Original research article

DRUG CONSUMPTION ROOMS FROM THE PERSPECTIVE OF SOCIAL WORKERS AND CLIENTS

Vojtěch Plitz, Stanislav Ondrášek *, Alena Hricová

University of South Bohemia in České Budějovice, Faculty of Health and Social Sciences, Institute of Social and Special-paedagogical Sciences, České Budějovice, Czech Republic

Abstract

Objective: To identify the attitudes, ideas, and needs of clients and contact centre workers in relation to the possible implementation of a drug consumption room in the Czech environment.
Methods: The qualitative study used semi-structured interviews with two groups of informants: five contact centre clients (IN1–IN5, CL) and six employees/social workers (IN1–IN6, EM). The data were obtained in the contact centre environment, anonymised, and analysed using open coding with a comparison of the perspectives of both groups.
Results: The analysis identified six thematic areas: ideas about the drug consumption room, motivations for use, reasons for non-use, appropriate parameters, expectations of additional services, and opinions on the location of the drug consumption room in the contact centre. The informants clearly supported the drug consumption room and perceived it as a safe and hygienic environment with the potential to reduce the risk of overdose, infections, and negative impacts of public application. Key barriers were concerns about control, stigmatisation, overly restrictive rules, and service availability. Both groups preferred integrating the drug consumption room into the contact centre and agreed on the importance of follow-up services (material exchange, basic treatment, testing, and possibly Naloxone distribution).
Conclusion: The findings indicate a high acceptance of drug consumption rooms among the target population and service workers, and the need for a low-threshold, trustworthy, and safety-balanced setting. The results may support professional discussion and preparation for a pilot implementation of drug consumption rooms in the Czech Republic.

Keywords: *Drug consumption rooms; Harm reduction; Intravenous drug use; Public health; Social work*

INTRODUCTION

Substance abuse and its health, social, and community impacts represent a long-term challenge in the field of public health and social services. Injecting is a particularly significant problem, which in the Czech environment is associated with an increased risk of transmission of infectious diseases, skin and systemic complications, overdose, and negative impacts on the public space. Low-threshold harm reduction services are a standard tool that assists people using addictive substances to minimise health and social risks. However, one of the key interventions common in many European countries is not yet available in the Czech Republic: drug consumption rooms.

Injection rooms are specialised, professionally managed spaces that allow users to inject addictive substances in a controlled, hygienic, and health-safe environment under the supervision of trained personnel. Foreign research confirms that these services reduce the number of overdoses, complications associated with intravenous use, the occurrence of discarded injection equipment in public spaces, and at the same time facilitate the establishment and maintenance of contact with services. In recent years, Czech professional discussion reflects the need to reduce the

health and community impacts of substance use, but the lack of empirical data on the attitudes of users and service workers complicates the rational planning of such an intervention. Contact centres represent a natural environment for the possible introduction of a drug consumption room. Their clientele consists of people who have been using addictive substances for a long time, often under risky conditions. Knowledge of their experiences, needs, and willingness to use a drug consumption room is key to assessing the feasibility of implementing such a service and informing its design and operation. Equally important is the perspective of workers who can assess the organisational, ethical, and safety aspects of implementation. The aim of this article is to identify and describe the attitudes, ideas, and needs of clients and contact centre workers in relation to the possible implementation of a drug consumption room in the Czech environment.

Theoretical background

The use of addictive substances – and especially risky forms of administration – represent a significant public health and social issue. Addictive substances affect cognition, emotions, and behaviour, and may lead to addiction and severe health and social consequences (Minařík and Kmoch, 2015; Nešpor and Csémy, 2003; WHO, 2023a). In the Czech Republic, methamphetamine and opioids are among the most problematic substances, particularly in relation to intravenous use. Methamphetamine use is associated with neurotoxicity, cardiovascular complications, and psychotic states, while opioids carry a high risk of overdose due to respiratory depression and fluctuating tolerance levels (Dvořáček, 2008; EMCDDA, 2013a; Minařík, 2003; Minařík and Kmoch, 2015). In recent years, fentanyl and its derivatives have further increased overdose risks because of their extreme potency (Kariisa et al., 2023; Prekupec et al., 2017).

Intravenous drug use poses the greatest health risks. Approximately 41,000 people in the Czech Republic inject drugs (NMS, 2023a). Injection use is strongly associated with the transmission of infectious diseases such as hepatitis C and HIV, bacterial infections, and severe complications including abscesses or septic conditions (Řehák and Minařík, 2015; Wright et al., 2020). Risks are further intensified by social marginalisation, unstable living conditions, and delayed access to healthcare (Hobstová and Minařík, 2003). Intravenous administration also significantly increases the likelihood of fatal overdose because substances reach the brain almost immediately (EMCDDA, 2013b). These risks form the basis for harm reduction approaches, which aim to minimise the health, social, and legal harms associated with substance use without requiring abstinence (IHRA, 2010; WHO, 2023b). Core harm reduction interventions include needle and syringe exchange programs, opioid substitution treatment, and overdose prevention initiatives. Needle and syringe programmes have proven effective in reducing HIV and HCV transmission (Fernandes et al., 2017), while opioid substitution treatment significantly lowers overdose risk and criminal activity (Kastelic et al., 2010; Popov, 2003). Take-home Naloxone programmes also represent an effective overdose prevention strategy and have already demonstrated positive outcomes in the Czech context (McDonald and Strang, 2016; NMS, 2023b).

A specific harm reduction intervention is represented by drug consumption rooms, which provide a hygienic and supervised environment for drug use. Their primary aims are overdose prevention, reduction of infectious disease transmission, limitation of public drug use, and establishment of contact with marginalised users (Hedrich, 2004; Hunt et al., 2003). Research demonstrates that these services contribute to lower overdose rates, reduced public syringe disposal, and increased engagement with addiction treatment services (Tran et al., 2021; Vecino et al., 2013). Drug consumption rooms may operate in integrated, specialised, or mobile forms and typically combine supervised consumption with sterile equipment distribution, education, and social support services (EMCDDA, 2018; Hedrich, 2004; Schäffer et al., 2014).

MATERIALS AND METHODS

The research was conceived as a qualitative study focused on understanding the opinions and experiences of two groups of key contact centre actors: its clients and employees. Given that drug consumption rooms represent a new

and as yet little-researched element of harm reduction in the Czech environment, a qualitative approach was chosen.

Data collection was carried out through semi-structured interviews, which combine a fixed thematic framework with the possibility of responding flexibly to specific responses from participants. This method was appropriate given the sensitivity of the topic and the need to capture the personal narratives of the respondents. Interview scenarios were created in two variants: separately for clients and separately for contact centre employees, to reflect the differences in their roles and experiences. The interviews took place in the contact centre environment, in a room ensuring privacy; they lasted between 30 and 45 minutes and were recorded on a mobile phone. The research set included two groups of informants obtained by the purposive sampling method. The first group consisted of five clients of the contact centre (IN1–IN5, marked as CL) who have used addictive substances for a long time and represent the primary target population of potential users of the drug consumption rooms. The second group consisted of six employees of the contact centre (IN1–IN6, marked as EM) who have professional experience with harm reduction services and regularly work with users in the field and outpatient parts of the service.

The data were analysed using open coding. First, all interviews were transcribed verbatim and repeatedly read. During the initial coding phase, meaningful segments of text were identified and assigned descriptive codes reflecting participants' experiences, attitudes, and perceived risks or benefits associated with drug consumption rooms. The coding process was conducted separately for the two groups of informants (clients and employees) to capture the specificities of their perspectives.

In the following phase, codes with similar meanings were grouped into broader conceptual categories through constant comparison across interviews. These categories were subsequently refined and organised into thematic areas representing recurring patterns in the data. The analytical process involved continuous comparison between the perspectives of clients and employees, which enabled the identification of both shared themes and divergent viewpoints. Initially, eight thematic areas were identified; however, two were excluded during the final reduction process due to their limited relevance to the scope of the study.

The ethical level of the research was ensured in accordance with Act No. 110/2019 Coll. Informants were anonymised using codes, location names were intentionally changed, and all participants were informed in advance about the purpose, process, and use of the data. An audio recording of consent to participate in the research was made.

RESULTS

A qualitative analysis of interviews with five clients and six contact centre employees revealed six thematic areas: perceptions of the drug consumption room (hereinafter referred to as DCR), motivations for use, reasons for non-use, appropriate parameters, expectations from additional services, and opinions on the location of the service in the contact centre. Although most informants had never personally visited a drug consumption room, their opinions were based on their everyday experience with drug use or the provision of harm reduction services. The results show a high level of agreement between both groups in assessing the benefits and need for this service.

Perceptions of the drug consumption room

The interviews showed that informants share relatively consistent perceptions of what a drug consumption room represents. All informants – without exception – supported the introduction of the service in the Czech Republic. Client IN2 stated unequivocally: *"Definitely yes, yes, yes. Definitely yes..."* (IN2, CL). The support was based on the feeling that AR is already a "proven concept" abroad and that its benefits are known.

Some clients also expressed support tinged with frustration that, despite long-term discussion of drug consumption rooms in the Czech Republic, no concrete outcome has been reached. Client IN1 said: *"Yes, I agree, but in my opinion it should have been done a long time ago... I don't know why it was constantly rejected. I don't know if it was easier to chase toxic people everywhere than to just have them in a room somewhere where they can take it in peace..."* (IN1, CL).

The clients' ideas focused mainly on safety, peace, and hygienic conditions. The idea of a DCR as a safe and calm place was repeatedly present: *"application in safety, in peace"* or *"application under supervision, without risk"* (IN3–IN5).

The employees imagined the DCR as a combination of safety standards, professional supervision, and space for broader intervention. They emphasised that the room allows *"preventing overdose"*, *"intervening in time"*, or *"finding out what the client is applies"* (IN3, EM). Some employees also pointed out the benefits of a public space: reduction of applications on the street, as well as the number of discarded syringes – which is also significant from the point of view of community health.

The results show that the ideas of both groups about the service are largely homogeneous: a DCR is perceived as a safe, protected, and controlled environment that brings benefits not only to users but also to the wider environment.

Motivation for using the service

The motivations of clients to use a DCR focused on several key topics: safety, comfort, and minimisation of health risks. Clients reflected on the risk of application in public spaces, especially in winter, deserted areas, parks, or toilets. They mentioned the risk of overdose more often. One client stated that a DCR would be a place where *"you know that if something happens, someone will intervene"* (IN3, CL). Fear of overdose was a prominent theme. The experience that *"when you use it outside, you never know what will happen"* (IN4, CL) was echoed in the interviews. This statement refers to the high risk of using an unknown or strong substance, but also to the loneliness of users in such situations. In the context of opioids, a DCR was perceived as potentially lifesaving: clients repeatedly stated that they would use the service because *"there is someone there who can call for help"* (IN5, CL). Hygiene was another motivation. Clients described that in the field they often use drugs *"in the dirt"*, *"on the ground"*, *"in the cold in the winter"*, or in an environment where they cannot prepare thoroughly. A DCR was therefore perceived as a place where *"it can be done cleanly and without stress"* (IN1, CL).

Psychosocial factors were also cited as motivations by staff. According to them, a DCR *"can be the first place where the client actually stays"*, which allows staff to establish contact, provide basic advice, or refer clients to treatment. One employee stated: *"When a client comes to a DCR, we have a better chance of working with them"* (IN2, EM). According to employees, a DCR naturally creates space for building a relationship between client and worker.

Reasons for not using the service

In addition to motivations, factors that could hinder the use of a DCR also emerged. The most common concern was the fear of control. Some clients expressed the fear that in a DCR *"they will be seen too much"*, or *"that someone will think they are evaluated"* (IN2, CL). This feeling reflects the users' long-term experience with institutionalised environments. Another barrier was the fear of stigmatisation. Informants stated that they would be afraid *"that no one would know about it"* (IN4, CL), or that they would not want *"someone to think that people go there to get high and have sex"* (IN5, CL). Employees confirmed that stigma is a major barrier in smaller towns and can significantly affect the usability of the service. The third area was the concern associated with the operating rules. Clients were primarily concerned about excessive regulation: time limits, mandatory registration, or the presence of staff at every application. *"If there are rules about what is not allowed and how long you can be there, it will discourage people"* (IN3, CL). On the other hand, employees stated that rules are necessary and that they must be set sensitively so as not to hinder clients' access. Another barrier was accessibility. Some informants stated that *"if it is far away, people will not go there"* (IN1, CL). Employees shared this concern and emphasised that the DCR must be strategically located near locations with a high concentration of users.

Suitable parameters of the drug consumption room

When describing suitable parameters of a DCR, informants emphasised functionality, safety, and cleanliness. Clients repeatedly stated that the room should be *"clean"*, *"warm"*, *"not too luxurious"*, but *"practical mainly"* (IN2, CL). Some stated specific ide-

as: available water, good lighting, a solid work surface, and sufficient space for preparing and handling injecting equipment. An important element was the presence of employees. However, clients demanded that supervision should not be perceived as control, but as security. *"Someone should be there, but not watch me do what I do"* (IN4, CL). This difference is of fundamental importance for the design of the service – the worker should be a support, not a supervisor. Employees supplemented the parameters with the need for a clear structure of the space, good ventilation, and the possibility of a quick response in case of complications. One employee stated: *"We have to see the client, but at the same time give them privacy"* (IN5, EM). This shows the need to balance monitoring and the intimacy of the space.

Additional services

Clients and employees agreed that a DCR should not only be a place of application, but should also provide basic additional services. Clients most often mentioned an exchange program, wound care, access to sterile supplies and basic hygiene equipment. *"Definitely exchange, water, disinfection"* (IN3, CL).

Employees expanded services to include counselling and testing. *"Tests for infections should be there"* (IN1, EM) was mentioned repeatedly. An interesting topic was testing the strength and purity of the substance, which, according to some employees, could significantly reduce the risk of overdose. Some employees also mentioned the possibility of distributing Naloxone: *"If we want to save lives, Naloxone should be there"* (IN4, EM). Clients were not unanimous in whether they wanted more extensive counselling directly in the AR. Some stated that *"when a person is about to administer, they don't want to deal with their lives"* (IN5, CL). However, others stated that they would welcome the opportunity to directly address other problems.

Application room in the contact centre

The interviews showed that placing the DCR in the contact centre is perceived positively. Clients appreciated that the contact centre is an environment *"they already know"*, where there are *"normal people"* and where they have trust. *"If it were here, I would go. It's close to me and I know you"* (IN2, CL). The employees saw connecting the DCR with the contact centre as logical: it allows for the provision of more services in one place, maintaining continuity of care and effectively using staff capacity. *"If it is in the contact centre, we can maintain it professionally and humanly"* (IN3, EM). However, they also mentioned the risk of an increased concentration of users, or potential negative reaction from the public around the centre. However, overall, the prevailing opinion was that the contact centre was the most natural and organised place to operate the drug consumption room.

DISCUSSION

The results of the study show that both clients and contact centre staff perceive drug consumption rooms as a meaningful and necessary part of the harm reduction system. These conclusions are in line with the extensive international literature, which confirms that a DCR is an effective tool for reducing the health and social risks associated with intravenous drug use (EMCDDA, 2018; Hedrich, 2004). Clients in the qualitative survey repeatedly stated that a DCR would allow them to apply (inject) *"in peace"*, *"without stress"*, and *"in safety"* (e.g., IN2, CL; IN3, CL), which exactly corresponds to the reasons for this service being introduced abroad (and why it is used by users.) International studies have long shown that safety, availability of supervision, and a hygienic environment are among the main motivational factors (Hunt et al., 2003; Wood et al., 2008). The possibility of using a DCR may be another important factor contributing to harm reduction and addiction treatment, along with other factors such as faith, the family situation, and others (Gerec, 2023). The fear of overdose plays a fundamental role in the motivation of clients. This motif is common in the literature, for example, Wood et al. (2004) and Potier et al. (2014) state that the availability of professional supervision significantly reduces the number of fatal and non-fatal overdoses. Some studies even show that no fatal overdoses have been recorded inside legal drug consumption rooms (Hedrich, 2004). The results of research are fully consistent with this finding: clients appreciate the potential for early intervention, which is often unattainable in field application conditions.

The research also shows that clients associate a DCR with the prevention of infectious diseases and complications associated with intravenous application. They mention the need for cleanliness, access to water, and sterile equipment. These factors are consistent with the findings of several studies that demonstrate a DCR leads to a reduction in the incidence of abscesses, skin infections, and other complications (Kerr et al., 2007), while also reducing the sharing of application equipment (Bravo et al., 2009).

Contact centre staff perceive a DCR not only as a safe environment for clients, but also as a tool for facilitating the establishment of cooperation, providing advice, and mediating follow-up treatment. The literature confirms that users who use a DCR are more likely to initiate addiction treatment, complete substitution therapy, and improve their overall contact with services (Reddon et al., 2021; Wood et al., 2004). A DCR thus functions not only as a harm reduction tool but also as a stabilising point that facilitates longer-term intervention. This finding is consistent with international research, which likewise highlights the role of DCRs in supporting ongoing engagement and longer-term interventions. However, the barriers that may hinder the use of a DCR are also a significant finding. Clients reported concerns about excessive control, stigmatisation, or a complex operating regime. These concerns are also well described in foreign literature. For example, McNeil and Small (2014) emphasise that trust in staff and a low-threshold setting are key for a DCR to be truly used. The literature describes this paradox as the need for *"supportive, not supervisory supervision"* (Hunt, 2006), which is fully consistent with the statements of informants.

Another interesting area is the issue of DCR placement. Both clients and staff expressed a preference for integrating drug consumption rooms into existing contact centres. This preference was primarily attributed to familiarity with the environment, established trust relationships, and access to follow-up services. This preference corresponds to the reality of most foreign facilities, where DCRs are most often part of larger harm reduction centres (EMCDDA, 2018; Schäffer et al., 2014). The integrated model is repeatedly assessed as the most effective because clients already know the location, staff, and services, which increases the likelihood of use. Additional services that informants mentioned can also be discussed – an exchange programme, infection testing, counselling, or Naloxone distribution. In the literature, the combination of these services is considered the key to effective harm reduction (McDonald and Strang, 2016; Potier et al., 2014). The results of the study thus indicate that the Czech environment can – to a large extent – be compared to foreign experiences, and that clients would use not only the application space itself, but also follow-up services that can minimise wider health risks.

An important contribution of the study lies not only in confirming the benefits of drug consumption rooms described in international literature, but also in highlighting the subtle differences between the perspectives of clients and professionals within the Czech harm reduction context. While both groups supported the introduction of DCR, their expectations and priorities differed in important ways. Clients primarily emphasised privacy, emotional safety, reduced stress, and the possibility of using substances without fear of judgment or excessive supervision. Their narratives reflected previous negative experiences with institutional environments and strong sensitivity to stigma and control. In contrast, professionals framed DCRs more strongly through the lens of public health, risk management, and continuity of care. Employees emphasised the importance of supervision, crisis intervention, and the integration of additional health and social services. These differences suggest a potential tension between the institutional need for safety and regulation and the users' need for autonomy and low-threshold access. The findings therefore indicate that the successful implementation of DCRs in the Czech Republic would depend not only on legislative or organisational readiness, but also on the ability to balance professional oversight with a non-controlling and trust-based approach toward clients. This aspect may be particularly important in the Czech context, where mistrust toward institutions and stigma associated with drug use remain significant barriers to service utilization.

Overall, the study supports the long-documented benefits of drug consumption rooms described in international literature. Clients and staff primarily described factors that the literature identifies as the main reasons for the

effectiveness of DCRs – increased application safety, reduced overdose risk, better control of hygiene conditions, reduced public application, and enhanced linkage to other services. The barriers described by informants also correspond with existing knowledge and highlight the need for a sensitive, low-threshold, and client-oriented service setting. The study is subject to several limitations resulting from the qualitative design. The research group consisted of five clients and six staff members of one contact centre, which allows for a deep understanding, but limits the generalisability of the results to the wider population and other regions or organisations. The attitudes of informants may be influenced by the specific environment of the service, personal experience with drug use, or the professional role of the staff. Another limitation is the sensitivity of the topic, which may have led to informants being cautious or giving socially desirable answers. Also, most respondents had no personal experience with drug consumption rooms, so their statements are based on hypothetical ideas. The interpretive nature of open coding introduces a certain degree of subjectivity, but the results provide valuable exploratory insight into the needs and expectations of users and workers and can serve as a basis for further research and consideration of piloting the service.

CONCLUSION

The study contributes to the currently limited discussion on drug consumption rooms in the Czech Republic by providing insight into the perspectives of two key groups directly connected to harm reduction practice – contact center clients and staff. The findings demonstrate a relatively strong consensus that supervised consumption services could address significant gaps in the existing system of care for people who use drugs, particularly in relation to overdose prevention, safer substance use, and the reduction of public health risks associated with unsafe injecting practices. The research also suggests that the Czech harm reduction system is well positioned to implement drug consumption rooms. In particular, established contact centres already provide the professional expertise, infrastructure, and long-term trust relationships with clients necessary for their operation. At the same time, the findings highlight that the acceptability and effectiveness of such services would depend on maintaining a genuinely low-threshold approach and minimising experiences of stigma or excessive institutional control.

From a practical perspective, the study indicates that integrating drug consumption rooms into existing harm reduction services could strengthen continuity of care, improve access to crisis intervention, and create additional opportunities for health and social support. From a drug policy perspective, the findings support the consideration of pilot implementation projects and broader professional discussion on legislative and organisational frameworks for supervised consumption services in the Czech context. At the same time, the absence of drug consumption rooms in the Czech Republic may also reflect broader structural and societal barriers, including persistent stigmatisation of people who use drugs, public concerns regarding the concentration of drug use in specific locations, and political reluctance to support controversial harm reduction interventions despite evidence of their public health benefits. These factors may contribute to the slow adoption of supervised consumption services, even in contexts where professional support for their implementation exists.

Although the study is limited by the small research sample and the specificity of one contact centre environment, it provides empirically grounded insights into the expectations, concerns, and perceived benefits associated with drug consumption rooms. The findings may therefore serve as a useful starting point for future research, policy development, and the practical design of harm reduction interventions in the Czech Republic.

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Ethical aspects and conflict of interest
The authors have no conflict of interest to declare.

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* **Corresponding author:** Stanislav Ondrášek, University of South Bohemia in České Budějovice, Faculty of Health and Social Sciences, Institute of Social and Special-paedagogical Sciences, Jírovcova 1347/24, 370 04 České Budějovice, Czech Republic; e-mail: ondrasek@zsf.jcu.cz
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