through an integrated system of services". In regards to the objective, through my experience in the organization I understood that AMOC is extremely useful to get in touch with a particular type of population that would be difficult to reach otherwise. This organization is a reference point for international homeless drug users in Amsterdam. Thanks to AMOC, they have the possibility to

[48] https://www.deregenboog.org/en/our-dream

consume illegal drugs inside the facility under the supervision of a trained staff and to be in contact with a social worker available to help them with their needs (find a job, apply for a methadone program and so forth).

The description of the organization's activity presented in the scope definition table is the following one: "AMOC is one of the 8 locations of *De Regenboog Groep* that deals with a specific target: marginalized people from foreign countries. This location provides a range of care services, addressed to the target group, including the possibility to use drugs inside a supervised room called Drug Consumption Room. The AMOC Drug Consumption Room is the object of this analysis". It is important to underline that AMOC is a huge facility composed by a wide range of services and connected with multiple external stakeholders. The focus of the thesis is on the Drug Consumption Room managed by AMOC but in order to explore the impact of the user room it is important to consider the whole structure in which this specific service is embedded. The DCR is able to achieve its goals and to create an impact through the activities implemented in the room: as reported in the scope definition table "the DCR leads to the desired impact by giving to marginalized drug users the possibility to use illicit drugs inside a supervised facility that can be considered as a safe environment".

The scope sheet requires also answering to a question about what are the decisions that will be influenced by this analysis: the analysis is finalized to my master thesis project. One of its goals concerns also the identification of new possible evaluation tools for the organization. Inside the related section in the table is explained that "this analysis is part of a Master thesis project that aims to evaluate the social value created by this supervised facility (DCR). One of its goals concerns also the identification of new possible evaluation tools for the organization". In conclusion, the scope definition spreadsheet has to be fulfilled with the time of period of analysis and the type of evaluation that are respectively one year and a forecast evaluation.

Once the scope has been identified, the SROI evaluation requires many steps that have to be achieved in order to understand the social impact created by the analyzed activity. The first one is the identification of all the stakeholders involved in the activity subject of analysis. According to the Social Value UK definition, the stakeholders are

«people or organizations that experience change or affect the activity, whether positive or negative, as a result of the activity being analyzed»[49]. This step is the starting point for the recreation of the Theory of Change that leads to understand how much value has been created or destroyed and for whom. During this phase, it is required to decide which stakeholders are included and which are not. A bigger number of stakeholders means a bigger number of sources of value even if, according to the standard of "understanding change", what is important is to include all the stakeholders that may experience material changes as a result of the activity. However, in this process of stakeholders' selection is not possible to be sure in a first stage if the chosen stakeholders have experienced material outcomes: that is why during the process it will be possible to confirm and refine the decision about the stakeholders included. According to limitations in terms of time, I decided to mention all the stakeholders that in my opinion are involved in this process of change but also to gradually reduce the analysis by focusing primarily on the clients that I have identified as the most important stakeholder in terms of experienced change.

The clients are indeed the first stakeholders in the Value Map: "client" is the name used by the facility staff to identify the beneficiaries of AMOC services. Briefly, the clients are homeless people who attend the facility registered in the system of the organization. The stakeholders' identification is divided in the spreadsheet of the Value Map into two categories defined by two different questions: "who do we have an effect on?" and "who has an effect on us?". Concerning the clients, I consider them belonging to the first category because thanks to AMOC they can have access to a fairly good amount of outcomes, further analyzed in the Value Map. The facility has more than an effect on them: they represent the focal point of the intervention. That is the reason why I consider them as the major stakeholder of the analysis. The outcomes related to the clients are: the attraction of high-risk marginalized users; the reduction of the risks related to the drug consumption (such as Hepatitis C or HIV) by

49 http://www.socialvalueuk.org/app/uploads/2016/03/The%20Guide%20to%20Social%20Return%20on%20Investment%202015.pdf

improving clients' health; the reduction of the overdose related deaths; the increase of the feeling of support of the clients; the stabilization of their life in psycho-social aspects; the drop-out or an aggressive behavior after expulsion. AMOC, as an organization busy with this particular target of people (international homeless people in Amsterdam), is a real point of reference for its target group and many aspects of the lives of these people are touched by AMOC's intervention. The multiple contacts that I have had with the clients during my three-months internship highlighted to me the importance of the organization in clients' life. This aspect arose also during the interview with a police officer from the Central Station of Amsterdam. He declared «I cannot imagine a city without AMOC because there are so many European citizens coming to Amsterdam and they all think it is easy to find a job here but the majority finds out that it's so difficult because they have no rights, no health insurance. That is why is very important to have an organization specialized in helping those people in Amsterdam».

The second column of the stakeholders' identification requires to provide the number of people for each stakeholder included in the analysis and that means answering the following question reported on the table: "how many in group?". Concerning the clients, I am supposing that 76 clients will attend the facility in the following year: this number is based on the average of the number of clients of the DCR in the past three years (2016, 2017, 2018) in accordance with the number of contracts stipulated. By analyzing the number of clients during the past 6 years I noticed a clear increase of this amount that goes from 28 clients in 2013 to 77 clients in 2018. This phenomenon is also related to an increase of the size of the user room during the years as we have seen in the Chapter II, paragraph "*1.5 DCR, AMOC as a case study for a social impact evaluation*".

Stakeholders **Who do we have an effect on?**	**How many in groups?**
Clients	76

Besides the clients, the next stakeholder is represented by the health system that, thanks to AMOC, can reduce the expenditure related to the care of the target group composed by PWUD. The presence of a place in which high-risk drug users can consume

illegal substances in a safe environment supervised by a trained staff, is important to prevent for example the cases of overdose on the street and consequently to save money for the emergency care. If an overdose happens inside the DCR, the staff is most of the time able to manage the situation on its own even if there were some cases in which the ambulance intervention was required. One example can be found in the paragraph "*Focus Group I - expert meeting on AMOC DCR outcomes*" in which a drop-in worker of AMOC explained: «one time, a couple of years ago, we were in time to save a guy that was in the toilet having an overdose. We called the ambulance because he was in really bad conditions. The ambulance came and they had to shoot up with the naloxone a couple of times and it was the only time I couldn't prevent anything. So eventually I think that the overdose prevention really works». In this specific case the overdose was difficult to manage by the staff because it happened in the toilet away from their supervision but, referring to the statistics of the DCR, the majority of the overdose cases inside the room are managed by the staff. The prevention of overdoses leads to a reduction of the expenses for the Dutch health system that does not have to manage this situation of the clients while they are attending the facility.

Moreover, also if the reduction of drug consumption related diseases (HIV, Hepatitis C) is one of the most important outcomes of AMOC Drug Consumption Room and of the DCRs in general, it is not the most relevant way in which the Dutch health system saves money because of the particular target group of AMOC. The clients of this organization in fact are European citizens mostly without a health insurance because they are unable to afford it due to their condition of social poverty. The cost of the health insurance in the Netherlands is about 100 € per month plus an annual franchise of about 385 €[50]. However, the reduction of the risks of blood borne diseases such as Hepatitis C and HIV among the clients does not have a direct impact on the cost savings of the Dutch health system. The reason is that this kind of people (clients from EU without health insurance) do not have access to the treatments for

[50] https://www.iamexpat.nl/expat-info/insurances-netherlands/dutch-health-insurance

both Hepatitis C and HIV in the Netherlands that would be available in the country of origin. Therefore, the health system is not saving money if AMOC is reducing the risk for these people to contract the diseases because the target group would be in any case out of the treatment in the Netherlands. On the other hand, what should be considered is that the reduction of this risk on AMOC clients implies the reduction of the risk for Dutch citizens to contract the diseases that leads to a cost saving in the health expenditure.

The health system should be included also within the stakeholders that have an effect on the organization and not only within the ones who receive something from AMOC as we have seen until now. Thanks to the provision of injecting materials, the redirection of potential clients to the organization, the provision of TBC free tests and the methadone pilot, the Dutch health system is surely generating an effect on the AMOC DCR service. However, in order to not double count the stakeholder I decided to insert the health system in the part of the spreadsheet dedicated to the question "who do we have an effect on?".

Stakeholders **Who do we have an effect on?**	**How many in groups?**
Health system	1

Another stakeholder that is influenced by the presence of the AMOC Drug Consumption Room is the neighborhood. The facility is located in a quarter of Amsterdam not far from the city center called *De Pijp*. Even though the presence of the DCR in the neighborhood is reducing the public nuisance (for example there are less discarded needles and syringes on the street), it is hard sometimes for the neighbors to accept the fact that many homeless and drug addicted people are hanging around their houses. This phenomenon is common and it is known as "nimbyism": NIMBY (acronym for "Not In My Back Yard") people are residents who are against a proposed development in their area only because it is close to them, otherwise they would tolerate or support it. The homeless shelter is one of the project that NIMBY people would not accept together with military, prisons, adult entertainment clubs, abortion

clinics, youth hostels and so on. Therefore, the DCR has a double effect on the neighbors: a positive effect in terms of reduction of public nuisance and a negative one related to the discontentment of the people who do not accept the presence of this facility in their neighborhood. The number of *De Pijp* habitants is about 33.120.

Stakeholders **Who do we have an effect on?**	**How many in groups?**
Neighborhood	33.120 habitants

Turning to the second part of the stakeholders column there are stakeholders who have an effect on the organization: staff members, security, students, volunteers, public administration, donors, other organizations and the police. The staff members are workers from the user room, workers from the drop-in and social workers. I decided to consider all of them in my analysis and not only the staff from the user room because this DCR is following an integrated model. As we have seen in *Chapter II*, the integrated model includes that the DCR provides several services such as drop in center, access to employment program, provision of food, showers and clothes. The strength of integrated DCRs model is the ability to put together many services in a single facility. The clients from the user room have access to all the services provided in AMOC and that explains my choice to consider the complete staff within the stakeholders. The workers from the user room have many tasks like register the clients when they come into the facility, supervise the room and give clean materials to the clients for the drug consumption. The workers from the drop-in manage the part related to the provision of food, showers, clothes, activities and they put them in contact with the social workers if it is needed. On the other side, the social workers try to help all the clients with different problems such as finding a job, handling medical problems, finding a place to stay and so forth. In total the staff is composed of 13 people.

The next stakeholder is the security staff. The security staff is employed by the *City Hall of Amsterdam* and it is composed by four people that cover all the opening hours

of the facility. They have the task of take action if something happens in the building (fights, clients who refuse to leave the building and so on).

Stakeholders **Who has an effect on us?**	**How many in groups?**
Staff members (drop in workers, user room workers, social workers)	13
Security staff	4

Students and volunteers are the following stakeholders: AMOC is hosting many students that spend a period of internship inside the facility. They are usually from 6 to 10 people (Dutch and international) per year who stay for a period that goes from 1 to 6 months. Most of the time they are students from the social field, for example people that are studying "Social Work" at the University. The students usually have to draw up a paper or a research for their University regarding the organization or the internship experience. The volunteers could be fix or not and their schedule depends from what they agree in according with their availability. There are also two volunteers from a German association, which every year send young people to work inside the facility for one year. The volunteers help the staff and the students with the daily tasks of the drop-in such as preparation of food, showers and so on.

Stakeholders **Who has an effect on us?**	**How many in groups?**
Students	10
Volunteers	4

The Public Administration (*City Hall of Amsterdam*) is another important stakeholder who is funding and supporting the all project by giving to AMOC the financial resources

needed to carry out all the implemented services. The Public Administration is the first investor in the activity of the organization.

However, AMOC and *De Regenboog Groep* in general is receiving many donations from different donors that I also included in the stakeholders that have an effect on the organization. The donations (coming from private people, the church and so on) are not only financial: they include also food and clothes and other material goods.

Other organizations are involved in this process of creation of value and they contribute in different ways (trainings, donations). They are about 8 organizations.

The last stakeholder considered is the police that has an important role of addressing of potential clients to AMOC as the police officer explains in the interview in *Chapter III*.

Stakeholders **Who has an effect on us?**	**How many in groups?**
Public Administration	1
Donors	■ Not available
Other organizations	8
Police	■ Not available

In order to rebuild the process of creation of value it is important to involve the stakeholders by asking them the information required from the Value Map and trying to find out together with them the strengths and the weaknesses of the activity analyzed. There are different ways to involve the stakeholders in the analysis such as:

- Get stakeholders together in one place and ask them directly;
- Try a workshop format, with informal discussions and a flipchart to record responses;
- Have stakeholders complete a form during a regularly scheduled meeting – for example, an annual general meeting of an organization, or other set gathering;
- Ring representatives from key stakeholder groups and ask them;

• Email a short form to representatives from key stakeholder groups;

• Have a social event and ask staff members to walk around and speak to stakeholders;

• One-to-one interviews[51].

A bigger number of stakeholders involved leads to a higher quality of the analysis and accuracy of the data. Nevertheless, limitations in terms of time and resources may bring to collect some information from the literature on the topic. Concerning my study, I involved some stakeholders in my analysis such as clients, staff members, students, volunteers and the police through focus groups, interviews, informal and formal conversations. Due to limitations in terms of time and resources, I obtained the missing data from the literature on the topic.

3.3 Value map, inputs identification and evaluation

The next step in the Impact Map is the identification of the inputs that make possible the implementation of the activity. The map requires to identify the contribution of each stakeholders - in terms of money or time - to realize the activity. This paragraph indicates what are the inputs for each stakeholder and the relative value.

The clients are the first stakeholder and their investments of resources in the activity are the following ones:

1. time spent in the DCR: **7 hours each day**

2. availability to give personal information to the staff and to have contacts with social workers

3. personal involvement: 1 meeting per month with all the clients / 1 customer satisfaction survey per year / 1 meeting per year only with DCR clients

First, the clients make a big investment in terms of time spent inside the facility: on average 7 hours each day. The user room is open from 10 until 17 during the week and

51 http://www.socialvalueuk.org/app/uploads/2016/03/The%20Guide%20to%20Social%20Return%20on%20Investment%202015.pdf

from 12 until 20 during the weekend. During the hours spent inside the facility, the clients from the user room have also access to the other services such as breakfast, lunch, change clothes, have a shower and talk with the social worker if needed. All the clients have a first meeting (called intake) with the social worker assigned to them in which they give an overview of their situation, their actual needs and their requests. Afterwards they can always ask to talk with their social worker and, on the other hand, the social worker can ask to talk with them. That is the reason why the second input of the clients refers to the availability to give personal information to the staff and to have contacts with social workers. Thanks to this network, the clients are always monitored and they have the possibility to share their problems with a trained staff that would try to help them. The third input referred to the clients concerns their personal involvement. The intervention is inclusive and tries to involve the clients into the process of decision-making in order to make the best choices by taking into consideration the opinion of the clients. The ways in which the organization involves the clients in this process are multiple. For example, there is a monthly meeting with all the clients (drop-in and user room) to discuss with them about the issues of the month. Once per year there is also a meeting only with the clients from the user room and a customer satisfaction survey managed from an external company and distributed to all the locations of *De Regenboog Groep*.

Turning to the health system, it contributes with the following inputs:

1. quantity of needles, syringes and other materials provided: 45.000 needles
2. time spent in redirect people to AMOC
3. TBC test for free and STD test for risk groups (ex. sex workers) for free
4. Methadone pilot (experiment including 10 not insured clients)

First, the health system has a crucial role in the proper functioning of the service thanks to the provision of materials such as needles, syringes, alcohol pads and so on. The material is always available for the clients in order to enable them to use drugs in a hygienic way and environment. Below I report the list of all the materials provided in the user room:

MATERIAL

Description of the material and its function in the user room

SYRINGES: 2ml or 1ml (insulin syringes)

ACID ASCORBIC / CITRIC ACID: used to liquefy the heroin/cocaine in the water

ALCOHOL PAD: used to disinfect the wounds before and after an injection

METAL TRAYS: used to prepare injections and maintain a clean place

INJECTION WATER / STERILIZED WATER: used as liquid for the injection

SPOON: used to cook drugs: every client who inject receive a personal spoon

FILTERS: used to filter the drug cooked. (filters are made out of clean cigarette filters)

TOURNIQUET: used as a garrotte to compress arms or legs: make the venal system visible

PLASTERS – LEUCOPLAST: used after the alcohol pad to cover up the injection wounds

DIVERSE BANDAGES: used for all kind of different wounds

CRABBERS: metal sticks used to clean the cocaine pipes

DIVERSE CREAMS: Betadine (healing of different wounds) Calendula (healing of dry skin)

ALCOHOL BOTTLE (DISINFECTION): used to disinfect everything needed

HIBI SCRUB: hospital disinfectant used to wash, heal and prevent skin infections

BIOHAZARD CONTAINERS: box to throw away the biohazard material (except syringes)

BIOHAZARD SYRINGES CONTAINERS: box to throw away the used syringes

PERSONAL SYRINGES CONTAINER CARRIER: given to every new injector client

CONDOMS: prevention of STD

STERILIZATOR: used to clean and sterilize the spoons each week

SPOONS: each personal spoon is cleaned, dried and sterilized every week. Every spoon belongs to one bag with the name tag of the client on it. The bags are also changed every week too.

The data concerning the quantity of materials provided by the heath system are not available, except for the needles that are about 45.000 per year.

The second input related to the health system concerns the time spent to redirect people in AMOC. It means that if a person from the target group of AMOC shows up in the hospital asking for care the health system would send him to the organization.

Moreover, the health system is offering free TBC tests to the clients of the DCR and a free STD tests for risk groups such as sex workers. Lastly, it also provides a methadone pilot for ten clients that have express the desire to take part to the methadone program. The column of inputs has another section concerning the financial value of the inputs divided for each stakeholders. The total amount of financial resources invested in material is **168761,35 €**, which represents the 10% of the total amount of inputs.

The neighborhood is the next stakeholder. It invests in the activity the following inputs:

1. time spent from the neighborhood commission in the meetings with AMOC: **1 meeting every 3 months**
2. availability to accept the presence of AMOC within the neighborhood

The presence of AMOC in the quartier is an issue that has to be carefully managed. As we have already seen in the previous paragraph, not all the neighbors agree with the presence of this facility next to their houses. Even if this service is able to reduce the public nuisance, many homeless and drug addicted people are hanging around the neighborhood because of AMOC. In order to maintain good relationship with the people that are living around the facility, AMOC implements multiple solutions. For example, every day some of the clients sweeps the neighborhood by maintaining it clean from wrappers, cigarette ends and so forth. Another way to keep in touch with the neighbors and discuss the problems is the meeting that AMOC has with the neighborhood commission every 3 months.

The following stakeholder is the staff of the organization, which means drop-in workers, user room workers and social workers. The input related to the staff are the working hours: the average is 24 hours per week. The biggest amount of financial resources is invested in salaries: 75% of the financial value invested in the facility is salary-related (**1.265.710,13 €** out of 1.687.613,5 €). I have considered the cost related to all the staff of the facility because of the integrated nature of the DCR that ensure that the clients from the user room can have access to all the services provided in AMOC.

The inputs from the security staff, the students and the volunteers are the working hours (32 on average for the students and 4 on average for the volunteers).

The Public Administration or *City Hall of Amsterdam* is giving the biggest contribution in terms of financial resources to the organization: the project is funded by the municipality of Amsterdam. The financial resources invested in the project amount to **1.085.345,5 €** and I have extrapolated this figure by dividing by 8 (number of locations managed by the organization) the total amount of money given from the PA to all the locations of *De Regenboog Groep*. The financial value related to this stakeholder is the part of the total amount used for the exploitation costs: it is about the 10% of the entire sum and it amounts to **168761,35 €.**

The donors are contributing to the activity both in a financial and non-financial way:

1. quantity of financial resources invested in the project: **120.792** €
2. quantity of non-financial resources invested in the project (food, clothes)

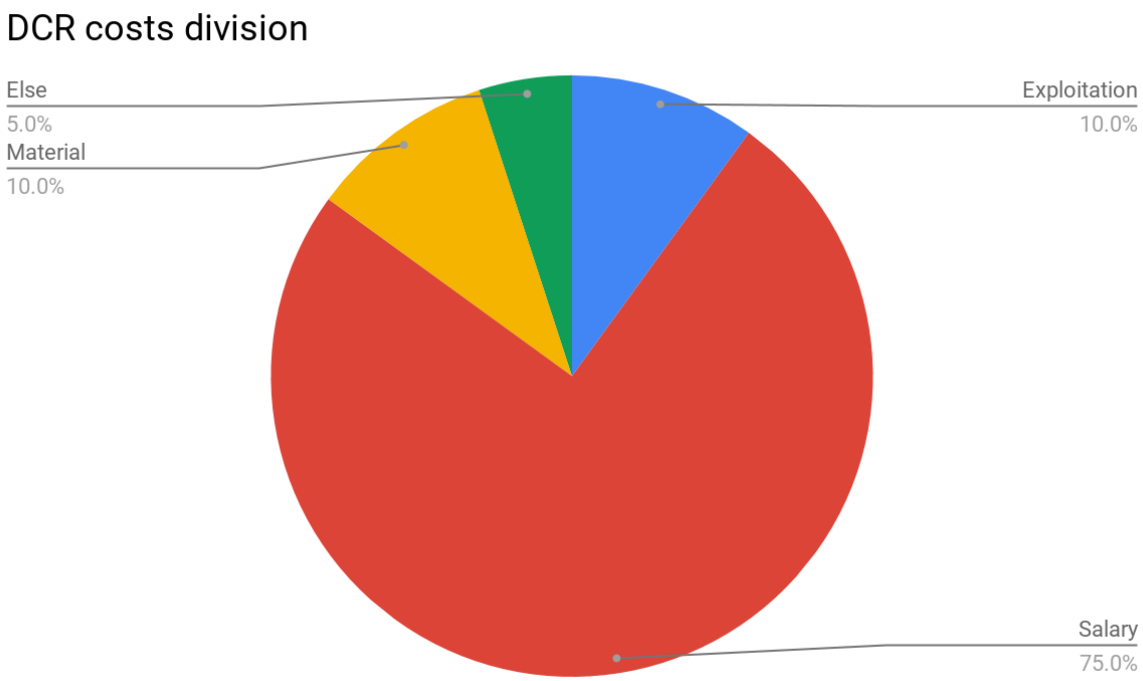
The amount of monetary donations is calculated by dividing by 8 the total amount of donations for all the locations of *De Regenboog Groep*. On the other hand, there are not data available about the amount of food, clothes or other tangible goods donated to AMOC. However, this amount should be considered as variable.

Many other organizations are working together with AMOC in different ways by providing different kinds of help. The list of "partner" organizations is quite long but I report here some of them: Jellinek, MDHG (union of users), Mainline, Volunteer Academy, Fire Brigade, Serve the City. For example, the Fire Brigade provides a first aid training to the staff and the Volunteers Academy educates the volunteers. The financial value of these inputs is about **84.380,68 €** (5% of the total amount of inputs).

The last stakeholder is the police and the contribution to the activity analyzed could be quantified with the working hours related to redirect the potential clients to AMOC and to solve critical situation related to the presence of the drop-in in the neighborhood as popped up from the interview with the police officer from the Central Station of Amsterdam.

In conclusion, the total amount of inputs is **1.687.613,50 €** that are invested in the activity to make it run. To sum up, this amount could be divided in the following way:

- 75% salaries
- 10% exploitation costs
- 10% material costs
- 5% else



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3.4 Value map, outputs identification

The next step is about the clarification of the outputs produced by the activity. According the SROI Guide from Social Value UK «outputs are a quantitative summary of an activity. For example, the activity is "we provide training" and the output is "we trained 50 people to NVQ level 3"». They are the direct and tangible products of an activity. Following the same process as before, I identified the outputs divided per stakeholders.

[52] Graphic provided by Cedric Charvet, AMOC DCR Coordinator

The outputs related to the clients are the ones below:

1. number of clients attending the DCR in one year: **76**
2. number of hours spent in the DCR: **7 hours a day**
3. attendance: **15 clients per day** during the week and **up to 36** during the weekend

Referring to the user room, the number of clients in one year would be about 76 clients, based on the average of the last three years. The number of hours spent in the facility would be about 7 hours each day that is equivalent to the opening hours of AMOC and the attendance would be about 15 clients per day during the week and up to 36 during the weekend by following the trend of the last years.

Later on, the outcomes related to the health system are:

1. quantity of needles, syringes and other materials provided: 45.000 needles
2. number of people redirect to AMOC
3. number of clients admitted to the methadone pilot: 10

As I reported in the previous paragraph, the amount of each material provided by the health system is not available, except for the number of needles provided in one year that is about 45.000 units. Similarly, the number of people redirect to AMOC from the health system is not available. Moreover, the methadone pilot is an experimental project managed by the health authorities that gives the possibility to 10 clients from the AMOC user room to be part of a methadone program.

The output relative to the neighborhood is represented by the number of meetings with the organization: 4 in an year (1 every three months). Furthermore, among the staff members, the output of the social workers is the number of meetings with clients that are about 261 in one year: all the clients have an intake with the social worker and they can ask to meet them if needed afterwards.

Concerning the security staff, they carry out on average 2 interventions per day by realizing about 730 interventions per year. Some examples of interventions could be breaking up of a fight or helping to drive away a banned client.

Turning to the students, I consider that they produce one paper/research/essay per person on the facility for their university. If there will be 10 students, 10 papers will be produced.

In conclusion, the output for the other organizations will be the number of trainings provided and for the police the number of people redirected to AMOC. Both data are not available.

Stakeholders	Outputs Summary of the activity in numbers
Health system	1. quantity of needles, syringes and other materials provided: **45.000** needles 2. number of people redirect to AMOC 3. number of clients admitted to the methadone pilot: **10**
Neighborhood	1. number of meetings with AMOC: **4**
Staff members (drop in workers, user room workers, social workers)	1. Social workers: number of meetings with clients: **261**
Security	1. number of security interventions required on average: **730** (2 per day)
Students	1. number of papers realized: **10** (one per student)
Other organizations	1. number of trainings provided: not available
Police	1. number of clients redirected to AMOC: not available

3.5 Value map, outcomes description and indicators

The following step is crucial in the process of evaluation of value: it consists in the identification of outcomes and their indicators. The SROI is an outcomes-based measurement tool and, only through the evaluation of the outcomes, it is possible to know if the changes for the stakeholders are taking place. The outcome is the result of an action and it could be positive, negative, expected or unexpected. Outcomes are changes that occur as a result of the activity. Once the outcomes are identified,

the following step concerns the selection of indicators for each outcome. The indicators provide useful information in order to understand if the change has taken place or not.

Therefore, the clients are the first stakeholder: they are related to different outcomes. The first outcome is the attraction of high-risk marginalized users: the DCR is useful to get in contact with a hard-to-reach part of the population. According to the EMCDDA report on drug consumption rooms (2004) the clients of those facilities have a specific profile: «the typical user of consumption rooms is older than 30 and has a history of problem drug use – mainly of heroin and/or cocaine – going back 10 or more years. Clients under 20 and recent drug users with a history of problem drug use of only one or two years' duration are uncommon, while the number of registered clients in their 40s, 50s and even 60s has increased». Without the DCRs, it would be hard to approach this target group and would be even more difficult to control them and build a trusting relationship able to re-connect them with the society. The very next column of the Value Map is asking to identify for every outcomes (divided per stakeholders) the indicators that you would use to measure it and to specify where you get the data from (source). According to the Social Value UK indicators are ways of knowing that change has happened and they are applied to the outcomes in order to measure the change we are interested in. Therefore, concerning the ability of the user room to attract high-risk marginalized users (outcome), the indicators that I have identified are the following two:

a. **100%** of the DCR clients are in accordance with the target thanks to the first intake with social workers to verify the requirements
b. number of ex-prisoners: **100%** of the clients
Source: interview with social worker and DCR coordinator

The first indicator of the outcome "attraction of high-risk marginalized users" is the fact that every clients in the user room is surely part of this category thanks to the intake with the social worker. The first meeting with the social worker aims to understand the needs and the situation of the potential client that has to be in accordance with the target group of the user room. All the clients of the AMOC DCR are high-risk marginalized

users (100% of the clients). The relative source is the interview with one of the social worker that explained me the process of acceptance of a new client. The other indicator that I have chosen is the number of ex-prisoners among the clients: 100% of the clients of the user room are ex-prisoners. The choice of this indicator is based on the remark that the prisoners are considered as part of the category of "marginalized" individuals and besides, this indicator is easily measurable and affords to provide a strong financial proxy of the outcome "attraction of high-risk marginalized users". The criminality and the public nuisance created by the target group is reduced thanks to the presence of the AMOC user room that gives them a safer space for the drug consumption: this leads to a reduction of the probability of these people to end up in prison while they are regularly attending the facility. The source related to this indicator is an informal interview that I had with the coordinator of the DCR.

The next outcome related to the clients is the reduction of the risks related to the drug consumption, such as HIV and Hepatitis C, by improving clients' health. As we have seen in Chapter II with the history of the DCRs, these facilities were born as a response to the HIV/AIDS emergence of the 80s related to the epidemics of heroin use and drug injecting. The DCRs are able to reduce the acute risks of disease transmission through unhygienic injecting by providing hygienic equipment for the drug consumption. That is the reason why, while the clients are inside the room, the risk of contracting the disease does not exist for them. Moreover, the staff has a deep knowledge about drug consumption risks and safe injection and they share information with the clients that are more aware of the risks. During the focus group with some people from the staff, the social worker declares that the clients are completely aware of the risks and that sometimes they come during the night just for ask for clean needles and condoms: «I agree that they are aware and I can give you an example. When I was working in the night-shelter people from the user room came during the night to ask for clean needles and I found it very responsible from their side. They know what are the risks of sharing needles. I was impressed» (Agnieszka Franczak - social worker). The indicator for this outcome is the following

one:

how many cases of diseases among clients? No cases of diseases due to the DCR attendance because the sterile equipment is always provided: **0 cases out of 76**
Source: daily experience

The clients inside the user room are always protected from the diseases transmission thanks to the hygienic equipment provided. It also important to underline that some of the clients already have one of the considered diseases when they end up in the facility but a percentage of the clients with blood borne diseases is not available because the staff is not allowed to record data and information about the medical condition of the clients.

Another outcome that I consider in my analysis is the reduction of overdose related deaths. In the supervised consumption area, emergency care in case of overdoses or other adverse reactions is provided. The staff members are trained and they control the clients by preventing overdoses or taking action if needed. The success of this outcome has been confirmed in the focus group with the staff. The drop-in worker declared: «one time, a couple of years ago, we were in time to save a guy that was in the toilet having an overdose. We called the ambulance because he was in really bad conditions. The ambulance came and they had to shoot up with the naloxone a couple of times and it was the only time I couldn't prevent anything. So eventually I think that the overdose prevention really works». The social worker added: «what I think that is important is that we all have trainings to know how to deal with overdoses. Since I am working in AMOC for me is important to recognize if is an up or down overdose and what kind of drugs are the cause also to instruct my clients on the risks and consequences of drug abuse. All the staff has a knowledge about drugs». The indicator of this outcome is that there are zero cases of overdose deaths in the DCR and the source is the report of the organization:

number of overdose related deaths inside the DCR: **0**

Source: DCR report

The next outcome is the reduction of the feeling of loneliness of the clients and the increase of the feeling of support. The DCR has a crucial role in breaking the vicious circle of loneliness, stress and drug use of the clients by creating a safe space in which drug users can consume their drugs in a stress-free environment surrounded by other people (users, staff). The clients of the user room are marginalized from the external society. Inside the facility, these people feel to belong to something and they eventually find a place in which people are listening and taking care of them. What is also important is the possibility to spend time with other PWUD and to share problems with them: the rat-park experiment from Bruce K. Alexander showed that drug addiction is not only related to drugs themselves but it is also strictly connected with the environmental conditions (setting) in which drugs are consumed. Therefore, an isolated setting increase the drug consumption, while a different social environment could reduce the drug consumption. Both the focus group with the staff and the one with the clients underline the importance of this outcome. For example, the social worker explained: «I remember for example one of our clients from the user room that told me that AMOC is the only place in which people take him seriously and in which he can have a normal conversation. Outside AMOC he doesn't feel part of the society. This is only one example but from my daily experience I can say that clients are not coming in AMOC only for food, but they come because here they feel that they belong to something. So, eventually, I think that the facility reduces the loneliness of our clients». The user room worker added: «I have seen multiple times people come to the drop in downstairs just to socialize with others because on the street they are a sort of invisible. Our clients share problems and they feel more protected here than on the street but then when they leave the building they leave alone, one by one. There are only few groups that are staying together. Anyway I believe that the loneliness is reduced for sure». Talking with the clients one of them used the Dutch word "*gezellig*" to describe the facility. This word means something

like “welcoming” or “friendly” and that reminds to a place in which they feel supported and listened. The indicators for this outcome are:

a. number of clients who feel more supported: **100%** of the clients

b. number of clients who come back to their country for therapy: **3**

Source: a. Focus groups (social, user, drop in workers + clients) - b. DCR report

According to the focus groups, the 100% of the clients feel more supported and less lonely by attending the user room and, in 2018, three of them came back to their country of origin for therapy. For the target group of AMOC it is not simple to build a life in the Netherlands because they basically have no rights in the country. That is why the social workers from AMOC have also the task of helping them to find a way to come back to their country of origin and to connect them with other services there. If the client declares that he/she wants to come back, the social worker will try to arrange his/her return by dealing with different aspects of it: they will buy the ticket to come back, they will get in contact with other organizations that can take charge of the client and so on. The comeback in the origin country for therapy could be considered as an indicator of the support given from the organization to the client.

The next outcome refers to the stabilization of clients’ life in psycho-social aspects, which means that clients feel more stable psychologically and socially speaking by attending the facility. This outcome is particularly complex and it is about the fact that the client of the drug consumption room gives a rhythm to his life by attending the facility. The clients know that if they want to consume drugs safely, to have breakfast and lunch, to take a shower or to talk with the social worker they have to follow AMOC’s opening hours and its schedule for the different services. Moreover, their situation and living condition is monitored in the organization by the staff and the social workers that can help them with dealing with their problems. This system ends up with incorporate them in a sort of “routine” and gives them some fixed points in their life. During the focus group with the staff members, the drop in worker declared: «thanks to the DCR they can stabilize their use and their life and they can focus on other aspects of their life». The indicators I am using to detect this outcome are:

a. number of clients who feel more stable: **100%** of the clients

b. number of clients who have found a job: **9**

c. number of clients attending the methadone pilot: **10**

Source: Focus groups (social, user, drop in workers + clients) + DCR report

According to the focus groups, both with the staff and the clients, it has emerged that the clients feel more stable in a psychological and social way by attending the facility for the reasons explained above. Other two important indicators of a more stable life are the number of clients that have found a job and the clients who are attending the methadone pilot: 9 clients out of 64 have found a job while they were attending the facility. I suppose the same result for the next year in the forecast analysis. Typical jobs of the clients are selling the newspaper from the neighborhood or working in a storage. I consider the variable "to find a job" as a proof that the client stabilizes his/her life because it represents an engagement for the client that also lays the groundwork for a process of social inclusion. The last indicator I have found related to this stabilization process is about the methadone pilot, a project that gives the possibility to 10 clients of the AMOC DCR, that want to start a path of detoxification, to have access to a methadone program. The project involves AMOC and the Health Authority of the city of Amsterdam. Thanks to this program, some clients have the possibility to stabilize their life. In this regard, the social workers interviewed in the focus group declared: «we don't have to convince the client to stop using. If they come to me and they say they want to stop, then we need to cooperate with institutions. Thanks to the methadone pilot for example people from AMOC, so without health insurance, can attend the methadone program. But eventually stop using is not our goal, we accept them as they are».

The last two outcomes referred to the clients are negatives: aggressive behavior or loneliness of the clients after the expulsion and the drop-out of the clients. Expulsion mechanisms are envisaged from the organization to all the clients that have critical behaviors and break the rules in a serious way. After the expulsion the organization does not have contacts with the banned client but the interview with the police

officer from the Central Station of Amsterdam highlights that some clients have aggressive behaviors after the expulsion and they require the police intervention. Below a part of this interview concerning this topic:

S: «There are clients that are banned from AMOC. Do they come back to the Central Station? »

M: «Yes they come back here because it is warm and safe. I have an example, there was a client that was banned from AMOC and he was causing problems in the Central Station. When it happens it is our problem again and then we try to think about different solutions».

However, it is not certain that all the clients that are banned from the user room act in an aggressive way afterwards. The indicator for this outcome is:

aggressive behavior or loneliness after expulsion: 2 out of 4 banned clients

Source: Police interview

The banned clients are supposed to be 4. I consider that is not verified that all of them will have an aggressive behavior or feel alone because of the ban, that is why I consider this outcome applicable to 2 clients out of 4.

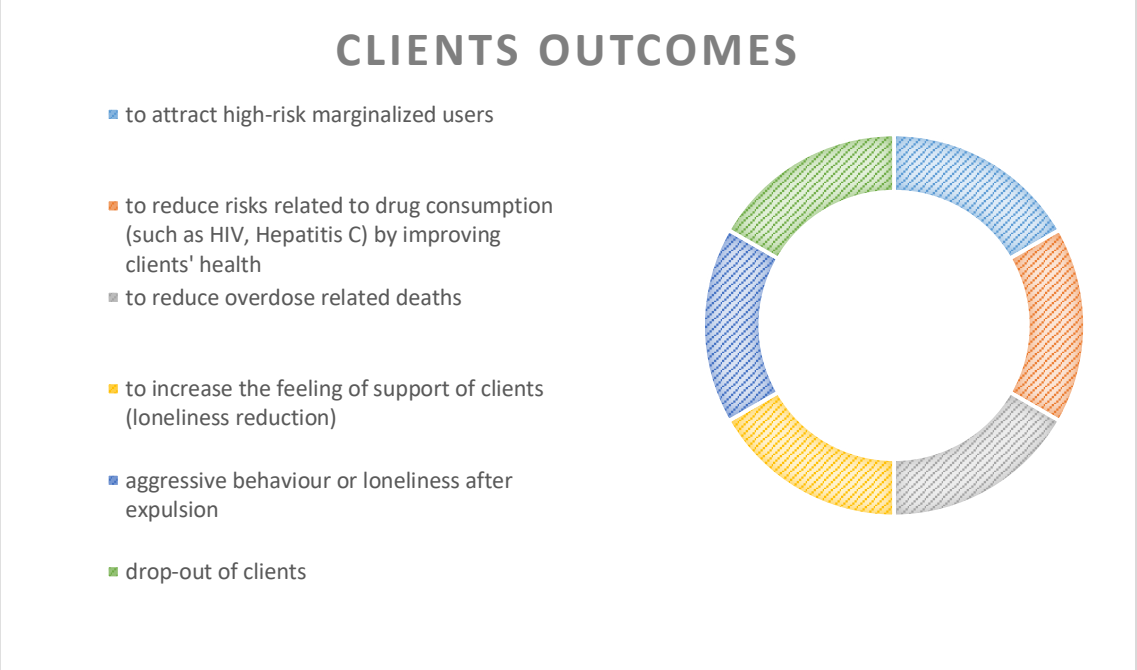
Concerning the drop-out of the clients it implies that not all the clients that start a path in the user room by signing a contract continue to attend the facility, some of them stop going and, according to the data of the last three years (2016, 2017, 2018), I suppose that 12 people will leave the facility the next year. The reasons that lead people to stop attending the user room are not really known from the organization that does not have contacts with the clients outside the facility. The indicator for this negative outcome is:

12 contacts lost

Source: DCR report

The drop-out is the last outcome that I consider referring to the clients.

Reached this point of the analysis the focus of the Value Map is especially on the clients and on the outcomes related to them. The reason is that the intervention of the DCR is “clients-based” and the majority of the outcomes produced are related to them and their lives.



However, moving forward in the Value Map, I consider some other outcomes related to some of the other stakeholders. For example, the outcome produced on the health system is the saving in health expenditure and the indicator is the less number of emergency intervention related to the drug consumption. As we have seen in the previous paragraph about the reduction and the prevention of overdose related deaths, the clients inside the facility are monitored and supervised by a trained staff that is the most of the time able to handle an overdose if it happens inside the user room by avoiding the costs related to the emergency care. The focus group underlines that the staff is trained to prevent the overdose but in a few cases it happened that the ambulance was needed: for example when a client had an overdose inside the toilet.

Turning to the neighborhood, I consider one positive and one negative outcome: the reduction of the public nuisance and, at the same time, the presence of many drug users around the quartier. The indicators of these outcomes are:

1. number of police interventions related to the clients avoided in the neighborhood

2. number of neighbors declaring that they do not accept the presence of many drug users around the quartier

Source: data not available

I consider the reduction of public nuisance as an outcome also for other two stakeholders: the Public Administration and the police.

In conclusion, I consider other two outcomes related to the volunteers: the personal satisfaction or the burn out. I do not provide an indicator for these outcomes because they are not relevant for the analysis that would be mostly focused on the clients and their relative outcomes.

The focus groups with the staff and the clients were useful to validate the clients-related outcomes that I had identified on my own during my daily experience inside the facility. During the focus groups, I presented my outcomes by discussing all of them with the participants. As a consequence of the two focus groups, I adjusted the outcomes. For example, I discarded the outcome "social inclusion": it turns out that it is not entirely applicable to the clients of AMOC because of the specific target group (European homeless). As the drop-in worker said: «social inclusion if we talk about AMOC target group is a complex issue because there is a big gap between AMOC and the society of the Netherlands». The social worker added: «the Dutch policy is based on the concept that if you want to stay in the Netherlands you should be able to be economically independent and is not the case of our clients. With this statement our clients are already excluded from the society». Even if the social inclusion should be probably considered as an outcome of the drug consumption rooms in general, when we talk about AMOC we are referring to a particular target of drug users without rights in the country in which they are living (the Netherlands). That is why even though the social workers always work hard trying to find solutions for them, the social inclusion is something hard to reach for the clients of this facility. This is the reason that led me to exclude the social inclusion as an outcome of my case study. Moreover, I have added to my outcomes the "attraction of high-risk marginalized users". It turns out from the focus

groups that the clients of AMOC are invisible for the rest of the society and this facility is the only one that is accepting and taking care of this particular target group that otherwise would be not accept in any other organization. The attraction of the target group is an important result of the intervention.

3.6 Value map, outcomes evaluation

The following steps will lead to the calculation of a total Present Value (PV) showing the sum of monetary values (financial proxies) of the outcomes selected for the evaluation and then to the SROI ratio. Therefore, once the indicators are defined, the Value Map requires information about the quantity of people that are experiencing the described change; the outcomes start; the duration of the outcomes; the valuation process and, eventually, the financial valuation. In this paragraph, I describe for every outcomes that I decided to evaluate the process that from the indicators leads to the financial proxy. All the outcomes evaluated are related to the stakeholder "clients". I consider the outcomes related to the clients as the most important because the intervention is entirely based on them and the majority of the activity's effects are on the clients. However, some outcomes related to the clients could be also be referred to other stakeholders such as the Health System and the Public Administration. For example, the outcome related to the Health System is "to save money on health expenditure". The cost savings in health expenditure will be evaluated through the calculation of the cost of the first aid (cost of the ambulance) in the Netherlands for the clients who will need it. This figure is the financial proxy of the outcome "to reduce overdose deaths" associated to the clients. In the same way, the Public Administration's outcome is the reduction of the public nuisance. It will be evaluated by giving a financial proxy to the outcome "to attract high-risk marginalized users". The user room reduces the public nuisance by attracting the target group inside the facility. In conclusion, in order to not double-count the outcomes, I evaluate them by referring them directly to the clients, even though another arrangement remains possible.

Coming back to the Value Map, the first outcome related to the clients is “to attract high-risk marginalized users”. The quantity of people who are experiencing this outcome is composed by the entire group of clients that, as mentioned in the indicator explanation, are all belonging to this category as a sort of requirement to have access to the different services. This outcome starts in the period of activity from the intake with the social worker and not in the period after. I suppose that the duration of the outcome is equivalent to the time in which the client is attending the facility and that is the reason why, since my analysis is led considering one year of activity, the duration of the outcome would be one year. The next step is the definition of the valuation approach used to give a monetary value to the outcome. Referring to the valuation process, the Guide to SROI from Social UK explains: «this process of valuation is often referred to as monetization because we assign a monetary value to things that do not have a market price. All the prices that we use in our day-to-day lives are approximations – ‘proxies’ – for the value that the buyer and the seller gain and lose in the transaction. The value that we get will be different for different people in different situations». The meaning is that the value is subjective and even the markets developed by mediating between people’s different subjective perceptions of what things are worth. The goods that we are going to estimate are not traded in the market but it does not mean that the social goods does not have a value for people. Thanks to the financial proxies given to the outcomes, it is possible to estimate the social value created by the activity.

The first valuation, referred to the outcome “to attract high-risk marginalized users”, is the firmest one. In order to evaluate the monetary value of the attraction of the target group I consider the cost of a day of prison in the Netherlands because all the clients from the DCR are ex-prisoners. As mentioned in the previous steps, all the clients from AMOC are ex-prisoners and I consider “ex-prisoners” as a part of the category “marginalized people”. If the clients would not be attracted by the organization, some of them will probably come back to prison. The evaluation process consists on the calculation of the cost of a day in prison in the Netherlands multiplied by the number of clients and by the 365 days in a year:

208 euro x (45% of 76 people) x 365 days= **€ 2.596.464**

A day in prison in the Netherlands costs 108 euro a day per prisoner but if the prisoner also needs the methadone because of his/her addiction the price goes up to 208 euro a day per person. Since all the clients of the user room are drug users, I consider that all of them will need to have access to the methadone. In addition, if the prisoner needs also a psychological or psychiatric therapy the cost increases and 85 euro extra would be needed. Probably, a relevant part of the clients would also need the psychological or psychiatric therapy but, since it is not possible to estimate the number of them who will need it, I decide to not consider it in the evaluation.

Moreover, it is not possible to affirm that all the clients (76 people) would come back in prison without the intervention of AMOC, which is the reason why I consider the reoffending/recidivism rate in the Netherlands and I calculate the costs only for the percentage of people that would be arrested again according to the statistics on this topic. In the Netherlands, the reoffending rate is 45%[53]. In conclusion, the attraction of high-risk marginalized users from the organization would create a cost-saving of 2.596.464 euro that corresponds to the monetary value of the outcome. From this amount should be taken off the amount of money related to the 12 people who will drop out the facility during the year (data based on the drop out previous years). I will discount this amount during the evaluation of the negative outcome "drop-out of the clients". Another solution would be consider the costs only for 64 clients instead of 76: I will adopt this second approach in the calculation of the next outcomes.

The next outcome is the reduction of blood-borne diseases among clients (Hepatitis C; HIV) and the indicator is the number of clients who does not contract the disease inside the facility. The number of clients who get sick inside the DCR is 0 because the organization provides clean material for the drug consumption and,

[53] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6351626/

therefore, the number of clients who does not get sick inside the facility is 64 (all the clients except for the 12 who will leave the facility during the period of activity). Also this outcome starts in the period of activity because from the first day in the user room the clients have access to a sterile equipment given in a safe environment. Concerning the duration of the outcome, the previous argument is still valid: I suppose that the duration of the outcome is equivalent to the time in which the client is attending the facility, which is the reason why, since my analysis is led considering one year of activity, the duration of the outcome would be one year.

Turning to the monetary evaluation approach, in order to measure the monetary value of the reduction of blood-borne diseases transmission among clients I consider the cost of the Hepatitis C and HIV treatment in the Netherlands. This amount would represent the saving of money for the clients who do not get sick thanks to the user room attendance:

HIV: covered by the health insurance: € 17.000[54]

Hepatitis C: 40.000 euro

Hepatitis C: 40.000 € x (85% of 64 clients) = **2.176.000 €**

HIV: 17.000 € x 64 clients x 0%= **0**

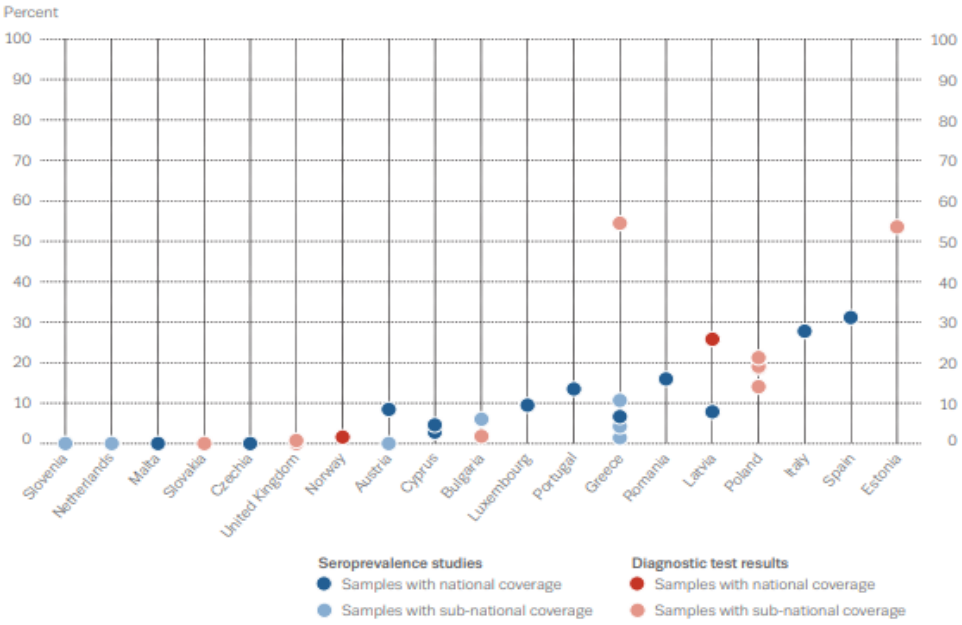
The clients of AMOC (international target group) do not have an health insurance, otherwise they would have covered the cost of the treatments. The cost of the HIV treatment is 17.000 euro but the percentage of people who inject drugs that are at risk of HIV infection in the Netherlands is about 0%[55] according to the data of the EMCDDA. The percentage in the Netherlands is lower in comparison to the other countries and, for the analysis, this data means that 0% of the clients are at risk of HIV and the cost saving is 0.

[54] https://www.everydayhealth.com/hiv-aids/can-you-afford-hiv-treatment.aspx

[55] http://www.emcdda.europa.eu/system/files/publications/11442/20192115_TD0219248ENN_PDF.pdf figure 5

FIGURE 5

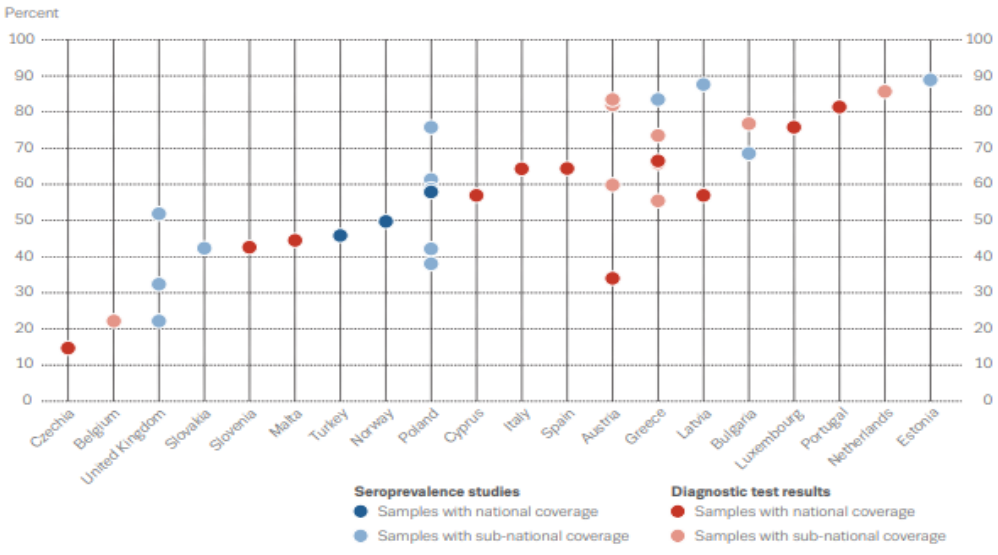
HIV antibody prevalence (percent) among people who inject drugs: results from seroprevalence studies and diagnostic tests, with national and subnational coverage, 2016-17



On the other hand, the cost of the treatment for the Hepatitis C is 40.000 € and, according to the EMCDDA, the prevalence of the HepC infection among PWID is 85% in the Netherlands:

FIGURE 3

HCV antibody prevalence (percent) among people who inject drugs: results from seroprevalence studies and diagnostic tests, with national and subnational coverage, 2016-17



Source: EMCDDA.

I consider that the 85% of the clients is at risk of Hepatitis C: the monetary value associated to the number of people who does not get sick inside the facility (indicator for the outcome "to reduce blood-borne diseases among clients") is 2.176.000 €.

The following outcome is the reduction of drug overdose deaths among the clients. The number of people that will not die for a drug overdose while they are attending the facility is 64, that means all the clients except the 12 that are supposed to leave the facility during the period of activity. The outcome starts in the period of activity because they are under the supervision of the staff from the first day in the user room and the duration of the outcome is supposed to be 1 year for the same reason of the previous outcomes. The monetary valuation approach used to evaluate this outcome consists in the definition of the cost of the first aid (ambulance) in the Netherlands for people without health insurance. I suppose that the people who are attending the user room do not need the ambulance in case of overdose and they do not die for drug overdose death inside the facility. A trained staff always supervises the clients. However, according to the literature, only the 2%[56] of opioid users dies for drug overdose in the Netherlands; that is why I suppose that only the 2% of the clients would need the ambulance if the user room does not exist:

600 € x (64 clients x 2%)= € **768**

The cost of the ambulance (first aid) in the Netherlands is 600 €[57]. The total amount of cost-saving in first aid is 768 €.

The next outcome is the increase of the feeling of support of the clients and the reduction of their feeling of loneliness. According to the Focus Group with the clients and the one with the staff, I consider that all the clients, except for the 12 who are supposed to leave, feel supported by attending the facility (64 clients). The outcome starts in the period of activity and the duration is related to the attendance. In order to

[56] http://www.emcdda.europa.eu/countries/drug-reports/2019/netherlands_en
[57] http://www.ehbobladel.nl/news/show/twijfel-niet-bel-112

measure the increase of the feeling of support of clients I consider the cost of psychological help in the Netherlands:

85 € per hour x 52 (1 session per week per 1 year) x 64 = € **282.880**

I suppose that the psychological therapy would have a similar effect on the clients to the user room attendance in terms of increasing the feeling of support. In the Netherlands the cost per hour of a psychologist is on average 85 euro[58]. I suppose that the outcome would be comparable to a psychological therapy of 1 hour session per week per 1 year: the total amount of money would be 282.880 €.

The last positive outcome related to the clients is the stabilization of their lives in psychosocial aspects. As mentioned in the previous paragraph, this outcome is complex to define and it is also consider as the last one in the ranking of outcomes completed by the staff members during the focus group. I decided to not evaluate it. However, one approach to give it a monetary value would be the evaluation of the medium wage of the clients who have found a job (9) but what makes this evaluation difficult is that the clients often have an independent job, such as the newspaper seller, without a fix monthly wage.

I also decided to not evaluate the negative outcome related to the aggressive behavior of the clients after expulsion because of the uncertainty of this outcome that has not been successfully verified. According to the interview with the police officer of the Central Station, I can suppose that some of the clients would have aggressive behaviors after the expulsion: 2 clients out of 4 banned would probably create problems. However, in order to calculate a financial proxy I should have given a monetary value to the working hours of the police related to tackling with situations created by the banned clients.

The last outcome evaluated is the second negative one referred to the clients: the drop out. I have already taken into consideration the drop out of the clients in the

[58] https://www.europsyche.org/situation-of-psychotherapy-in-various-countries/netherlands/ hourly cost of a psychologist in the Netherlands

evaluation of the other outcomes by considering 64 clients instead of 76 (drop out: 12 clients), except for the first outcome ("to attract high-risk marginalized users"). Therefore, I consider that the 12 clients would come back in prison when they stop attending the facility. I obtain a negative value referred to the destroyed/lost value generated from the drop out:

- 208 € x 12 clients x 365 = **- 911.040 €**

In order to define the total amount of value created by the outcomes to which I have assigned a financial proxy, it is important to assess all the proxies by understanding how much value is caused by the activity analyzed. The next paragraph explains this process of proxies' assessment.

Outcomes	Financial proxy
To attract high-risk marginalized users	In order to measure the capacity of the DCR to attract high-risk marginalized users I consider the cost of a day of prison in the Netherlands due to the fact that all the clients are ex-prisoners. 108 euro per person a day + 100 euro per person per day (methadone provision) applicable to 45% of the people because it is re-offending/recidivism rate 208 euro x (45% of 76 people) x 365 d= **€ 2.596.464**
to reduce risks related to drug consumption (such as HIV, Hepatitis C) by improving clients' health	In order to measure the capacity of the DCR to reduce the risks related to the drug consumption I consider the cost of the Hepatitis C and HIV treatment in the Netherlands. **HIV:** covered by the health insurance: € 17.000 **Hep C**: 40.000 euro **Hep C** 40.000 x 64 x 85%= **2.176.000 €** **HIV** 17.000 x 64 x 0%= **0**
to reduce overdose related deaths	I consider the cost of the first aid (ambulance) in the Netherlands for people without health insurance: I consider only the 2% of the total because it is the number of people who will need the ambulance according to the literature

	600 € x (2% of 64)= **€ 768**
to increase the feeling of support of clients (loneliness reduction)	in order to measure the increase of the feeling of support of clients I consider the cost of psychological help: 85 € per hour x 52 (1 session per week per 1 year) x 64 = **€ 282.880**
Drop out of the clients	I measure the drop out related to the first outcome because it is the only one in which I did not taken into consideration the drop out in the number of people experiencing the change (76 instead of 64): - 208 x 12 x 365 = **€ - 911.040**

3.7 Value map, establishing the impact

The last stage (stage 4) of the Value Map consists in establishing the impact by considering for every evaluated outcome deadweight, displacement, attribution and drop-off. This stage is important to reduce the risk of over claiming by measuring and accounting the value through these factors.

According to Social Value UK the deadweight is «a measure of the amount of outcome that would have happened even if the activity had not taken place. It is calculated as a percentage». The deadweight is related to the control group. The perfect comparison, in order to calculate this factor, would be the comparison between the same group of people taken into consideration with and without the intervention. This kind of experiment is not possible in the reality and that is why the measure of the deadweight will always be an estimation. A high deadweight means that the contribution of the intervention to the outcome is low and the deadweight percentage would be deducted from the total quantity of the outcome.

The first outcome considered is the attraction of high-risk marginalized users and the corresponding financial proxy has been determined calculating the cost of one year in prison in the Netherlands multiplied by the number of clients who would come back in prison according to the reoffending rate in the Netherlands. The value expressed in monetary terms is 2.596.464 €. The deadweight drives the analyst to consider the following question “what would have happened to the considered group of people without the intervention?”. Actually, I have already taken into consideration the question above by considering the reoffending rate in the

Netherlands (45%) during the calculation of the monetary value of the outcome. I decided to discount this percentage directly during the outcome's calculation because I wanted to use the deadweight to catch other smaller shades and to adjust the data from the literature. Therefore, in regard to this outcome, I suppose a deadweight amounting to 5% because I consider that not all the 45% of the clients would have a relapse without the intervention as the literature suggests.

The next component required to establish the impact is the displacement that shows how much the outcome displaces the other outcomes: the first one ("to attract high-risk marginalized users") is the only outcome with a percentage of displacement among the evaluated ones. I suppose a displacement amounting to 15% for this outcome because of the issue related to the neighborhood mentioned in the previous paragraphs. Actually, the displacement would be related to the stakeholder "neighborhood" but, since I did not evaluate the discomfort of the neighbors for the presence of the facility in the quarter, I decided to move the displacement by putting it in relation with the outcome "to attract high-risk marginalized users". The argument behind this choice is that the fact of taking away the clients from the prison by attracting them could increase the perception of lack of security of the neighborhood. However, the percentage is not high because the organization carries out a range of strategies in order to maintain good relationship with the neighbors such as the sweeping service daily realized by the clients in the quarter and the meeting every three months between the neighborhood commission and the organization.

The third factor that has to be considered is called attribution and it takes into consideration how much of the outcome is caused by the contribution of other organizations or people. As also the Social Value UK guide reminds, it will never be possible to define a complete and accurate assessment of attribution and the meaning of the stage is more about being aware that the analyzed intervention it may not be the only one contributing to the change observed. Concerning the intervention analyzed, it is important to underline that AMOC is the only facility in Amsterdam with a specific target group composed by European homeless people and that is why the outcome produced could be almost entirely attributed to AMOC. The percentage of attribution

discounted from all the evaluated outcomes refers to a program called “methadone pilot” addressed to 10 clients of AMOC user room. The methadone pilot is a program managed by the organization together with the Health Authority that aims to reduce the consume of drugs of 10 clients by giving them the methadone. The clients that are taking part to the program are only the ones who declare the intention of reduce/stop using drugs. Referring to the first outcome I consider that 10 clients out of 76 will follow the methadone program: 13,2% would be the percentage of clients that would reduce their drug use also through the methadone program and subsequently the probability to commit crimes related to the drug addiction. Therefore, the outcome is the result of two interventions (DCR and methadone pilot). I assume that both interventions are responsible for 50% each of the evaluated outcome. Therefore, I will not use 13% as the attribution rate, but instead 6,6% (the 50% of 13,2%). On a similar note, the attribution would be 7,8% for the other outcomes because they are evaluated already considering the drop out of 12 clients: 10 clients on the methadone program over 64 clients (net of 12 drop outs) gives 15,6%, which divided by two gives 7,8%.

The last assessment is the drop off and refers to how long the outcomes last. According to Social Value UK «in future years, the amount of outcome is likely to be less or, if the same, will be more likely to be influenced by other factors, so attribution to your organization is lower». The drop-off is calculated only for outcomes that last more than one year. In my analysis, I consider the drop off 0% for all the evaluated outcomes. The reason of this choice is that the majority of the outcomes end when the period of activity ends. Inputs and outcomes are repeated every year: the investment from the PA to the organization is provided every year and the outcomes arise every year as long as the client is attending the facility.

The impact (value after the deduction of deadweight, displacement and attribution) related to the first outcome, the attraction of high-risk marginalized users, is **1.958.266,13 €**.

The second outcome is the reduction of blood-borne diseases among clients (Hepatitis C; HIV) evaluated with the cost-saving for the clients who do not get sick

thanks to the user room attendance (total value: 2.176.000 €). In this case deadweight, displacement and drop off are 0% and the attribution is 7,8% because of the methadone pilot that helps the clients to reduce the drug use and the probability to contract blood-borne diseases. The deadweight is already taken into consideration in the calculation of the financial proxy by looking at the percentage of users that are at risk of contracting the HepC (85% in the Netherlands) and the HIV (0% in the Netherlands). The impact of the outcome is **2.006.272 €.**

The next outcome is the reduction of drug overdose deaths evaluated with the cost saving in first aid (ambulance) for the number of clients at risk of overdose death (2% in the Netherlands) according to the EMCDDA data. The deadweight is already included in the financial proxy by considering the number of clients at risk of drug overdose death. The displacement and the drop off are 0% and the attribution is 7,8% for the methadone pilot that reducing the consume of drugs of the clients is also reducing the probability to have an overdose. The impact of this outcome is amounting to **708,10 €**.

The following outcome is the increase of the feeling of support of the clients that I have evaluated with the cost-savings of a psychological therapy of 1 year. This proxy is the weakest one because it is not proved that a psychological therapy always reaches the goal of reduction of the feeling of loneliness of the patient. Even if the proxy is not the strongest one, the outcome is emerged from the focus group as one of the most important and that is the reason why I decided to evaluate it. The deadweight, displacement and drop off are 0% and the attribution is always 7,8% because of the methadone pilot that give them the possibility to reduce the drug consumption and the psychological problems related to it. The impact of this outcome is amounting to **260.815,36 €.**

The last outcome taken into consideration is the drop-out of the clients, which is referred to the first outcome in which I had considered the effect on 76 clients instead of 64 (76 clients - 12 drop out). All the assessment factors are 0% except for the deadweight (5%) because I suppose that not all the 12 clients came back to prison after the drop-out. The negative impact of this outcome is **- 865.488 €.**

The impact calculation is carried out by following the steps of the Value Map:

- Financial proxy multiplied by the quantity of the outcome gives you a total value. From this total you deduct any percentages for deadweight or attribution.
- Repeat this for each outcome (to arrive at the impact for each)
- Add up the total (to arrive at the overall impact of the outcomes you have included)[59]

By summing up all the considered financial proxies (after deduction of deadweight, displacement and attribution) the total impact amounts to **3.360.573,59 €**.

At this stage, all the information required to the calculation of the Social Return On Investment (SROI) are collected. The final stages enable to summarize all the recorded information of the previous steps. The first stage in calculating the ratio would be the projection of the value of the outcomes into the future (year 0-1-2-3-4-5) by considering the drop-off. However, our outcomes last as long as the period of activity and the inputs and outcomes are repeated every year (drop off: 0%): that is the reason why I suppose that the SROI will remain unchanged for the following 4 years. According to this argument, my analysis stops at the year 1 without taking into consideration the temporal wake of the outcomes.

Once the value of the impact for each outcome is established and the total amount of impact is calculated, the following step refers to the definition of the present value, the total present value, the net present value, and eventually the SROI. The present value is the total value of the impact discounted by the discount rate 3,5%: it amounts to **3.246.931,00** €. The discounting process is based on the theory that «people usually prefer to receive money today rather than tomorrow because there is a risk (eg, that the money will not be paid) or because there is an opportunity cost (eg, potential gains from investing the money elsewhere). This is known as the 'time value of money'»[60]. The discounting rate used in order to calculate the present value in this analysis correspond to 3,5%: there is a range of different discount rates but the one that is usually recommended for the public sector from the HM Treasury's Green

59 http://www.socialvalueuk.org/app/uploads/2016/03/The%20Guide%20to%20Social%20Return%20on%20Investment%202015.pdf

60 http://www.socialvalueuk.org/app/uploads/2016/03/The%20Guide%20to%20Social%20Return%20on%20Investment%202015.pdf

Book is 3,5%. Moving forward in the Value Map, the total present value is calculated by summing up the present value of each year but, since I considered only the first year of activity, the total present value will correspond to the present value of the year 1 (3.246.931,00 €). The Net Present Value (NPV) is calculated by deducting the total amount of inputs from the total present value:

NPV = [present value of benefits] - [value of investments]

Therefore, the net present value of the analyzed drug consumption room would be:

NPV = 3.246.931,00 € - 1.687.613,50 € = **1.559.317,50€**

At this point all the information needed in order to calculate the ratio (SROI) are available:

SROI ratio = Present Value / Value of inputs

SROI ratio = 3.246.931,00 € / 1.687.613,50 € = **1,92**

The SROI ratio is the result of the relationship between the monetary value of the generated change (present value) and the investments required in order to achieve this change (inputs). The SROI identifies the value generated from every euro invested. Therefore, for the considered DCR there are 1,92 € of social value for every 1 € of investment. The result shows that the overall social impact, resulting from the reduction of the risks related to the drug use for PWUD, is estimable by comparing the Present Value (3.246.931,00 €) with the total amount of investments (1.687.613,50 €). Therefore, the forecast analysis predicts that the next year every euro invested in the facility (AMOC DCR) will create 1,92 € of social value.

To sum up, the forecast analysis shows that the number of clients attracted from the DCR will be composed of 76 people (even if there will be a drop out from 12 clients); the social impact will amount to 3.374.045,28 € and the SROI ratio to 1,92. An important point that has to be underlined is that the process that leads to the SROI ratio is more important than the ratio itself. The whole process is useful in order to identify a logical

framework to think about the impact that the organization would like to create through the activity in order to achieve the intended outcomes.

There are many critical points arising by using this tool: the complexity of the collection of information and data; the fact that not all the value produced could be associated to a monetary value and the arbitrary decisions regarding indicators and proxies. Concerning the result of this analysis the major limits are related to the fact that not all the outcomes have been evaluated through a financial proxy and that some proxies are weakest than others. The reason is that I attributed a financial proxy only to the outcomes related to the clients because limitations in terms of time and resources led me to choose to evaluate only the major outcomes related to the most important stakeholder: the clients. As mentioned in the first part of the previous paragraph, some outcomes related to the clients could be also be referred to other stakeholders such as the Health System and the Public Administration. In order to not double-count the outcomes, I evaluate them by referring them directly to the clients, even though another arrangement remains possible.

Moreover, among the different financial proxies, some of them are strongest than others. For example, the strongest financial proxy is the one that is measuring the capacity of the DCR to attract high-risk marginalized users through the cost of a day in prison in the Netherlands for PWUD. Since all the clients are ex-prisoners is realistic to say that all the people attracted from the user room are avoiding the prison by attending the facility. On the other hand, the weakest financial proxy is the one related to the increase of the feeling of support of the clients. The reason is that this proxy is measured by calculating the cost of a psychological therapy in the Netherlands, but it is not certain that a psychological therapy always has the effect of increasing the feeling of support and the self-confidence of the patients.

In conclusion, the results of the evaluation process show that the intervention is producing a certain amount of social value (3.246.931,00 €) associated to the evaluated outcomes and that the activity is generating an overall positive social impact (SROI ratio = 1 : 1,92).

Total	3.360.573,59		0,00	3.360.573,59	0,00	0,00	0,00	0,00
Present value of each year			0,00	3.246.931,00	0,00	0,00	0,00	0,00
Total Present Value (PV)								3.246.931,00
Net Present Value (PV minus the investment)								1.559.317,50
Social Return (Value per amount invested)								1,92

3.8 Future perspectives and new evaluation tools

Once the SROI is calculated the analysis is still not completed, there are other important steps that have to be fulfilled: reporting the results to the stakeholders, communicating and using the results and embedding the SROI process in the organization. This work is functional to my Master thesis with academic purposes, which means that the concrete use of the study results in order to improve the intervention is not planned. However, by realizing the evaluation process I made some considerations about missing information and improvable tools that are useful to make new proposals and to improve the available evaluation material of the organization.

Measuring the social impact of an activity requires the collection of a huge quantity of data and information related to the intervention itself. By collecting the data, it is possible to understand what is missing and how to improve the available material for a better evaluation of the social impact. I use this paragraph to describe the change and the proposals that I have hypothesized in order to evaluate the social impact in a more complete way.

The first element of improvement comes from a consideration: the outcome that is considered as the most important from the staff members does not have good indicators. According to the "*Focus Group I – expert meeting on AMOC DCR outcomes*" the reduction of the feeling of loneliness of the clients represents the most relevant outcome for the staff members. Nevertheless, there is not a good available indicator able to collect information about this outcome in an effective way. That is the reason why my first proposal concerns the creation of a customer satisfaction survey built *ad hoc* for the DCR managed by AMOC. Actually, the organization *De Regenboog Groep*

already has a customer satisfaction survey addressed to all the clients of the eight locations that is carried out every year. This survey features some substantial limits: the results of the survey are available only in an aggregate form; the survey is the same for the drop-in and the user-room; it is available only in Dutch.

The first limit concerns the fact that the survey is managed by an external enterprise (*DRG Deelnemersonderzoek*) that is handing out the survey to all the walk-in-centers of *De Regenboog Groep* once a year. All the answers from the clients to the survey are combined afterwards and the results are given back to the organization in an aggregate form. The results of the customer satisfaction survey are then available only for an internal use. The way in which the survey is carried out is not complying with the disparities of the different locations in terms of size, target, management, and so forth.

The second limit is about the missing distinction of the survey into drop-in and user room, which means that the questions are the same regardless of the *status* of the client (just homeless or also drug addicted). The clients from the user room are more problematic than the ones attending just the drop in because besides the homelessness they also have to deal with their drug addiction. Their addiction affects in a negative way multiple aspects of their lives such as the research of a job or their health. A different customer satisfaction survey for the clients of the user room might help into have a better image of their situation by asking them specific questions.

The third limit regards the language in which the survey is delivered. The current survey is written in Dutch because all the locations from *De Regenboog Groep*, except for AMOC, host Dutch clients. As we have already seen, AMOC is an exception because the target is composed by European homeless people. The clients from AMOC need to fill the survey with the help of the staff for the translation. The presence of the staff, while the clients are answering to personal questions related to the facility, does not represent an optimal condition for the fairness of the answers.

Against this background, I propose the creation of a new customer satisfaction survey *ad hoc* for AMOC. The survey should be written in English in a way of every

clients would be able to understand the questions and answer properly. Moreover, it should be a distinction between the survey delivered to the clients of the drop-in and the clients of the user room in view of their more problematic situation. The main goal of the survey will be the evaluation of the outcomes “reduction of the feeling of loneliness” and “the stabilization of clients’ lives in psycho-social aspects” through specific questions on this topic. Besides the closed-ended questions, I would insert a part with some open questions in which the feelings and the opinion of every clients could arise in a full way. A model for the implementation of this part of the survey could be pick up from the questions I have used for the focus group with the clients. In that occasion, I divided the questions in three areas: feelings, health and lifestyle. The questions in the section “feelings” and “lifestyle” are useful to collect qualitative information regarding the outcomes mentioned above by asking for example “do you feel supported by the staff of AMOC?” or “do you think that the quality of your life is higher thanks to AMOC?”. The section “health” could be useful in order to collect more information about the health of the clients by asking for example questions regarding their awareness of the risks connected to the drug use. This part adds qualitative information useful to better evaluate the outcome “reduction of the risks related to drug consumption (such as HIV, Hepatitis C) by improving clients' health”. If the clients declare that they are aware of the drug consumption related risks, they probably do not share needles and syringes during the closing hours of the user room by avoiding the risk of contracting Hepatitis C or HIV. This information is valuable also in view of another limit to the evaluation process that is the missing data regarding the medical situation of the clients because of privacy reasons. I will return to this topic further in this paragraph.

The part of the survey dedicated to the open questions could be also used during the meetings with the clients of the user room (once a year) in order to discuss the anonymous answers and try to improve the success of the intervention.

Thanks to such a new structure of the survey, the new indicator of the outcomes “reduction of the feeling of loneliness of the clients” and “stabilization of the lives of the clients on psycho-social aspects” would be the number of the clients who declare

respectively to feel less lonely and more stable thanks to the user room's attendance. In my analysis I have used as main indicator for both outcomes the information collected from the focus group with the clients. A survey in which the same questions are proposed to all the clients would represent a better indicator of these two important outcomes.

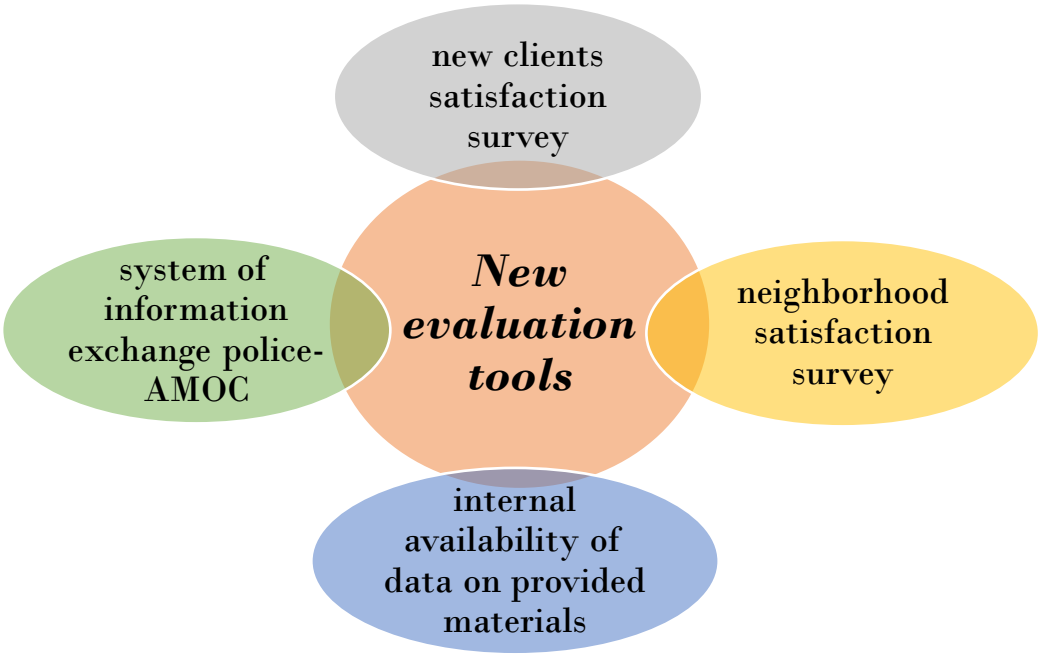
Another limit that I have faced during the evaluation process is the lack of registered data concerning the medical situation of the clients. The medical conditions of the clients are not reported in the documents of the organization because of privacy reason. One of the most important outcome of the DCR is the reduction of the risks related to the drug consumption such as the possibility to contract the HIV or Hepatitis C. The first DCRs have been created to fight against the spread of HIV and Hepatitis C in the 90s. While the clients are attending the user room, they have access to clean and hygienic material for the drug consumption. This explains why it is sure that the clients, during the time in which they are inside the facility, they cannot contract any blood-borne diseases. In this sense, the facility's attendance ensures that the clients are not in danger of contracting the disease inside the facility by reducing the drug consumption related risks. Nevertheless, because of the lack of information about the medical situation of the clients it is not possible to check if some clients contract blood-borne diseases outside the facility during the same period in which they are attending the user room. According to the focus groups with the staff and the clients, they should have a greater awareness about the risks connected to the drug consumption by attending the facility. The implication would be that also if the clients are not physically inside the room, they are aware of the risks and they adopt safe and hygienic attitudes during the injection. Without data regarding the medical condition of the clients, this aspect is hardly evaluable. Nevertheless, the new customer satisfaction survey, through the section dedicated to the clients' health, would be useful to collect information on this topic.

Another important issue emerged during the analysis is the relationship between AMOC and the neighborhood. One of the outcomes of the user room is the reduction of the public nuisance by providing to PWUD a space in which use drugs

alternative to the street and by reducing the number of discarded needles and syringes from the streets of Amsterdam. Nevertheless, because of the DCR, there is a high presence of homeless and PWUD around the facility that could create some problems with the neighbors. In my analysis I have included this element in the evaluation process by discounting from the first financial proxy the percentage of damage created towards the neighbors (displacement: 15%): taking away the clients from the prison by attracting them could increase the perception of lack of security of the neighborhood. The displacement percentage, referred to the discomfort of the neighbors, has been choose in an arbitrary way. I made this choice by considering different elements such as the fact that the organization is implemented multiple actions to decrease the discomfort of the neighbors (meetings, sweeping activities). However, it would be useful to dispose of a tool able to give a more precise percentage of the feeling of insecurity of the neighborhood. In this regard, I propose the creation of a satisfaction survey *ad hoc* for the neighbors. It can be proposed during one of the four meetings that the organization has with the neighbors committee. The main goals will be the identification of a discomfort percentage to use in order to calculate the displacement and the highlighting of the possible improvements in the relationship between AMOC and the neighborhood.

One of the two negative outcomes of the user room is the aggressive behavior of the clients after their expulsion. The interview with the police officer of the Central Station of Amsterdam declares that sometimes the banned clients take on a bad behavior. However, the number of clients affected from this phenomenon remains uncertain. In the Value Map I assumed that 2 clients out of 4 banned clients will have an aggressive behavior after the expulsion. This number comes from a supposition based on the interview with the police officer. I propose the establishment of a systematic information exchange between the police stations in Amsterdam and AMOC in order to understand how many clients take on an aggressive attitude by taking part in fights or other crimes after their expulsion. Thanks to this kind of information, the gravity of this problem will arise and it would be possible to say if it is something that affect only a small group of the banned clients or if it is a more serious issue that has to be handle in some way.

Finally yet importantly, another obstacle to the evaluation process is the difficulty to get data regarding the material provided by the health authority. As already mentioned, the health system provides a wide range of materials for the drug consumption to the DCR. However, the data relatives to the quantity of the provided material are not included in the internal accountancy of the organization, except for the number of needles. The internal availability of this kind of information would be useful in order to clarify the investment of the health system in the project.



The organization do not usually evaluate the social impact of the Drug Consumption Room that manage. In view of my thesis work, I believe that this kind of evaluation referred to the user room brings many positive aspects. In the first place, the analysis shows that the activity produces a value that encompasses not only economic but also social issues. The activity is for example affecting the feeling of support of people who use drugs and the public nuisance. Those elements are part of a broader definition of the concept of value. According to Social Value UK: «every day our actions and activities create and destroy value; they change the world around us. Although the value we create goes far beyond what can be captured in financial terms, this is, for the most part, the only type of value that is measured and accounted

for. As a result, things that can be bought and sold take on a greater significance and many important things get left out». Thanks to the evaluation of the social impact, it is possible to try to capture the value created by the activity in its entirety. The process is complex, it requires time and resources and it always includes some weaknesses in the analysis. Nevertheless, the reconstruction of the whole process of creation of value gives the possibility to better understand and communicate the impact of the activity and to improve the activity itself. The SROI ratio of the AMOC DCR shows that the activity generates a positive social impact and the logical framework behind gives the possibility to understand what the possible improvements are. Thanks to the SROI framework, the organization can improve the ability to account and manage the social value created also by identifying new evaluation tools as I tried to do in the current paragraph.

Moreover, the DCRs are featured in seven countries in Europe and there are still many countries that decide to not implement this kind of harm reduction intervention, such as Italy. The social impact evaluation of this kind of facility is important also to increase the awareness about the costs and the benefits of a user room in an international level. Concerning the DCRs, the positive impacts for the society are not immediate. In addition, the debate around them leads to ethic issues related to the permission to consume illegal drugs inside a facility. For these reasons, the necessity to show the costs and the benefits produced by the activity in an impartial way seems to be urgent.

In conclusion, the importance of this thesis project relates to the demonstration of an overall positive social impact of the analyzed Drug Consumption Room; to the identification of a set of new tools in order to improve the accountancy of the social value created and to the provision of a detailed analysis about a current controversial issue in Europe.

Conclusion

This thesis aimed to achieve a threefold goal: to evaluate the social impact generated by the analyzed DCR in Amsterdam by using the SROI; to explain the whole process of creation of social value; to identify new possible evaluation tools.

The thesis reaches the first goal through a forecast SROI analysis that tries to predict how much social value will be created in one year if the activity meet the intended outcomes. The result shows that the DCR will create an overall positive social impact with a SROI ratio of 1:1,92, indicating that an investment of 1 € delivers 1,92 € in social value.

The thesis reaches the second goal by building a Theory of Change (TOC) through the tool of the Value Map. The tool provides a logical framework that make clear how the activity creates change by considering the cause-and-effect chain of inputs, outputs, outcomes and impacts.

The thesis eventually reaches the third goal by identifying what have been the missing information during the evaluation process. Starting from them, the thesis indicates some proposal concerning new evaluation tools that could be implemented by the organization.

Besides, this work also aims to give a background on the harm reduction topic in order to enable the reader to contextualize the case study inside a faceted issue. This objective is carried out in *Chapter I* and *II*.

However, the thesis also features limitations in the SROI analysis related to the fact that not all the intended outcomes have been associated to a monetary value and to the arbitrary decisions regarding indicators and proxies.

Nevertheless, based on the overall positive results emerged from this work, the organization should consider to adopt the evaluation of the social impact of its activity as a useful tool to better understand and communicate the social value created.

The results of a systematic evaluation of the social impact generated by these facilities could be useful also to add material on the topic in the international literature: many countries in Europe, even if they have some kind of harm reduction interventions, do not have DCRs (such as Italy).

In conclusion, SROI analysis referred to the DCRs could be useful in a both micro and macro level: for the organization provider of the service in order to better understand and communicate the impact to the stakeholders; for the international political debate on harm reduction in order to add material relates to the social impact of the DCRs.

Appendix: Focus groups and interviews

Collecting qualitative information

4.1 Focus group I – expert meeting on AMOC DCR outcomes

This focus group is focalized on the outcomes produced by AMOC and the DCR on the clients in order to explore them and to define a ranking among the outcomes.

Participants:

Agnieszka Franczak - social worker

Irina Morozova - user room worker

Jorn Dekker - drop in worker

Outcome number I – Loneliness reduction

S: «Do you think that AMOC clients feel less lonely and more supported by attending the facility? »

A: «Yes, this is something that I hear from the clients if they are in a "good mood". They say that thanks to AMOC they meet other people in the same situation. I remember for example one of our clients from the user room that told me that AMOC is the only place in which people take him seriously and in which he can have a normal conversation. Outside AMOC he doesn't feel part of the society. This is only one example but from my daily experience I can say that clients are not coming in AMOC only for food, but they come because here **they feel that they belong to something**. So, eventually, I think that the facility reduces the loneliness of our clients».

J: «I can give you another example. We have this client at the moment that stopped using drugs but he still wants to come inside the user room to have a coffee and talk with his "colleagues" because he considers the **DCR also as a place to socialize**. I think loneliness reduction should be considered as one of our goals. Also if we talk about AMOC in general, not only about the user room, people come inside everyday also to talk with other people».

I: «I have seen multiple times people come to the drop in downstairs just to socialize with others because on the street they are a sort of invisible. **Our clients share problems and they feel more protected** here than on the street but then when they leave the building they leave alone, one by one. There are only few groups that are staying together. Anyway I believe that the loneliness is reduced for sure».

J: «When they eventually get a job or a house they still come back to AMOC to socialize a bit because there is no network around them».

A: «I think that our specific target group (marginalized people from foreign countries) desire to be together but at the same time they don't trust each other until the end. They have a lot of reserve».

Outcome number II – Reduction of overdose related deaths

S: «Do you consider the reduction of overdose related deaths as an outcome of the DCR and do you have any experiences with overdoses inside the facility? »

I: «In one year we had three cases of overdose. One person was picked up by ambulance and in the other two cases we managed ourselves. The only thing is that in the user room there are not so many people so is easy to see if someone is having an overdose but the drop in is really busy and if it happens there is more difficult to see».

J: «One time, a couple of years ago, we were in time to save a guy that was in the toilet having an overdose. We called the ambulance because he was in really bad conditions. The ambulance came and they had to shoot up with the naloxone a couple of times and it was the only time I couldn't prevent anything. So eventually I think that the **overdose prevention really works**».

S: «Did somebody die from overdose in the DCR? »

J: «Not in the DCR. It still never happened».

A: «What I think that is important is that we all have trainings to know how to deal with overdoses. Since I am working in AMOC for me is important to recognize if is an up or down overdose and what kind of drugs are the cause also to instruct my clients

on the risks and consequences of drug abuse. **All the staff has a knowledge about drugs**».

J: «What I do when there is an intake or if I notice that a client is using something new or is combining drugs I always try to tell him/her some tips that he/she should consider, because for example sometimes a downer plus a downer is even worse than heroin».

Outcome number III – Social inclusion

S: «Do you consider the social inclusion of the clients as an outcome if the DCR? »

I: «I think that if people feel excluded from the society they have a more provocative behavior. In general people are more relaxed if they feel they belong to something».

A: «We, as social workers, we help clients by motivating them in the research of a job. We have contacts with job agencies but we have to consider also the internal motivation of the clients because some of them are coming here with this goal but is not simple to find a job because of drug addiction. **We try to find solutions to move them closer to the society**. We start with some pilots for users such as the methadone pilot».

J: «Social inclusion if we talk about AMOC target group is a **complex issue** because there is a big gap between AMOC and the society of the Netherlands».

A: «The Dutch policy is based on the concept that if you want to stay in the Netherlands you should be able to be economically independent and is not the case of our clients. With this statement our clients are already excluded from the society».

J: «So I think we can do as much as we can do but I don't know if we can talk about social inclusion».

S: «Do you also try to convince people to come back to their country because it would be simpler for them to get into the society? »

A: «I never convince people to come back to their country unless they want to. I am honest with them, I show them what they need to do to build their life in the Netherlands and I alert them from the beginning that it would be difficult. If they want to come back we always **try to connect them to the society in their country of origin** by talking with their familiars, friends or with other associations with shelters for homeless».

I: «From my perspective society looks to them like something they are not belonging to, but I think that the fact that they **come to the user room or the drop in brings some progress**».

S: «What kind of jobs addicts are able to do? What are the **most common jobs** they find? »

I: «Some of them sell newspapers, some people help to clean cafes, and others do house-cleaning».

A: «Clients that are really addicted cannot have a job but some of them they can still work and have a normal life. Sometime I feel that this is our goal because I think they need to work. Our **goal is to help vulnerable people**, to take care of them and to make sure that they are in good health conditions».

Outcome number IV – Reduction of drug related diseases (HIV, Hepatitis C)

S: «Do you think that by attending the DCR the clients reduce their risk of contracting drug related diseases? »

I: «Thanks to the provision of sterile injecting equipment **they never share needles** and they are also aware of the risks. There are also clients who come only for needles».

A: «I agree that **they are aware** and I can give you an example. When I was working in the night shelter people from the user room came during the night to ask for clean needles and I found it very responsible from their side. They know what are the risks of sharing needles. I was impressed. When I came here from Poland and I saw the user room for the first time I was shocked that something like this exists but then when I saw people happy to have the possibility to inject drugs in a safe environment I changed my opinion.»

J: «I want to add that they usually also **ask for tests** if they think they have problems and so we send them to places in which they can check».

Outcome V – Stabilization of clients' life in psycho-social aspects

S: «Do you think that the clients stabilize their life by attending the DCR and do you think that this can eventually contribute to stop using drugs? »

J: «There are a lot of reasons for which people use drugs, like traumas. If they want to stop using they have to deal with their trauma before, that is not simple for our clients because they don't have health insurance. So what eventually they can do is to attend the methadone pilot to stabilize their life that is still something that we provide through the user room. **Thanks to the DCR they can stabilize their use and their life** and they can focus on other aspects of their life».

A: «We don't have to convince the client to stop using. If they come to me and they say they want to stop, then we need to cooperate with institutions. Thanks to the methadone pilot for example people from AMOC, so without health insurance, can attend the methadone program. But eventually **stop using is not our goal, we accept them as they are**».

J: «**I think we are the first step after the street** so we are useful for them to stabilize their life and after that people that leave the user room, probably they are still using and they still have problems, but eventually they might find a way back to a "normal life" again but this is something we never see».

A: «I have an example of one client that now has a stable life who was also addicted to alcohol and heroin and now he is helping our clients. So I think is possible sometimes».

J: «There are also people that are **still using and they have a job, they have a house and they are pretty stable**. It happens».

Final considerations

S: «Do you have any final considerations or other aspects do you like to underline? »

I: «In my opinion, the thing is that our actions are really limited by our government and I think that most of our clients are in need of psychological therapy or psychiatric. The majority of the people don't decide to become homeless and it happens due to bad circumstances and to leave in the street is a traumatizing experience. We cannot provide this help to this kind of people that are completely outside the society».

A: «Our cooperation with institutions it starts to become better but it is still difficult. Sometimes, as a social worker, **I feel like I am between two walls: clients and institutions,** especially if we ask for psychiatric help. Sometimes we need to ban the clients because they are aggressive for their mental state and then they start to make problems outside of AMOC and only at that point the government starts to do something for them. It seems like we need to wait until that moment in which the person starts to make trouble outside so it would be possible to find a solution for them.»

Outcomes ranking

Could you please rank the proposed outcomes from the most to the least important?

4.2 Interview with a police officer from the Central Station of Amsterdam

S: «How would you describe the relationship between AMOC and the police?»

M: «From my point of view the relationship is very good because we work together a lot. Every week I call AMOC and I am in contact with AMOC's social workers because sometimes we have difficult clients and we don't have a clear idea about what to do with them. So what we try to do is to find a way to deal with the person and his/her situation: sometimes is very easy, I bring him or her to AMOC and the problem is solved; sometimes is much more complicated for example if the person doesn't want any help.

So **I believe the relationship is very good because we work together and the collaboration is going well so far. I'm happy with AMOC**. I know is not the same for all the police stations, here is easier because if we have possible clients from AMOC we bring them there and the problem is solved but for example the police station that is in the area (De Pijp) has a different idea because they see all the clients hanging around. So, from my point of view, I am very happy and I really appreciate our collaboration but I can imagine that other colleagues think different about AMOC».

S: «Is only your team that is collaborating with AMOC?»

M: «As far as I know it is only us. We are the only police in Amsterdam that collaborates with AMOC.»

S: «What are in your opinion the positive and negative effects of AMOC in terms of public order and safety?»

M: «One positive effect is for example the fact that is better for us to have less clients here (near the Central Station) for the safety feeling of travelers. I find also positive that there is an actual place where they can go if they want to have food, a shower or ask for the night shelter. **This is really what we need, if we don't have this in Amsterdam those people would be on the street all the time**.

Since our team works with AMOC we have 46 people that are back to their country thanks to AMOC and I think one or two people came back but all the other people didn't come back and I think this is also positive. The focus is not only about "we will keep you

here" but is also "here you have no rights basically so it would be difficult for you, that is why is better to come back to your own country".
A negative aspect is that in the area of AMOC there are a lot of clients hanging around and this is not always good for public order but, in my opinion, we really need a place like AMOC and that is why I think that it is anyway positive that it exists.
Basically we move the problem from the Central Station to *De Pijp*».

S: «There are clients that are banned from AMOC. Do they come back to the Central Station? »

M: «Yes they come back here because it is warm and safe. I have an example, there was a client that was banned from AMOC and he was causing problems in the Central Station. When it happens it is our problem again and then we try to think about different solutions».

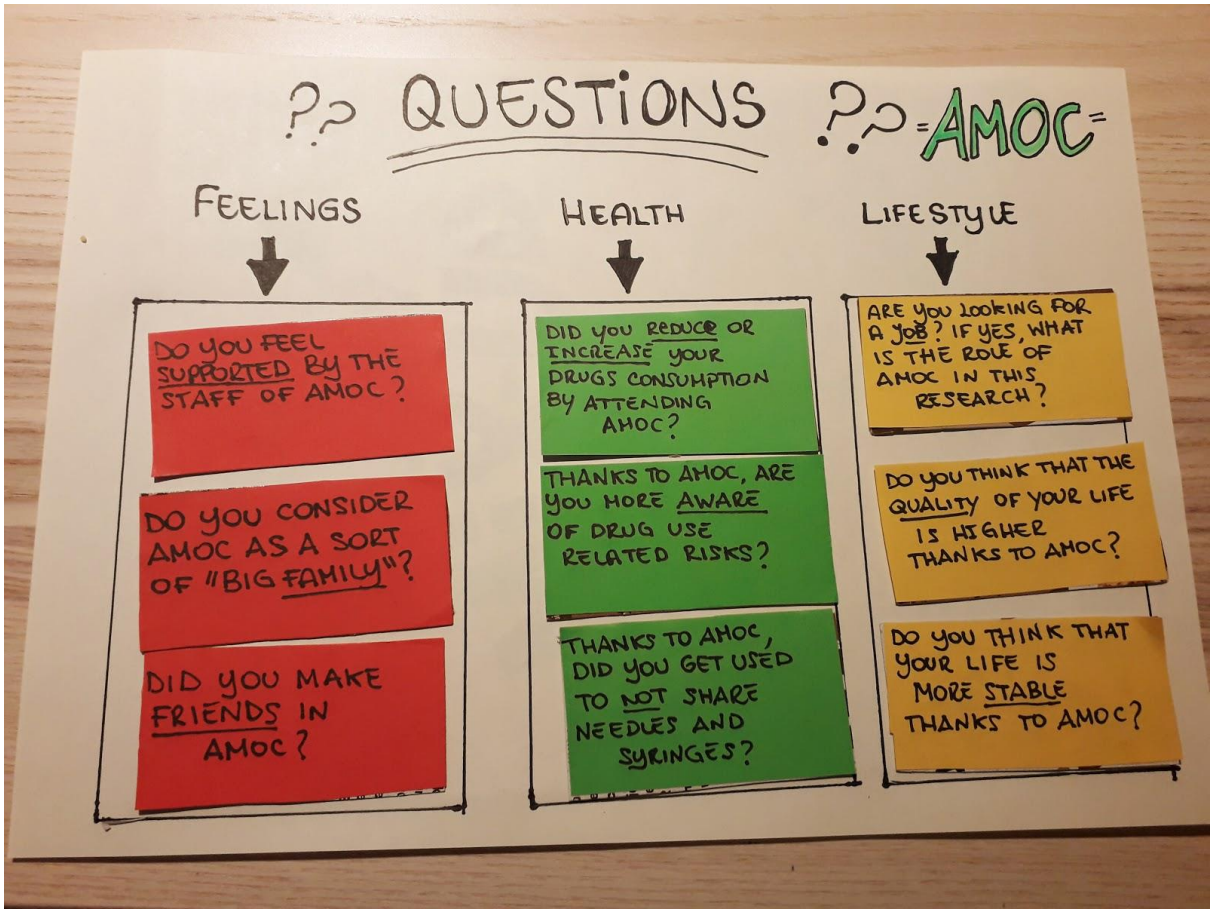
S: «Do you think that the presence of the Drug Consumption Room in AMOC is useful in terms of public order? »

M: «I think the presence of the DCR keeps the environment safer because there are no needles on the street, people who use drugs are not using them in public space. I think is very positive to a place like that inside, definitely».

S: «Do you have any final considerations? »

M: «**I cannot imagine a city without AMOC** because there are so many European citizens coming to Amsterdam and they all think it is easy to find a job here but the majority finds out that it's so difficult because they have no rights, no health insurance. That is why is very important to have an organization specialized in helping those people in Amsterdam».

4.3 Focus group II - meeting with clients



The focus group has been realized in the form of a conversation with two clients focused on three different aspects: **feelings**, **health** and **lifestyle**. The three different categories are related to the outcomes that I figured out through the Value Map and that I validate thanks to the first focus group. The "*Focus Group I – expert meeting on AMOC DCR outcomes"* showed me that the most important outcome of the DCR, for the people who work in the organization, is strictly related to the feelings of the clients. According to the opinion of the staff members, the clients feel less lonely and more supported by attending the facility:

A, social worker: «I can say that clients are not coming in AMOC only for food, but they come because here **they feel that they belong to something.**»

J, drop in worker: «he (a client) considers the **DCR also as a place to socialize**»

I, user room worker: «**Our clients share problems and they feel more protected** here than on the street»

These considerations brought me to realize the category “feelings” to understand if the clients agree with this picture or not. What turned up by asking them about their feelings is that there is a Dutch word that would be able to represent their emotions about AMOC and the DCR: “**gezellig**”. I can translate this word as “friendly” or “welcoming” but as far as I understood from the Dutch culture there is not a real translation able to bring justice to the real meaning and value of this word. I would say that they consider the user room as a nice place in which they can spend time with other people, socialize and share problems with others in a similar situation. They believe that the user room is not only a place in which they can use drugs. There is something more that is going on inside the “room” and it is related to a reduction of the feeling of loneliness and to the reassuring idea of having a place in which they can have a coffee and talk with others. From the perspective of the interviewed clients, even though they consider the user room as a nice place to socialize they do not believe that it could be considered as a “big family” because «family is something else» and it is related to blood ties.

Another important aspect, that was highlighted also from the user room worker, is that the clients usually are not friends outside the facility. They spend time together during the day but then, despite some exceptions, «when they leave the building they leave alone, one by one». From the point of view of the clients they find hard to trust the other clients outside the user room even if they spend a lot of time together inside it.

They also think that the staff is available to support them if they need something even if one the interviewed clients declare to have find a job without asking to the staff to help him in his research. However, from what I have seen during my internship period, I would confirm the big commitment of the staff in the research of solutions

to clients' problems even if it is not always simple to find one the specific target of people to which the service is addressed.

Thanks to this conversation with the clients, I have also confirmed the information that the staff members gave me about clients' awareness on drug-related risks. They are very aware of the risks and, for the clients who inject, they always try to use clean needles and syringes. One of the clients also declared to have reduced a bit his drug consumption by attending the facility and stabilizing his life. They would not say that the quality of their life is higher thanks to the facility but it is anyway useful to stabilize their life in psychosocial aspects and to provide them a place to stay if they need one.

As a conclusion, I would say that the user room plays an important role in clients' lives by providing them the possibility to have a space in which people take care of them and listen to their problems.

4.4 Survey: Harm Reduction, a comparison between the Italian and the Dutch model

In November 2019 a multidisciplinary group of experts from Bologna came in Amsterdam to visit a DCR managed from *De Regenboog Groep* in order to study this kind of HR intervention and to improve their services in Italy. The aim of the survey is to understand the main differences between the Italian and Dutch harm reduction interventions. I propose a survey to one of the expert of the mentioned group from Bologna, Sebastiano Nisi.

1. Would you like to make a comparison between the "Unità di strada" intervention managed by OpenGroup in Bologna and the Drug Consumption Rooms in the Netherlands in terms of offered services, strengths and weaknesses of both?

«The comparison between IDS and DCR is really difficult because they are different services in a different context and environment. The first and most important difference is that the DCR has a fix place where users come and could access to different services. In UDS, the social workers reach users directly on the street offering them needles exchange and counselling.

The DCR gives to the users a place where they can use drugs but also they have the possibility to access to different services, take rest, food, shower, talk to social workers and so on. If I have to find a weakness I would say that the user needs to go to DCR and sometimes is not so easy for them. UDS have a lot of weaknesses but the reach at part of homeless users maybe fix DCR couldn't reach».

2. Do you think that the Italian socio-economic context is supportive towards harm reduction interventions?

From what you have seen in Amsterdam, do you think that the socio-economic context of the Netherlands is more or less supportive towards this kind of interventions compared to the Italian one?

«If we consider the intention of the Italian socio-economic I could say yes, in fact harm reduction was insert in the LEA (Livelli Essenziali di Accesso) couple years ago, but the problem is that never became to harm reduction intervention.

I think the socio-economic context in Netherlands is more supportive in Harm reduction than in Italy. I think the problem is the mentality we have in Italy, the common think about drugs is "or you are a drug users so you are shit or you go to rehabilitation with abstinence and you are fine" there is not something in the meddle. For this reason there are not harm reduction interventions in Italy, or there are very few and isolated».

3. Referring to the harm reduction policies in Italy, what are in your opinion the future prospects in terms of implementation of new interventions and/or improvement of the existing ones?

«I hope we can do something nice, but to be realistic, it is really difficult to do. The problem is that, in Italy, without political support you cannot do anything. So, at now it is really difficult for me to think to improve or create new service in Harm Reduction. Also if you start form the local cites you need to have political support. I think if

someone have a good project that is good and does not matter which government is in charge. But in Italy didn't work like that».

4. Do you think that a DCR, structured in the same way as the ones you have seen in Amsterdam, would work in Italy?

«Yes and no. The thing is that you cannot transfer a service form the Netherlands to Italy without some changes. Beside the political situation, you have different environment and also the users are different. So, we can take something from DCR in Amsterdam but you need to adapt the model for Italian environment».

4.5 Blank Value Map

SROI Value Map

This sheet is designed to help you develop your SROI analysis. If your analysis does not use monetary valuation of outcomes, please use the "Value Map (non-SROI)" tab. For further information please see the "Guidance" tab.

Stage 1		Stage 2				
Who and how many?		**At what cost?**		**Outputs**	**What changes?**	
Stakeholders		**Inputs**			**Outcomes**	Indicator and source
					Outcome description	
Who do we have an effect on? / Who has an effect on us?	How many in group?	What will/did they invest and how much (money, time)?	Financial value (for the total population for the accounting period)	Summary of activity in numbers.	What is the change experienced by stakeholders?	Describe how you will measure the described outcome (including any sources used)

How much?		How long?	
Quantity (scale)	Amount of change per stakeholder (depth)	Duration of outcomes	Outcomes start
Number of people experiencing described outcome.	Describe the average amount of change experienced (or to be experienced) per stakeholder.	How long (in years) does the outcome last for?	Does the outcome start in Period of activity or in the Period after?
		1	

How valuable?		
Express the relative importance (value) of the outcome		
Weighting	Valuation approach (monetary)	Monetary valuation
How important is this outcome to stakeholders? (e.g. on a scale of 1-10) (N.B. To make comparison between outcomes possible, your analysis should be consistent in the type of weighting used).	Describe the monetary valuation approach used to express the relative importance (value) of each outcome. (N.B. If your analysis does not use monetary valuation of outcomes, please use the Value Map (non-SROI) tab of this spreadsheet).	How important is the outcome to stakeholders (expressed in monetary terms)?

Stage 4

How much caused by the activity?				Still material?
Deadweight %	**Displacement %**	**Attribution %**	**Drop off %**	**Impact calculation**
What will happen/what would have happened without the activity?	What activity would/did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Number of people (quantity) times value, less deadweight, displacement and attribution
0%	0%	0%	0%	0,00

Calculating Social Return						
Discount rate		**3,5%**				
Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	
0,00	0,00	0,00	0,00	0,00	0,00	

Total	0,00	0,00	0,00	0,00	0,00	0,00	0,00

Present value of each year		0,00	0,00	0,00	0,00	0,00	0,00
Total Present Value (PV)							0,00
Net Present Value (PV minus the investment)							0,00
Social Return (Value per amount invested)							#DIV/0!

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