

# DRUG FREE AUSTRALIA

## ANALYSIS OF KPMG EVALUATION of the SYDNEY MEDICALLY SUPERVISED INJECTING CENTRE October 2010

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The KPMG report analysed here by Drug Free Australia is an independent evaluation of the Kings Cross Medically Supervised Injecting Centre (MSIC). Requisitioned by the NSW Government at a cost of \$240,000, the KPMG evaluation reviewed indicators of the effectiveness and efficiency of the MSIC, particularly focusing on the NSW Government's stated objectives for the facility:

- decreasing overdose deaths
- providing a gateway to drug treatment
- reducing discarded needles and drug use in public places
- reducing the spread of diseases such as HIV and Hepatitis C

This Drug Free Australia analysis follows the general format of the KPMG evaluation report, which reviews the data on the objectives in the order they appear above.

## Executive Summary

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Drug Free Australia's analysis of the KPMG evaluation contains the following observations and concerns:

### Client Characteristics

- The MSIC has had low rates of utilisation, running continually below 2/3rds capacity throughout its 9 years of operation. The 7% of the 12,050 clients who attended most often still injected 80% of the time outside the centre, and the 26% who injected there between 10 and 98 times per year still injected 95% of the time on the street, in a toilet, a car or at home.
- MSIC registrations show a clientele statistically less at risk of overdose than other studied groups of heroin users in Sydney and other States.

Regarding the following MSIC objectives:

### 1 Decreasing overdose deaths

- The KPMG evaluation found no measurable impact on drug overdose deaths in Kings Cross, nor on nearby hospital presentations for drug overdose.
- Drug Free Australia calculates that the injecting room statistically saved less than 0.5 lives per year, or 4 lives in 9 years, at a cost of more than \$23 million - an extremely poor cost/benefit ratio. This calculation of lives saved is notably backed by the only two major international reviews of injecting rooms worldwide .
- The KPMG evaluation unfortunately perpetuates the demonstrable error of two previous MSIC evaluations which calculated their lives saved estimates from the number of overdose events in the MSIC while failing to examine the level of disproportion between overdoses inside and outside the facility. Overdoses in the facility were 32 times higher than the overdose histories of clients before they registered to use the MSIC. Such a failure of method is academically indefensible.
- The KPMG evaluation supports the erroneous conclusion of a 2007 MSIC evaluation which credited the MSIC with reducing ambulance callouts in the Kings Cross postcode. This previous evaluation failed to examine or even consider the effect, beyond that of the heroin drought, of sniffer dog policing which has been central to deterring drug users and dealers from the area for eight of the MSIC's nine years of operation.
- Calculations by Drug Free Australia show that the MSIC should only be intervening in 10-12 overdoses per year, rather than 390 per year. If rates of overdose were normal in the MSIC, it would reduce ambulance callouts in the area by less than 5%.
- The 2003 MSIC evaluation, noting the high overdose rates in the facility, stated that clients may be taking higher risks with drugs in the safety of the room. This inevitably means that the MSIC is facilitating more drug use and enhancing the profits of local drug dealers, which alone is sufficient reason to close the facility.

## **2 Providing a gateway to drug treatment**

- The KPMG evaluation reports 3,871 referrals to drug treatment or counseling without indicating the very low percentage of clients receiving those referrals. In 2003 and 2007 the percentage was just 11% of clients, which in light of known motivations of drug users to quit, has been abnormally and unjustifiably low.

## **3 Reducing discarded needles and drug use in public places**

- Objective data reviewed in the KPMG evaluation shows reductions in publicly discarded needles and related public injections which were also replicated across the whole of Australia due to the heroin drought which commenced 6 months before the MSIC opened and which still continues in 2010. The KPMG evaluation importantly fails to assess, or even make mention of, the impact of tougher policing of Kings Cross drug hotspots over the last 8 years.
- The KPMG evaluation credits the MSIC with reducing publicly discarded needles and public injecting by using the subjective responses of Kings Cross residents and businesses, many of whom could not be assumed to know of the existence of the 10 year heroin drought and its effect on discarded needles and public injection Australia-wide.
- The KPMG evaluation also relies on clients' self-reported behaviours which cited less public injecting, a measure which does not appear to be objectively validated.

## **4 Reducing the spread of diseases such as HIV and Hepatitis C**

- The KPMG evaluation does not attribute any impact on blood-borne virus transmissions in Kings Cross to the MSIC, however despite not one previous MSIC evaluation attributing any impact on blood-borne viruses to the MSIC, the MSIC Fact Sheet 2010 clearly, publicly and speciously claims success in reducing blood-borne viruses.

## **Conclusion**

- The MSIC has saved only a handful of lives at high cost in 9 years, referred an abnormally small percentage to drug interventions, not objectively shown any significant effect on discarded needles and related public injection, and failed to impact blood-borne viruses. This represents insufficient impact across all objectives.
- The KPMG evaluation has uncritically cited previous demonstrably flawed MSIC evaluations regarding various perceived positive outcomes for the facility eg lives saved estimates. Drug Free Australia has noted that MSIC evaluations, excluding SAHA International 2008) were each produced by colleagues of the MSIC's first Medical Director, creating a conflict of interest in terms of arms-length independence which thereby should have precluded an uncritical acceptance of previous findings.

## INTRODUCTION – Client Information

### Summary

- The MSIC has had low rates of utilisation, running continually below 2/3rds capacity throughout its 9 years of operation. The 7% of the 12,050 clients who attended most often still injected 80% of the time outside the centre, and the 26% who injected there between 10 and 98 times per year still injected 95% of the time on the street, in a toilet, a car or at home.
- MSIC registrations show a clientele statistically less at risk of overdose than other studied groups of heroin users in Sydney and other States.

### Low utilisation rates of facility

The ever-present danger of fatal drug overdose for heroin users was the dominant, promoted rationale for establishing the Kings Cross injecting room in 1999, with the threat that every heroin injection can be a heroin user's last. Clients of the facility, though, demonstrated little regard for their own safety, with the facility running at less than 2/3rds capacity across all 9 years of operation.

With 12,050 clients registered during its nine years of operation, the MSIC, with its total of 604,022 injections, has had very low rates of utilisation. With a capacity of 330 injections per day<sup>1</sup> the facility has averaged 185 injections per day over 9 years.

The KPMG evaluation reports that 7% of clients in 2010 were responsible for 59% of the facility's injections.<sup>2</sup> Even with this group of less than 200 clients, who are more likely to be dependent heroin users injecting at least three times a day<sup>3</sup> their average injections of 200-230 per user per year represents only 20% of their injections in the facility, with 80% of their injections being on the street, in a toilet, a car, at home or a dealer's or friend's home.

The next most diligent group, the 26% who were responsible for another 33% of visits, injected just 5% of the time at the MSIC, (assuming that these clients were more likely to inject once or more daily). And this 26% combined with the 7% above still only represent one in every three clients. Two in every three clients were rarely ever there, showing an even greater disregard for their own safety.

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<sup>1</sup> MSIC Evaluation Committee. (2003) *Final Report on the Evaluation of the Sydney Medically Supervised Injecting Centre*. Sydney: Mattick, RP; Kaldor, J; Lapsley, H; Weatherburn, D; Wilson, D. p 38

<sup>2</sup> KPMG (2010) Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007 – 2011) p 60

<sup>3</sup> MSIC Evaluation Committee. (2003) *Final Report on the Evaluation of the Sydney Medically Supervised Injecting Centre*. Sydney: Mattick, RP; Kaldor, J; Lapsley, H; Weatherburn, D; Wilson, D. p 58

### **Clientele lower-risk than other cohorts**

Clients of the MSIC had a lower risk of heroin overdose than other studied cohorts of heroin users around Australia. Between 2001 and 2002, only 44% of MSIC registrants had ever overdosed, as compared to a Sydney study in 1996 in which 68% had previously overdosed, or the Australian IDRS study of 1999 in which 51% had previously overdosed across all States of Australia.<sup>4</sup> The percentage of new MSIC registrants who had ever previously overdosed reduced over the years, as would be expected with the heroin drought which had commenced in the year 2000 and which continues in 2010.

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<sup>4</sup> ANCD (2001) Heroin overdose: prevalence, correlates, consequences and interventions p 10

# 1 DECREASE DRUG OVERDOSE DEATHS

## Summary

- The KPMG evaluation found no measurable impact on drug overdose deaths in Kings Cross, nor on nearby hospital presentations for drug overdose.
- Drug Free Australia calculates that the injecting room statistically saved less than 0.5 lives per year, or 4 lives in 9 years, at a cost of more than \$23 million - an extremely poor cost/benefit ratio. This calculation of lives saved is notably backed by the only two major international reviews of injecting rooms worldwide.
- The KPMG evaluation unfortunately perpetuates the demonstrable error of two previous MSIC evaluations which calculated their lives saved estimates from the number of overdose events in the MSIC while failing to examine the level of disproportion between overdoses inside and outside the facility. Overdoses in the facility were 32 times higher than the overdose histories of clients before they registered to use the MSIC. Such a failure of method is academically indefensible.
- The KPMG evaluation supports the erroneous conclusion of a 2007 MSIC evaluation which credited the MSIC with reducing ambulance callouts in the Kings Cross postcode. This previous evaluation failed to examine or even consider the effect, beyond that of the heroin drought, of sniffer dog policing which has been central to deterring drug users and dealers from the area for eight of the MSIC's nine years of operation.
- Calculations by Drug Free Australia show that the MSIC should only be intervening in 10-12 overdoses per year, rather than 390 per year. If rates of overdose were normal in the MSIC, it would reduce ambulance callouts in the area by less than 5%.
- The 2003 MSIC evaluation, noting the high overdose rates in the facility, stated that clients may be taking higher risks with drugs in the safety of the room. This inevitably means that the MSIC is facilitating more drug use and enhancing the profits of local drug dealers, which alone is sufficient reason to close the facility.

### a. Only 4 lives saved in 9 years

The number of lives likely to have been saved in the MSIC is the most publicly influential of issues, both for the NSW public and for NSW politicians. It is therefore crucial that these estimates are realistic.

Concerning the number of lives saved in the MSIC, the KPMG evaluation merely perpetuates the error of two previous MSIC evaluations (2003 and 2008), both of which incorrectly calculated their estimates from the total number of overdoses in the facility without examining whether these overdoses were more numerous inside than outside the facility. This is a methodological error that would not be academically countenanced elsewhere, and Drug Free Australia questions why these estimates have

continually been used to favourably influence the public and the legislature despite the demonstrably incorrect methodology exposed by Drug Free Australia in 2003.

The only two major international reviews to date of injecting rooms worldwide both make calculations of the number of lives saved by injecting rooms in a particular country. Both use a defensible method that gives a more realistic estimate.

The 2004 review by Dagmar Hedrich for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) estimated the number of lives saved for the 500,000 opiate injections across all 25 injecting rooms in Germany, calculating that they cumulatively saved 10 lives per year.

The other, a 2008 review by the Canadian Government's Expert Advisory Committee, calculated that Vancouver's Insite, with 145,000 opiate injections annually, saved just 1.08 lives per year.

Using the EMCDDA method for calculating lives, (which used with Canadian data yields the same result as the Canadian Expert Committee's), the MSIC's lesser 55,000 opiate injections per year yields only 4 lives saved across its entire 9 years of operation, at a total cost in excess of \$23 million not including setup costs.

In bioethics there is a problem known as distributive justice ie how can a limited health budget be best distributed for the common good of the community? The extremely low cost/benefit ratio displayed by the MSIC data disqualifies the MSIC as a viable intervention for saving lives. The same expenditure would fund several thousand rehabilitation places in NSW.

## **The method**

The European Monitoring Centre (EMCDDA) 2004 Review of Drug Consumption Rooms<sup>5</sup> <http://www.emcdda.europa.eu/html.cfm/index54125EN.html>, which notably is highly supportive of injecting rooms, uses the following method on page 54 to calculate lives saved for all 25 consumption rooms across Germany. It calculates from:

1. known overdose mortality rates per 100 dependent heroin users (2%)
2. the number of injections per 100 person years per dependent heroin user (1,000 injections per year per user)

Thus 100 dependent heroin users, cumulatively injecting 100,000 times a year, will be expected from the review's designated mortality rate to have 2 overdose fatalities annually. 500,000 injections yield 10 expected fatalities averted by the 25 injecting rooms across Germany. Drug Free Australia notes that the EMCDDA review's 2%

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<sup>5</sup> Hedrich D, European Report on Drug Consumption Rooms; Lisbon: EMCDDA, February 2004

overdose fatality rate seems excessive in light of the EMCDDA's own mortality studies for 5 European countries<sup>6</sup>, (where Germany was not included, but where Spain, with the highest heroin overdose mortality, was still well below 2%). The percentages by country were:

Barcelona - Spain	1.4%
Rome - Italy	0.2%
Sweden	0.7%
Amsterdam - Netherlands	unknown
Vienna - Austria	0.2%

The Canadian Expert Advisory Committee 2008 review [http://www.hc-sc.gc.ca/ahc-asc/pubs/\\_sites-lieux/insite/index-eng.php#insite](http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php#insite) did not declare the method by which it concluded that 1.08<sup>7</sup> lives are saved by Vancouver's Insite per year, but the EMCDDA method, used with Canadian data and assumptions, yields the same result. Canadian heroin mortality in 2002/3 was roughly the same as Australia's at 1% (958 deaths from more than 80,000 dependent heroin users)<sup>8</sup> and mortality percentages for 2006 or 2007 might well be expected to be little changed. Further, the Expert Advisory Committee clearly state their assumption that a typical Canadian heroin user injects 4 times daily,<sup>9</sup> a higher average than the 2-3 times daily assumed by the EMCDDA review.

Thus 100 Canadian heroin users will cumulatively inject 146,000 times annually, and the 144,000 opiate injections in the room might be expected to avert the death of the one injection in 146,000 which would likely have been fatal. It is likely that the Expert Advisory Committee's estimate also includes a calculation for cocaine mortality.

The Sydney injecting room has hosted 604,022 injections in 9 years, of which around 80% were heroin or other opiates. Given that the percentage cannot be exactly calculated due to lack of precise data in the KPMG evaluation, this gives roughly 485,000 opiate injections in the room.

Using the EMCDDA method, heroin overdose mortality in Australia is 1% and dependent heroin users are estimated to inject 'at least' 3 times a day according to the injecting room's own 2003 government-funded evaluation.<sup>10</sup> 100 Australian heroin users will therefore experience one fatality for every 109,500 injections, which yields 4.4 lives

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<sup>6</sup> EMCDDA, Implementation, follow-up and analysis of cohort studies on mortality among drug users in European Union member States; Lisbon: EMCDDA, July, 1999 (first and second phase reports)

<sup>7</sup> See the Expert Advisory Committee's Executive Summary – section vii **Cost-Benefit/Effectiveness**

<sup>8</sup> Popova S, Rehm J, Fischer B, An overview of illegal opioid use and health services utilization in Canada; Public Health (2006) p1

<sup>9</sup> See the Expert Advisory Committee's **Background** section, 4<sup>th</sup> paragraph

<sup>10</sup> MSIC Evaluation Committee. (2003) *Final Report on the Evaluation of the Sydney Medically Supervised Injecting Centre*. Sydney: Mattick, RP; Kaldor, J; Lapsley, H; Weatherburn, D; Wilson, D. p 58

saved for the 485,000 injections across the 9 year period of the Sydney injecting room's operation.

### **b. Invalid calculations from overdoses in the facility**

The comprehensive 2003 MSIC evaluation calculated 6 lives saved during the first 18 months of the facility's operation as found on page 59 of the report. The evaluators used a method which calculated the number of lives saved from the number of overdoses in the injecting room during that period. What they demonstrably failed to do was examine whether rates of overdose in the injecting room accorded with other known rates of overdose outside the facility.

The 2008 SAHA International Evaluation of the MSIC's cost effectiveness calculated 25 lives saved from 496 overdoses in a 'comparison year' at the injecting room, again making the demonstrable error of not first comparing overdoses in the room for over-representation.

That the numbers of overdoses in the facility are extraordinary is beyond question. The 2004 EMCDDA review found that overdose rates across the world's injecting facilities (where heroin is injected rather than smoked) ranged from 5 in every 10,000 injections to a high of 40 per 10,000, with just one German facility recording 68/10,000. The Sydney injecting room had the highest rates worldwide at 72 overdoses per 10,000 injections in its first 18 month evaluation period.<sup>11</sup> Heroin overdoses in the MSIC in 2009/10 were an even more extraordinary 146 per 10,000 injections.

By comparison, one reliable external measure of normative rates of overdose comes from the MSIC's own client database which showed 44%<sup>12</sup> of clients having previously overdosed at some time in their average 12-14 year<sup>13</sup> drug use careers, with a median rate of three overdoses each, or (if a median is calculated as a mean) at a rate of one non-fatal overdose every four years, or every 4,380 injections. (Of course a median is not a mean, and the rate of overdose could be something less than 1/4,380 injections, but the fact that just 44% of the MSIC registrants had ever overdosed previously, and that our estimates apply their overdose rate to 100% of injecting room clients gives latitude in calculating a median as a mean).

However, in the injecting room, where 94% of the 3,426 overdoses in 9 years were opiate overdoses according to the KPMG data, the rate of overdose is one non-fatal overdose for every 139 injections. This is 32 times higher than clients' previous overdose rates of one for every 4,380 – an extraordinary figure. As a result, the 2003

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<sup>11</sup> Hedrich D, European Report on Drug Consumption Rooms; Lisbon: EMCDDA, February 2004 p 45

<sup>12</sup> MSIC Evaluation Committee. (2003) *Final Report on the Evaluation of the Sydney Medically Supervised Injecting Centre*. Sydney: Mattick, RP; Kaldor, J; Lapsley, H; Weatherburn, D; Wilson, D., p 16 – the 2003 data is here used because the heroin drought artificially distorts later client data with even lower overdose rates

<sup>13</sup> *Ibid*, p 15

evaluators' estimate of 6 lives saved in the first 18 months should have been corrected for this vast over-representation of overdose in the room, yielding just a fraction of a life saved annually for the then 65 heroin injections per day in the room. The same is true of the SAHA International evaluation.

**c. KPMG Error regarding reduced ambulance callouts in Kings Cross**

KPMG unfortunately perpetuates another influential error – that of the 2007 evaluation which incorrectly found that the injecting room had reduced ambulance callouts in the Kings Cross postcode. An 80% callout reduction in Kings Cross compared to 61% reductions for the rest of NSW due to the heroin drought, while reductions in neighbouring Darlinghurst/Surry Hills were only 45%.

The 2007 MSIC evaluation appears to have either neglectfully or very carefully ignored the introduction of changed policing in May 2002, exactly one year after the MSIC opened. Legislation passed 6 months after the injecting room opened legitimated the use of sniffer dogs in Kings Cross to move drug-related loiterers and dealers away from the drug hotspots in Kings Cross. This policing with sniffer dogs continues unabated eight years later. Any misapprehensions concerning the importance of this change can be dispelled by accessing <http://www.abc.net.au/news/newsitems/200205/s558480.htm> and <http://www.zdnet.com.au/update-drug-sniffer-dog-alert-site-strains-under-pressure-120265435.htm>.

The effect of the introduction of sniffer dogs in 2001 in Cabramatta, combined with the onset of the heroin drought starting late in the year 2000, reduced ambulance callouts by at least 83% in Cabramatta.

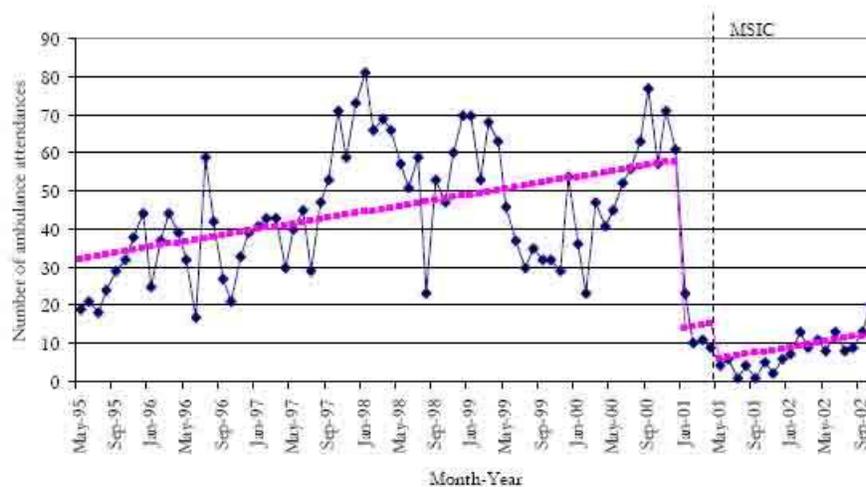
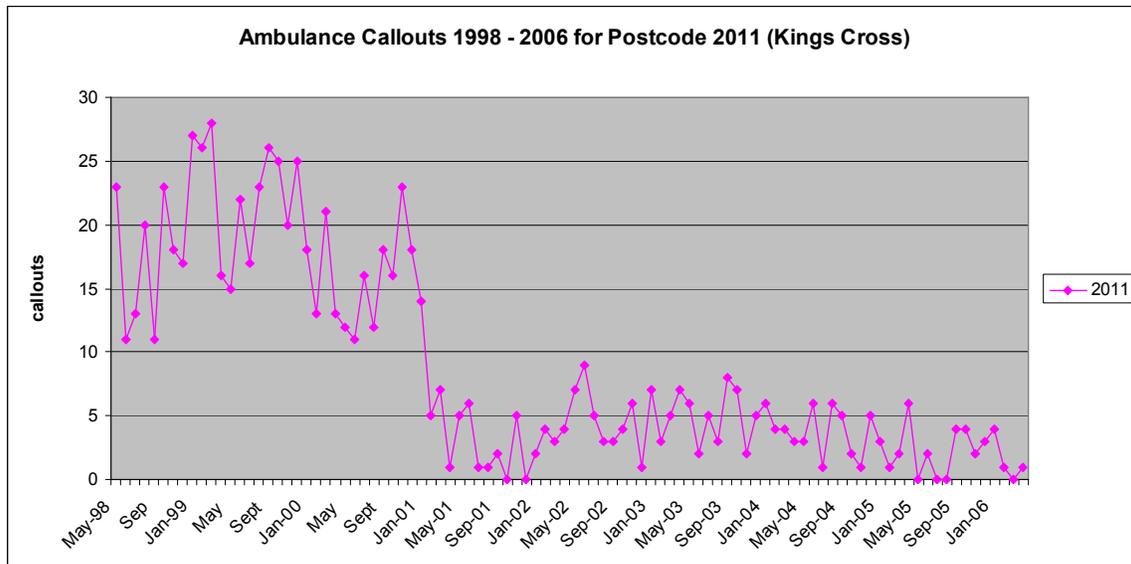


Figure 3.3: Cabramatta: Times series of ambulance attendances

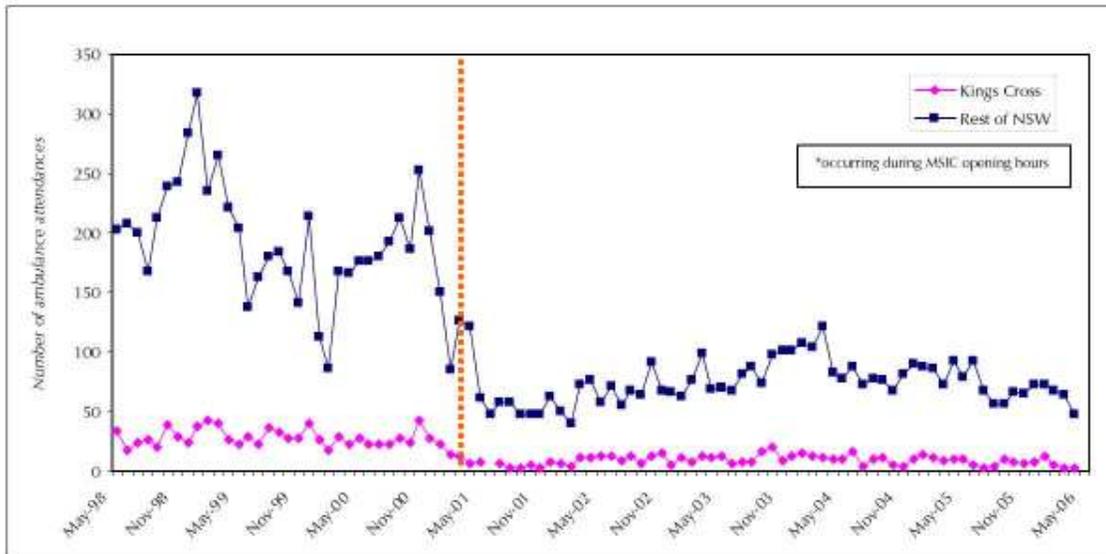
It is clear that a new Kings Cross policing strategy designed to deter drug dealers and drug-related loiterers from the back streets and alleys of Kings Cross should be expected to show very visible results. It is also clear from a comparison of ambulance callouts for the Kings Cross postcode versus the Darlinghurst/Surry Hills postcode, that drug users and their overdoses have noticeably been displaced by the tougher policing in Kings Cross to other postcodes, with the greater majority moving to Darlinghurst/Surry Hills where the expected 61% reduction in ambulance callouts, which the heroin drought caused for all other postcodes across NSW, was not realised via a lesser 45% reduction.

The displacement effect, usually the result of changed policing, is very clear in the comparison ambulance callout graphs below where Kings Cross replicates the same significant reductions in callouts as did Cabramatta with its tougher policing measures in 2001 (compare the Cabramatta graph above).

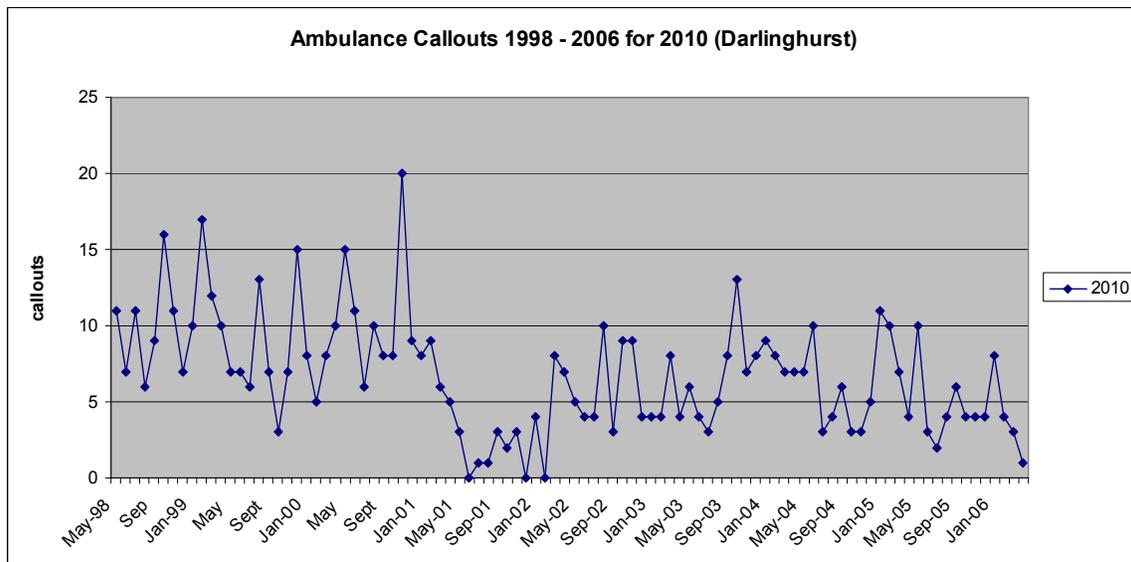


Significantly, the rest of NSW had 61% reductions in ambulance callouts due to the heroin drought as seen in the following graph,

Figure 6: NSW Ambulance attendances at suspected opioid overdoses, within MSIC opening hours: May 1998 to end April 2006



yet Darlinghurst shows significantly less change in callout reductions caused by the heroin drought.



The KPMG evaluation, like the 2007 evaluation, is negligent in its failure to study the effect of the changed policing of the last 8 years. If the policing of hotspots in Kings Cross was ineffective, it would certainly have been discontinued. The reduced ambulance callouts in Kings Cross are entirely to be expected where drug users and dealers are being ‘moved on’ or arrested in tougher police operations.

Drug-related crime and offences in Kings Cross would also be expected to reduce beyond the effects of the heroin drought with the introduction of police using sniffer dogs. It is notable that the KPMG uncritically cites the BOCSAR evaluations (2006, 2008, 2010) of crime in Kings Cross, which found reductions in drug-related crime and offences matching the rest of Sydney under heroin drought conditions without once mentioning the additional introduction of sniffer dogs and the targeting of drug users and dealers.

#### **d. Expected overdose numbers in the injecting room**

The June 2007 NCHECR evaluation of the MSIC claimed a significant reduction in ambulance callouts caused by the presence of the MSIC, a finding which the KPMG evaluation emphasises. Drug Free Australia has demonstrated above that the heroin drought, which intervened 6 months before the MSIC opened and which continues today, was responsible for most of the ambulance callout reductions, and tougher policing of the drug hotspots in Kings Cross with sniffer dogs, introduced eight years ago, was responsible for drug users and their overdoses largely transferring to the neighbouring Darlinghurst postcode, a clear displacement effect from the policing measures.

The expected number of overdoses in the MSIC can be calculated by using the EMCDDA saved lives method in tandem with an Australian study, used by the 2003 MSIC evaluators to calculate their upper estimate of lives saved, which found that 24 out of every 25 heroin overdoses is non-fatal.<sup>14</sup> The number of overdoses expected in the MSIC would then reduce ambulance callouts in the Kings Cross postcode by that same figure.

By applying this research finding to the EMCDDA method, it is clear that a cohort of 100 heroin users, cumulatively injecting 109,500 times per year, will experience one fatal overdose per year according to Australian heroin overdose mortality rates, and will also experience 24 non-fatal overdoses for the 109,500 injections. The MSIC with its 55,000 opiate injections per year, or enough injections for only 50 person years, should experience just 12 overdoses per year. This would avert less than 12 ambulance callouts in the Kings Cross area, against an average 208 overdose callouts per year for the two years preceding the heroin drought.

The SAHA International evaluation of 2008 cited a more recent study which found a ratio of one overdose fatality for every 20 overdoses. Using this finding, the MSIC would be expected to intervene in just 10 overdoses per year.

Clearly, the MSIC should be intervening in only 10-12 overdoses per year, and because not all overdoses are attended by ambulance, it should save the local ambulance service

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<sup>14</sup> Ibid, p 59

an even lesser number of callouts. At best, the MSIC could reduce ambulance callouts by less than 5%.

The 2003 MSIC evaluation, noting the high overdose levels in the MSIC, stated that:

“In this study of the Sydney MSIC there were 9.2 heroin (sic) overdoses per 1000 heroin injections in the MSIC, and this rate of overdose is likely to be higher than among heroin injectors generally. The MSIC clients seem to have been a high-risk group with a higher rate of heroin injections than heroin injectors who did not use the MSIC, they were often injecting on the streets, and **THEY MAY HAVE TAKEN MORE RISKS AND USED MORE HEROIN IN THE MSIC.**”<sup>15</sup>

Testimony of an MSIC ex-client in the NSW Legislative Council’s Hansard on 26 July 2007 records his words:

“They feel a lot more safer, definitely because they know they can be brought back to life straight away. What users look for in heroin and pills is to get the most completely out of it as they can, like virtually be asleep but awake for 4 - 5 hours. For instance to get that you have to test your limits. And by testing your limits that is how you end up dropping.”

It is clear that the high overdose rates, after recognising that MSIC clients are actually at LOWER risk of overdose than other studied cohorts, are likely due to more heroin and poly-drug cocktails being used in the MSIC, with the safety of the facility as a guarantee against such risky behaviour. This inevitably implies that the MSIC is an accessory to the enhanced profits of local drug dealers and this alone should lead to its closure.

#### **e. KPMG’s perpetuated error regarding saved lives**

The KPMG evaluation on page 15 cites the finding of a previous 2008 SAHA evaluation:

“assuming a ‘mid-point value’ of human life at \$3.5 million, breakeven analysis indicates that MSIC’s operations would have to prevent only 0.8 deaths per year to break even on operational costs, significantly fewer than the estimated 25 lives saved in the comparison year”

Relying on the same indefensible calculations by SAHA it concludes:

“It is also highlighted that an economic evaluation of the MSIC was commissioned by the NSW Government as part of the Trial under the current extended Trial period, and was completed in 2008. The evaluation, which aimed to ‘undertake a robust economic analysis of the Centre [ed. MSIC] to determine the costs and benefits in relation to the broader health budget in NSW as well as to any related government agencies and private enterprise’ found that:

*‘even conservative estimates of the number of deaths which MSIC may prevent each year results in massive positive outcomes in economic terms for the current funding of the Centre [ed. MSIC]’*

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<sup>15</sup> Ibid, p 62

The KPMG evaluation merely compounds the errors of previous evaluations, disregarding defensible methodologies in favour of clearly erroneous (yet still erroneously influential) methods of calculating from unexamined and non-compared overdose numbers in the room which are clearly not equal to rates of overdose on the street.

Contributors to this Drug Free Australia analysis, Dr Joe Santamaria and Dr Robert DuPont, were both particularly critical of the flawed evaluation processes used to justify the existence of the MSIC. The assumptions in the calculations of lives saved are hypothetical and based on many assumptions that are untestable. The MSIC effectiveness calculations are comparable to reducing speeding fatalities by teaching survival strategies to speeders without getting them to stop speeding and then comparing the deaths from speeding for the groups of trained speeders vs the untrained speeders as a way of validating this public health strategy -- when the death rate from both groups is appalling and preventable by stopping their speeding.

Cohort studies should clearly have been implemented, whereby 200 MSIC users were followed over a number of years. For instance, a cohort study of the first 200 patients who presented to the facility in May 2001 would investigate how many were alive or dead. Of those who had died, it would investigate when and where they died and from what cause. It would ask what happened to each over the 9 years of MSIC operation. Did they gainfully recover or did they remain on social services or end up in other institutions? How many were referred for treatment? How many actually got there? What were the comparable results from other treatment services that did not offer self injecting facilities? Of course such a study could have been commenced with 200 clients presenting at year 3, after the centre had stabilised its procedures.

Further, the evaluations beg the question of how trustworthy the responses of clients and caregivers are who have a native bias to praise the centre.

**f. Overdose deaths in Kings Cross continued unabated**

Overdose deaths in Kings Cross, as recorded on page 19 of the KPMG evaluation, were 12% of all overdose deaths for NSW before the opening of the MSIC, and remained at 12% for the years 2001-2009.

<b>Year</b>	<b>Kings Cross area</b>	<b>Rest of NSW</b>
1998-9	63 (13%)	437 (87%)
1999-00	42 (12%)	303 (88%)
2000-01	33 (11%)	254 (89%)
2001-02	10 (7%)	136 (93%)
2002-03	15 (10%)	133 (90%)
2003-04	26 (16%)	134 (84%)
2004-05	14 (10%)	125 (90%)

2005-06	7 (12%)	52 (88%)
2006-07	10 (12%)	74 (88%)
2007-08	13 (13%)	90 (91%)
2008-09	6 (9%)	61 (91%)
<b>TOTAL</b>	<b>239 (12%)</b>	<b>1,799 (88%)</b>

Of the 101+ deaths recorded in Kings Cross since the opening of the MSIC, a proportion of these deaths were undoubtedly MSIC clients, of which a percentage would certainly have died during MSIC opening hours. This again highlights the low utilisation rates of the facility by clients who were rarely there, as well as the failure of MSIC evaluators to conduct meaningful evaluation of the effectiveness of the MSIC via cohort studies.

## 2 PROVIDE A GATEWAY TO DRUG TREATMENT AND COUNSELLING

### Summary

- The KPMG evaluation reports 3,871 referrals to drug treatment or counseling without indicating the very low percentage of clients receiving those referrals. In 2003 and 2007 the percentage was just 11% of clients, which in light of known motivations of drug users to quit, has been abnormally and unjustifiably low.

### Low referral numbers to drug treatment and counseling

The KPMG evaluation reports 3,871 referrals to drug treatment of any kind, but fails to report the crucially important percentage of the 12,050 clients that received such referrals. Despite 60% of MSIC clients in 2007 having previously been in drug treatment of some kind according to MSIC Evaluation 4 of that year, the then 2,360 referrals to drug treatment and counseling applied to just 11% of clients (the same percentage as in the 2003 evaluation).

It is unlikely that the 2010 percentage is much higher than 11%, a very low rate of referral in light of the numbers of clients who were clearly not refractory to the idea or suggestion of treatment.

These referrals were as follows:

Referral type	2007	2010
Pharmacotherapy treatment	897	1,569
Detoxification program	764	1,292
Drug & alcohol counseling	421	576
Residential rehabilitation	220	334
Narcotics Anonymous/self help	49	77
Naltrexone maintenance	9	23
<b>TOTAL</b>	<b>2,360</b>	<b>3,871</b>

The KPMG evaluation gives 4 pages explanation (pp 125-128) to why referrals to drug treatment should not be expected to be high. Notably, though, 20% of all tobacco smokers, using the most addictive of all commonly used drugs, are reported in this KPMG explanation to be currently ready to quit at any point in time.

Alternately, the MSIC has had opportunity to continuously assist their clients over a period of many years and not just at a single point of time. If, as the KPMG evaluation states on page 125, research shows that 37% of tobacco smokers are quitting and 42%

are contemplating quitting, why would referral rates to drug treatment not be significantly higher than the 11% of clients recorded by the MSIC in 2003 and 2007?

Dr Charles Slack, an ex-addict now residing in Western Australia who worked as a professor in Psychology at Harvard, experimenting with drugs alongside Harvard's Dr Timothy Leary, a key founder of the 60's drug culture, believes much more could be done by the MSIC to help users get off drugs.

His testimony is that 35 years ago a criminologist planted the idea of a 12 step program in his mind, and when coincidentally asked some days later whether he was looking for an AA meeting, he said yes. Dr Slack, who currently works to help drug users become drug free, believes that if the MSIC really wishes to save lives it would have strong links to a local Narcotics Anonymous program, even hosting such a program, and day by day linkages to local residential rehabs, strongly encouraging clients to quit. This has clearly not been the case.

The referral rate to drug treatment and counseling is abnormally and unjustifiably low.

### **3 REDUCING DISCARDED NEEDLES AND DRUG USE IN PUBLIC PLACES**

#### **Summary**

- Objective data reviewed in the KPMG evaluation shows reductions in publicly discarded needles and related public injections which were also replicated across the whole of Australia due to the heroin drought which commenced 6 months before the MSIC opened and which still continues in 2010. The KPMG evaluation importantly fails to assess, or even make mention of, the impact of tougher policing of Kings Cross drug hotspots over the last 8 years.
- The KPMG evaluation credits the MSIC with reducing publicly discarded needles and public injecting by using the subjective responses of Kings Cross residents and businesses, many of whom could not be assumed to know of the existence of the 10 year heroin drought and its effect on discarded needles and public injection Australia-wide.
- The KPMG evaluation also relies on clients' self-reported behaviours which cited less public injecting, a measure which does not appear to be objectively validated.

#### **Inexcusable failure to mention heroin drought or tougher law enforcement**

The KPMG evaluation, in reviewing the various data on discarded needles and associated public injecting, appears intent on keeping both the heroin drought and tougher law enforcement a well-kept secret, with no mention of either in its discussion pages regarding improved public amenity.

The heroin drought which commenced in late 2000 reduced heroin user numbers and heroin deaths throughout Australia by 60-70%, reductions which have continued over the ten years since it commenced. Central to any discussion of improved public amenity due to reduced numbers of discarded needles in Kings Cross should be the effect of the heroin drought.

Changes to policing of hotspots around Kings Cross should also be expected to reduce needle counts and sightings of public injections as drug users and dealers were moved out of the Kings Cross area with the threat of continued use of sniffer dogs.

Yet discussion surrounding needle counts in the 2003 MSIC evaluation could not separate any effect by the MSIC on discarded needles and public injecting from those of the heroin drought. The 2007 MSIC evaluation did not make a finding other than that there had been a 48% decrease in discarded needles in Kings Cross, and failed to even mention either the heroin drought as cause, or the tougher policing measures since 2002.

Notable for their absence in both the June 2007 MSIC evaluation and the KPMG evaluation are graphs showing the lesser number of needles distributed by needle exchanges and pharmacies in Kings Cross. Such a graph did appear in the 2003 MSIC evaluation, which demonstrated that publicly discarded needles declined in line with the lesser demand for clean needles as a result of the heroin drought.

The overwhelming majority of injection episodes occurring outside the MSIC means that the MSIC cannot possibly account for the observed decline in discarded needles or public injecting. For example, if we use the 10% figure for injection episodes in the MSIC, then a concomitant decline by 10% in discarded needles and public injecting, all other factors being equal, is the best that can be expected. Other factors might include changes in injection practices, needle sharing, alternate disposal methods, etc. The style of the KPMG report in this section seems to simply assume that the MSIC is responsible (despite weak disclaimers). Furthermore, the steady ongoing decline in discarded needles year by year (KPMG Fig 11-2) suggests that something other than even the heroin drought is going on, since that seemed to be a relatively sudden event (as indicated by the drop in ambulance callouts).

The KPMG evaluation on page 169 records needle counts for various hotspots around Kings Cross and further afield from 2003-2010. Significantly, neighbouring Surry Hills records increases in discarded needle counts while Kings Cross hotspots record decreases, again adding weight to the thesis of policing displacing drug users from Kings Cross to neighbouring postcodes.

Notably, the KPMG evaluation on page 171 does not make a finding from the objective data that the MSIC impacted discarded needle counts, rather they inconclusively state that there was insufficient comparison data to infer any correlation.

Nevertheless the KPMG evaluation finds positively for the MSIC, basing its conclusion on subjective observations by local residents and businesses, most of whom would be unaware that a heroin drought was responsible for reductions in discarded needles and public injecting across the entirety of Australia, and therefore would have significant impacts on Kings Cross. Again, the KPMG evaluation is silent on the tougher law enforcement which would definitely have impacted both public injecting and related publicly discarded needle counts.

The KPMG evaluation further relies on self-reported changes in behaviour from MSIC client surveys. Section 11.3 in the KPMG report on reducing public injection is feeble. Asking new registrants about public injection in the past month tells us nothing about the possible influence of the MSIC. There appears to have been no attempt to follow those clients through their time at the MSIC with the same sorts of questions. The only reported 'result' from current MSIC clients is their response to the statement "Since coming here, the MSIC has helped me to reduce injecting in public places". The only real surprise is that anyone was brave or honest enough to answer "No", yet 8% did.

The statement is a leading one, and the chance to get more useful information is gone. This part is not KPMG's fault as they can only use the data fed to them, yet it is an oversight for a respected independent organization like KPMG to make no statement about the weakness of this finding. On a more pedantic note, clients are also likely to have simply replied to the statement in the affirmative since one interpretation of the statement is that it would be logically inconsistent to answer "No". That is, someone who attends the MSIC at all, must by definition, be injecting less elsewhere.

In summary, it is poor science for the KPMG evaluation to fail to separate and then assess the effect of various confounders regarding objective discarded needle counts. This lack of critical enquiry is endemic to the KPMG report, and its elevating of subjective perceptions where ignorance was most likely to predominate, and reliance on self-report of clients to leading questions is disappointing in the least.

## 4 REDUCING THE SPREAD OF DISEASES SUCH AS HIV AND HEPATITIS C

### Summary

- The KPMG evaluation does not attribute any impact on blood-borne virus transmissions in Kings Cross to the MSIC, however despite not one previous MSIC evaluation attributing any impact on blood-borne viruses to the MSIC, the MSIC Fact Sheet 2010 clearly, publicly and speciously claims success in reducing blood-borne viruses.

### No impact on blood-borne viruses

The KPMG evaluation did not attribute any change in HIV, HCV and Hep B incidence to the MSIC, citing the absence of data from the period before the commencement of the MSIC.

Drug Free Australia notes that despite not one MSIC evaluation attributing any impact on Blood-Borne Viruses (BBV) to the MSIC, the MSIC Fact Sheet 2010 clearly, publicly and speciously claims success in reducing BBVs.

If the logic of this MSIC claim is that clients were supervised after being given clean needles, the fallacy of this illogic must be exposed. For it is very evident that a drug user who has accessed clean needles from the many free needle outlets surrounding the MSIC is 100% likely to use one of those clean needles if unsupervised, in exactly the same manner as if supervised.

Dr Kerstin Käll, a contributor to this Drug Free Australia analysis, notes:

1. Incidence of HIV: Australia has been fortunate in that there has been very little spread of HIV among injecting drug users (IDU). I understand that this is also the case in the (Kings Cross) area studied. It is therefore impossible to draw any conclusions about the trend of HIV incidence among IDU from the data in table 12-4, since the vast majority of reported cases are from men who have sex with men (MSM).
2. As for Hepatitis C (HCV) the main population at risk today is intravenous drug users (IDU). In Europe HCV has been suggested as an indicator for IDU prevalence in comparisons between countries, since most IDU seem to become infected, more so the longer they have been injecting. If this is true in NSW also fig. 12-5 would indicate a downward trend in IDU in the area, although less so in the Kings Cross area. Another interpretation could be that HCV-testing among IDU has decreased.

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3. In summary it seems rather speculative to attribute any of the trends noted to any (positive or negative) effect of supervised injection centre.

## Conclusion

### Summary

- The MSIC has saved only a handful of lives at high cost in 9 years, referred an abnormally small percentage to drug interventions, not objectively shown any significant effect on discarded needles and related public injection, and failed to impact blood-borne viruses. This represents insufficient impact across all objectives.
- The KPMG evaluation has uncritically cited previous demonstrably flawed MSIC evaluations regarding various perceived positive outcomes for the facility eg lives saved estimates. Drug Free Australia has noted that MSIC evaluations, excluding SAHA International 2008) were each produced by colleagues of the MSIC's first Medical Director, creating a conflict of interest in terms of arms-length independence which thereby should have precluded an uncritical acceptance of previous findings.

### Lack of Independence in MSIC Evaluations

Drug Free Australia notes with concern that the KPMG evaluation has uncritically cited previous demonstrably flawed MSIC evaluations, each produced by colleagues of the MSIC's first Medical Director, Dr Ingrid van Beek, or otherwise by advocates of drug liberalization in Australia.

These evaluations have been characterised by conclusions which are not supported by the data, conclusions contradicted by the data, silences regarding negative outcomes for the MSIC, failures in methodology creating favourable and influential false outcomes, and a tendency to ignore the most obvious causal factors for an observed positive outcome so that the MSIC can be held responsible.

Key evaluators straddling the various evaluations have been Richard Mattick, John Kaldor, Margaret MacDonald, and Don Weatherburn. Below are journal studies in which Dr van Beek has worked closely with these evaluators before the first 2003 MSIC evaluation was released, indicating a closeness of working relationship which was never arms-length. Various of these colleagues, like Dr van Beek, are or have been Australian drug liberalisation advocates, and can be construed as possibly operating with an agenda.

1. Shearer J, Wodak A, Mattick RP, Van Beek I, Lewis J, Hall W, Dolan K. Pilot randomized controlled study of dexamphetamine substitution for amphetamine dependence. *Addiction*. 2001 Sep;96(9):1289-96.
2. van Beek, I., Dwyer, R., Dore, G. J., Luo, K. & Kaldor, J. M. 1998, 'Infection with HIV and hepatitis C virus among injecting drug users in a preventative setting: retrospective cohort study' in **British Medical Journal**, Vol. 317, pp. 433-437.

3. MacDonald, M., Wodak, A. D., Ali, R., Crofts, N., Cunningham, P. H., Dolan, K. A., Kelaher, M., Loxley, W. M., van Beek, I. & Kaldor, J. M., on behalf of the Collaboration of Australian Needle Exchanges 1997, 'HIV prevalence and risk behaviour in needle exchange attenders: a national study' in **Medical Journal of Australia** 1997, Vol. 166, pp. 237-240.
4. MacDonald, M. A., Wodak, A. D., Dolan, K. A., van Beek, I., Cunningham, P.H. & Kaldor, J. M. 2000, 'Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia, 1995-1997', in **Medical Journal of Australia** 2000, Vol. 172, pp. 57-61.
5. Weatherburn, D, Kimber, J, MacDonald, M, Van Beek, I, Kaldor, J, Lapsley, H & Mattick, R 2002, 'The Sydney Medically Supervised Injection Centre: Client characteristics and predictors of frequent attendance during the first 12 months of operation', *Journal of Drug Issues*, vol. 33, no. 3, pp. 639-648.

Don Weatherburn is known for his support of drug liberalisation agendas and advocacy for heroin trials and prior advocacy for injecting rooms. Don was involved in the 2003 MSIC evaluation and had organisational oversight of the three BOCSAR evaluations on crime reductions in Kings Cross which failed to assess the impact of changed policing since 2002.

[nceph.anu.edu.au/Publications/Opioids/finalrep.pdf](http://nceph.anu.edu.au/Publications/Opioids/finalrep.pdf) - heroin trial advocacy

<http://www.sydneymxic.com/dsummitoutcome1.htm> - drug summit advocacy for injecting rooms

Dr Lisa Maher is best known for her study on the displacement effect created by tough policing in Cabramatta in 2001. As an evaluator in the June 2007 MSIC Evaluation No. 4 which showed a clear displacement effect in ambulance data, there is no evidence that these evaluators, including Dr Maher, even considered the idea of a displacement effect. The Cabramatta study:

*British Journal of Criminology*, Volume 39, Issue 4 pp. 488-512.

**Policing and public health: Law enforcement and harm minimization in a street-level drug market**

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*Abstract*

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This article describes the impact of street-level law enforcement on Australia's principal heroin market. Based on three years of research, including interviews and extended ethnographic fieldwork, it uses data on drug-use, risk practices, crime, and policing to examine the relationship between law enforcement and harm minimization. Findings suggest that the 'successes' of police crackdowns and their impact on drug markets (including threats to public health and community safety as a result of geographical, social, and substance displacement) may be won at substantial costs, raising doubts as to their value.

## Appendix A

### Assessment of the KPMG Evaluation

*Dr Stuart Reece*

The report by KPMG is a stereotypically sycophantic “Yes Minister” type of production which fails to assume an independently critical stance to the operation of the highly controversial Medically Supervised Injecting Centre (MSIC) at any point. In this it continues a long tradition of rubber stamping this extreme, and extremely unsuccessful measure both from KPMG and other highly paid commentators, and of the East Sydney addiction treatment industry itself. One of the major recommendations of the report, that its nominally “trial basis is problematic’ and therefore requires to be replaced by permanency (p 188), has already been implemented by the NSW Government.

Many of its key conclusions are variously:

- 1) Not supported by the data presented;
- 2) Contradicted by the data presented;
- 3) Internally inconsistent;
- 4) Based on samples which are so tiny as to be meaningless.

One notes that the key contributors and advisors of the project all or mostly have a history of commitment to the drug decriminalisation agenda (see acknowledgements pages (ii), pp 195, 196).

The data presented does not support that the MSIC had any effect whatsoever on:

- 1) Opiate overdose rates, which instead are highly elevated to the point where most of the interviewees have seen someone overdose either in or nearby the MSIC;
- 2) HIV infection rates;
- 3) Hepatitis C infections rates;
- 4) Hepatitis B infection rates;
- 5) The assessment techniques for chronic diseases are weak or meaningless in this group who have previously been shown to have high rates of subclinical diseases. No tests for psychiatric disease, brain scans, osteoporosis tests, or atherosclerosis tests were performed in this vulnerable group whatsoever, which might reasonably be expected to detect evidence of the long term negative health effects of opiate use.

Data presented on nearby crime is meaningless.

Data presented on the opinion of nearby businesses of the operation of the MSIC is superficial and uncritical and known to be highly *un*-representative of the opinion of local businesses.

The extensive data on referral patterns is irrelevant and all but meaningless as similar results would be achieved by any other treatment facility of any nature. Moreover a close reading reveals that these referrals are largely ineffective due to the long waiting time of the medical treatment services to which it refers (p 110, points 2 & 6).

The report does reveal that the MSIC is something of a masterpiece or *tour de force* of bureaucratic administration with over 50 policy and procedures manual, which are central to its protocols and processes (p 98).

The report reflects what may be a growing dependence by Kings Cross users on welfare (up from 58% in 2001 to 70% in 2010) and employment down from 21% to 16% over the history of its operation (Fig. 5.7, p 70)

The MSIC appears to be the place to go to use illegally obtained and illegally used street opioids. This abuse and illegal diversion has increased from 1% in 2001-02 to 53% in 2009-10 (p 112, Fig, 8.1) as “other opioids” are now the most commonly injected form of drug.

The MSIC seems to be the place to go to overdose with “*nearly all*” clients having observed this (p 153, point 1).

The supplementary medical care offered in the MSIC appears to be mainly trivial (Table 8.5 p 116 ff). The vein care which is much vaunted probably has the effect of prolonging the period of intravenous drug abuse, because irreversible collapse of veins is one of the major factors precipitating patients into treatment services. In this sense their efforts are strongly counter-therapeutic.

Oddly this strongly pro-drug treatment stance is strongly at odds with the strong endorsement of the Government’s official anti-smoking policies (described on p 126).

In stark contrast, in relation to the use of illicit drugs the MSIC appears to be self-evidently a treatment of ***despair***. It obviously encourages drug use. Patients begin injecting at 19.8 years, but begin attending the MSIC at 34.3 years (2010) (Tables 9.14 p 85 & 5.2 p 63). One notes also that the great majority of its referrals (59%) are to methadone clinics which is also an addiction maintenance paradigm (Tables 3.2 and 8.13 pp 27, 129). The despair appears to be spreading with 68 new registrants monthly (p 2). Only 12% of drug referrals were to drug free models such as naltrexone, narcotics anonymous or residential rehabilitation combined.

One notes that the financial cost of the MSIC appears to not be fully given. It is nevertheless in the millions of dollars annually. These resources would be much better spent on a naltrexone implant clinic. Indeed one could well argue that if the Government is serious about creating opportunities for all options for vulnerable patients as the report repeatedly suggests, then it is simply negligent not to do so, especially now with several randomised clinical trials supporting this newer treatment modality, and increasing international support for this approach. This is particularly pertinent in the present context where no measures of chronic disease were implemented, as naltrexone has been shown in the published literature to reverse many of the opiate induced pathophysiological changes of long term opiate addiction. Moreover the effects of opiates to increase hedonic and consumptive behaviours as recently noted has not been considered in this report. In particular, by its favourable effect on the immune system, naltrexone would be a greatly preferred treatment for patients with blood borne viral infections such as HIV, and hepatitis B and C. A boards-based and long running Australian experience shows that it would also be a treatment of choice for prisoners upon exit, to positively interrupt the addiction – incarceration cycle so characteristic of inmates imprisoned for drug related offences.

## Appendix B

### Note on overseas injecting facilities

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*It is here noted by Drug Free Australia that European consumption rooms have uniformly been only weakly evaluated.*

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## User rooms

FRANS KOOPMANS

### Preliminary remarks

First some personal preliminary observations: for me it is important to realize that user rooms are part of a broader Harm Reduction paradigm, and that this paradigm itself is part of a broader philosophy of man and his world. *Within a harm reduction (medical) paradigm* a user room can be regarded as something that is understandable. However, change the paradigm, and this understanding disappears. Inherent in the medical view of addiction is an *a-moral* (not: immoral!) ‘non-judgmental’ approach. I regard the almost exclusive medical approach of addiction as an aberration, which doesn’t do justice to what in-depth addiction is about, and which doesn’t do justice to who the addict is and what he needs.

### The Netherlands/Europe

In the Netherlands – and broader, Europe – user rooms have been established (within the framework of so called ‘social addiction care’) as *public health* and *public order* measures with respect to high-risk populations of drug users, especially drug injectors and those who use in public spaces.<sup>16</sup> In general, on the basis of present experience, there is the awareness by those in favor of user rooms that though (in their opinion) the evidence suggests that the benefits of consumption rooms can outweigh the risks, one has to set this phenomenon in the wider context of problem drug use and of responses to it, and to be *modest* in claiming what consumption rooms can or cannot achieve. They realize that user rooms are not able to prevent all public drug use, will not persuade all clients to reduce risky drug use or enter treatment, will not in themselves be the major factor in reducing morbidity and mortality and will not solve wider problems of drug markets and drug dealing. In the Netherlands the user rooms are part of an integral

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<sup>16</sup> *Public health measures*: 1. help drug users survive by reducing the immediate health risks related to drug use in high-risk settings; 2. to provide a safe place that enables lower risk, more hygienic drug consumption; to reduce mortality and morbidity among their target population by providing risk reduction education and health promotion advice; 3. and to stabilise and promote the health of their clients through increasing their access to and uptake of medical care and drug treatment services.

*Public order measures*: reduce nuisance and threats to public safety that arise from open drug scenes by providing a sheltered environment for drug consumption and thus reducing the level of public drug use.

approach of, on the one side, repression, and, on the other side, care. All relevant parties are involved: police, justice, municipality, care, treatment centers.

### **Data**

The following data are based on the *European report on drug consumption rooms* (Hedrich 2004, p. 71). The number user (consumption) rooms in Europe, and the year they were introduced

Switzerland	12 user rooms in 7 cities (1986)
Germany	25 user rooms in 14 cities(1994)
Netherlands	22 user rooms in 12 cities (1994)
Spain	3 user rooms in 3 cities (2000)

On the basis of a recent report (Van Laar et al 2009), the number of user rooms in the Netherlands has increased to 40 in 2006 in about 15 cities. There is, however, some fluctuation in this number as – because of resistance in the population – some user rooms are closed and others are opened. I assume that in other countries there also will have been a rise in the number of user rooms.

### **Conclusions on the basis of several surveys (EMCDDA)**

On the basis of five targets, the EMCDDA concludes the following regarding user (consumption) rooms:

#### *1. reaching the target population*

The consumption rooms reach their defined target population, including street users and older, long-term users who have never been in treatment. There is no evidence that they recruit drug users into injecting. It is seen as very important that staff will be sympathetic and non-judgmental towards problematic, marginalized and sometimes difficult clients, yet at same time be clear and consistent about admission criteria and house rules.

#### *2. Immediate health objectives*

The report states that consumption rooms achieve the immediate objective of providing a safe place for lower risk, more hygienic drug consumption without increasing the levels of drug use or risky patterns of consumption.

#### *3. Medium-term health objectives*

The report indicates that consumption rooms have encourages sustainable changes in risk-taking behavior by some (so not all! FK) clients and has contributed to reducing drug-related health damage among a difficult to reach target group. This could only be realized by systematic safer use education in consumption room settings. The report is, however, aware of the fact that no conclusions can be drawn about the direct impact on infectious disease incidence owing to a lack of studies and methodological problems associated with isolating the effect of consumption rooms.

#### *4. Long-term health objectives*

Consumption rooms, says the report, clearly increase access to drug services and health and social care. And this would promote the ‘social inclusion’ of a group of extremely marginalized problem drug users. Only a small proportion of clients use the facilities for

drug consumption purposes only. The report denies that consumption rooms hold clients back from starting treatment by making drug use more ‘comfortable’. It is, however, aware that consumption rooms might conflict with treatment goals.

#### 5. *Public order and crime objectives*

Reduction of public nuisance, i.e. reducing the level of drug use in public, is one of the targets for establishing user rooms. The success depends on their accessibility, opening hours and capacity to accommodate drug consumptions that would otherwise occur in public. One has to take into account the needs and expectations of local residents. The user rooms need to be part of a comprehensive local strategy, so that reduction in one area does not lead to increase in other areas (the ‘waterbed-effect’).

The evidence, according to the EMCDDA, suggests that consumption rooms only make sense, and can only be effective, if they are:

- established within the wider framework of a public policy and network of services that aim to reduce individual and social harms arising from problem drug use;
- based on consensus and active cooperation between key local actors, especially health workers, police, local authorities and local communities;
- seen for what they are – specific services aiming to reduce problems of health and social harm involving specific high-risk populations of problematic drug users and addressing needs that other responses have failed to meet.

#### **The Netherlands**

Initially, in the Netherlands there was some anxiety with the policy makers regarding such facilities. User rooms fall under the responsibility of the so called local triangle: the chief of police, the mayor and the public prosecutor. At a national level the following conditions prevail: 1. No large-scale character; 2. Dealers are not condoned; 3. No free access of addicts. There has been emphasis on integration of user rooms within the regular addiction care (so called ‘integrated’ user rooms, meaning being attached to already existing low threshold addiction care facilities). The first official user rooms were established in the nineties, financed by the local municipality. By formal instruction of the Narcotics Law in December 2000, the user room has been given a legal status, under the condition that use of drugs is done under supervision and that dealing is prohibited. The first results (Trimbos-instituut 2000) were regarded to be positive: less use in the streets and in the nearby ‘dealing apartments’ and better access to care for this group of addicts. The conditions were long opening hours, an adequately equipped room, a low stress setting, good cooperation with the police and involvement of the neighborhood. Access to the user room is by use of identity card system, thereby ensuring that it will not be possible for youngsters and occasional users to enter the user room.

The writers of the *Evaluation of the Dutch national drug policy* (2009), state that by and large the experience in the Netherlands with user rooms has been positive, based on research of 2002 and 2004. They point to the fact that only in a limited number of countries in the world this phenomenon has been established and that international research into user rooms is therefore scarce. Even though there are many user rooms and hostels for drug users, there has not been a systematic evaluation of their effect. There only are some local evaluations that not always can be compared.

On the basis of the small research in the Netherlands, indicated above, they hold that user rooms have a positive influence on the health situation of the visitors, that public nuisance decreased and that the reach of the addiction care is broadened. However, so they admit, the measure in which this positive influence has actually occurred is hard to record numerically, so firm judgments about the effectiveness are not possible. Other more qualitative studies indicate that user rooms contribute, though on a moderate scale, to the improvement of the overall health condition of the users, reduce the risk of infectious diseases, reduce the number of drug deaths (by overdoses) and stimulate the users to go for treatment.

Even though in general there is support for user rooms in the general population, the support depends on the actual reduction of public nuisance. Not always do users make use of the user rooms when they have acquired their drugs. The writers state (with regard to addicts in Rotterdam): ‘Addicts, especially the target group of the user rooms, do not have the time and the rest to save their drugs and use it elsewhere’. In other cities there is the so called NIMBY effect: Not In My Back Yard. Even though the general population is in favor of user rooms, they don’t want them in *their* neighborhood, as they fear increase of public nuisance. In the cities where there was this resistance and user rooms were still established, there appeared to be no increase in public nuisance (however, these data are from 1998-2000). From other (local) research it appears that few addicts stop their use by joining specific programs aimed at reduction of public nuisance. Few addicts were capable of achieving an independent, regulated existence. Still, reduction of public nuisance was achieved.

The writers point to the fact that user rooms are not accepted by the INCB. They quote the INCB Annual Report 2005 (p.77): ‘The Board also reiterates that drug injection rooms are against the central principle embodied in the international drug control treaties, namely that the use of drugs should be limited to medical and scientific purposes only.’ The INCB has also openly criticized other countries with user rooms (like Canada, Germany and Switzerland).

## **Literature**

Garth Davies (2006), *The impact of supervised injection facilities: a critical review*, Addictive Drug Information Council

Dagmar Hedrich (2004), *European report on drug consumption rooms*, EMCDDA

Grazyna Zajdow (2006), ‘The narrative of evaluations: medically supervised injecting centers’, *Contemporary Drug Problems*, vol. 33/3, pp. 399-426

Van Laar et al (2009), *Evaluatie van het Nederlands Drugsbeleid* (Evaluation of the Dutch national drug policy), WODC (Research and Documentation Centre of the Ministry of Justice), Trimbos Instituut (Netherlands Institute of Mental Health and Addiction)