CORRESPONDENCE BETWEEN DRUG FREE AUSTRALIA AND THE KINGS CROSS INJECTING ROOM

Sent to Dr Van Beek and Update Listserver on 27/9/2003

Open letter re MSIC Overdoses 27/09/2003 3:20:18 PM

From: Gary Christian
To: vanbeek
Cc: R.Mattick
Bcc: update@ilanet.net.au
Attachments:

OPEN LETTER TO DR INGRID VAN BEEK - MEDICAL DIRECTOR, SYDNEY MSIC

Dear Dr Van Beek

Thank you for professionally engaging our analysis of the MSIC evaluation report last Wednesday evening in Canberra.

I particularly want to reply to your explanation concerning the very high number of overdoses in the Centre. Using the report's own estimates of the number of injections per day in Kings Cross, overdoses in the Centre were 36 times higher on average than the rest of Kings Cross (the overdoses for Kings Cross are estimated on the report's own method of calculating total overdoses ie ambulance overdose callouts divided by 51 and multiplied by 100). You criticised the MSIC report's own estimate of 6000 injections perday in the Cross as overstated and we would be happy to accept your concern. But even cutting the user numbers to 1000 instead of the report's estimate of 2000 heroin users per day in the Cross still leaves the MSIC with 18 times the overdose rate of the area. Cutting it to 500 per day in the Cross still leaves it 9 times more overdoses than the rest of Kings Cross.

Your second reply on this over-representation of overdose in the MSIC was to posit a bi-modal heroin user population at the Centre. This would mean that the high-risk users tended to inject many times in the MSIC, while low-risk users injected very few times, perhaps just once. This would remove many of the overdoses from the Kings Cross area into the MSIC and explain the high numbers inside and the relatively low numbers outside. In other words 10% of the MSIC clients could be having 85% of the injections in the MSIC.

However, the number of overdoses in the MSIC is simply so high that even a bi-modal explanation cannot suffice.

The nature of the problem is this - there are approximately 34,500 heroin injections in the MSIC over the 18 month evaluation period, and 329 heroin overdoses. This yields the astonishing rate of one overdose

for every 105 heroin injections. One can imagine what would happen if this rate was applied to every heroin injector across Australia. Users would be dropping like flies.

Regular users injecting once daily would average 3-4 overdoses per year. Users who inject three times a day would have 10 overdoses per year. Users who inject 6 times a day would have 20 overdoses per year.

Applied to the official estimate of Australia's heroin user population which injects at least once daily, the 74,000 users would have 257,520 overdoses per year. And that is for regular users having only one injection per day. If the average for regular users is two per day, then the overdose count would be more than half a million. And the overdose estimate for Australia annually is only 15,000 per annum (see the ANCD paper on heroin overdose p 12).

You can see the problem. The MSIC rate of overdose creates a bizarre world of massive overdoses when applied to the world outside the MSIC. And it this extremely low number of injections per overdose which causes problems for the MSIC. Also remember that this overdose rate is raw MSIC data, with no imported assumptions or otherwise-derived estimates to cloud the issue.

Now applied to the bi-modal explanation, here is the problem. The MSIC massive overdose rate means that if one high-risk user has 600 injections in the MSIC, statistically that user should have roughly 6 overdoses (at the rate of 1 overdose every 105 injections) in the 18 month evaluation period. But what it also means is that if that same high-risk user injects regularly at the MSIC report's own conservative estimate of 'at least' 3 injections per day over the 544 days of the trial period, their injections outside the MSIC are going to yield another 10 overdoses outside the MSIC. (By the way, the manager at my ADRAcare Centre at Cabramatta, which has up to 22,000 visits per year by mostly heroin users says that 6 injections per day is the average for his clientele, which tend to be the high-riskhomeless and street users, so we are happy to accept the MSIC report's estimate of 'at least' 3 injections per day as conservatively realistic).

These 10 overdoses should somehow be partially captured in ambulance callout data for the rest of NSW. Of course, 16 overdoses for one person is an extraordinary scenario, but the bi-modal interpretation of the data implies exactly this. High numbers of injections in the MSIC by high-risk clientele does indeed reduce the overall overdose impact by these clients on the rest of NSW, but it comes at a statistical cost - an unrealistic loading of these high risk clients with an over-representative number of overdoses per person.

For instance, if you posit that 250 of the 2080 heroin injectors in the MSIC were the high-risk clients who had the 329 overdoses, you will average 1.32 overdoses for each of these clients for their (average) 126 visits to the Centre. But because these high-risk clients are also most likely to be daily injectors with at least three injections per day, they are statistically going to have another 15.7 overdoses each on the street. That means 3926 overdoses for just 12% of the MSIC heroin users (if they are indeed all high-risk MSIC clients), which when adjusted for likely ambulance callouts (the MSIC report itself estimated that 51% of overdoses are attended by an ambulance) is roughly the same as the entire number of ambulance callouts for the whole of NSW (n=2,178) during the evaluation period.

This is the problem with the massive overdoses at the MSIC. Whichever way you push the data, the one overdose for every 105 injections inside the MSIC still makes for massive overdose implications OUTSIDE

the MSIC, which can be compared with outside data (such as we have here with ambulance callouts) for its validity and reliability.

This is a major problem for the MSIC that arises from its own data. Our concern is not merely one of one-upmanship in the course of a debate. Rather it is a concern that the massive overdose rate implies that more heroin is being purchased from local drug dealers around the MSIC, and that the presence of the MSIC is the sufficient cause of this higher heroin trade. The most plausible explanation we can see is that MSIC clients use the MSIC to test their tolerance levels to heroin by injecting more than usual, knowing that they can experiment with the insurance of nursing staff present if anything goes wrong. And if today's experiment of 10% more heroin was safely negotiated, then that user will be buying 10% more heroin off the dealer for every day after, ensuring permanent increases in profit for the heroin dealers. On this scenario. the MSIC is aiding and abetting the drug trade in Kings Cross, a problem that would not have existed if the overdose rates in the MSIC were the same as for the rest of Kings Cross.

Ingrid, I believe that you are doing what you do out of a deep, heartfelt compassion for the users of Kings Cross. It is a hard call to speak against the MSIC with this in mind. But we believe that the people of NSW would be highly concerned by the implications of the MSIC overdose rate. And it is our commitment to evidence-based drug policy, with the views of NSW citizens in mind, that leads us to question the viability of the MSIC's future on this elevated numbers of overdose.

We are certainly open to a response.

Regards

Gary Christian
(Drug Free Australia)

"Ingrid van Beek"
<VanBeekI To: <gichristian>
cc: <R.Mattick, <jkaldor>
Subject: RE: Open letter re MSIC Overdoses
13/10/2003 07:06 PM

Dear Gary

I herewith attach my reply to your open letter to me.

You will note that I begin with the definition used by the MSIC to diagnose heroin overdoses, and include how these were verified by the evaluation team.

As you are probably aware, your colleague Michael D. Robinson has questioned what we define as an overdose, stated publicly that the evaluation team relied on self-report from the MSIC in this regard, going on to suggest that the clinicians at the MSIC may have inflated this, in order to keep their jobs.
We respect the right of people not to agree with MSIC as an approach to the drugs problem in Kings Cross, but would hope that this could be expressed without needing to cast doubts about the professional integrity the people who work there.

I would like to think that despite differences in approach, all of us working in this field have the same goals.

Best wishes
Ingrid van Beek

Mr Gary Christian

(Drug Free Australia)

13/10/03

Dear Gary,

I write in response to your "open letter" to me regarding heroin overdoses at the MSIC. It would seem worthwhile to begin by stating that the MSIC defines the opioid (including heroin) overdose syndrome according to Harrison's Principles of Internal Medicine (13th Edition, Vol 2, page 2426) as: shallow respirations (of 2 – 4 per minute), pupillary miosis ("pin point" pupils), bradycardia (slow heart rate), a decrease in body temperature and a general absence of response to external stimulation (decreased level of consciousness). The MSIC uses the internationally recognised and validated Glasgow Coma Scale to objectively assess clients' level of consciousness.

If this medical emergency is not treated immediately with oxygen, these symptoms can progress to cyanosis (manifest as blueness of the lips) and death can ensue from respiratory depression and cardio-

respiratory arrest. While not all heroin overdoses will result in death, hypoxia (low oxygen levels in the blood) will cause damage to the vital organs, particularly the brain, if not treated promptly. Such damage can be progressive among people who suffer multiple episodes of hypoxia in association with heroin overdose over time.

All drug overdoses assessed and managed at the MSIC are documented in the client's medical file by the registered nurse involved in the resuscitation procedure. All medical files at the MSIC are legal documents and are subject to random audit by the NSW Health Department. All drug overdoses documented by the MSIC during the evaluation period were individually verified by the independent evaluation team.

In contrast to the community situation, health professionals in the MSIC setting are able to systematically and objectively identify all heroin overdoses as well as the number of heroin injections by individual IDUs, thereby providing a reliable and accurate estimate of the rate of heroin overdose at the MSIC for this IDU population.

To reiterate my reply to you following my recent presentation in Canberra, I noted that your assertion regarding the MSIC's heroin overdose rate compared to elsewhere in Kings Cross was based on the Final Report of the Evaluation of the MSIC's estimate that 6,000 heroin injections occur in the Kings Cross area each day. This estimate seemed high to me, given that the primary needle syringe program in the area distributed less than 2,000 needles syringes a day from all of its outlets during the period, that not all of these needle syringes would have been used to inject in this area, and less than half would have been used to inject heroin at that time. However, in the absence of a better estimate, I recommended that a local methodology be developed to monitor the size of the IDU population and patterns of drug injection in Kings Cross, important indicators of the effectiveness of the MSIC and other drug strategies.

In your letter you have estimated that at the heroin overdose rate of the MSIC, IDUs injecting 3 times a day would have 10 overdoses a year. Among the core population of IDUs seen at the MSIC on a regular basis, probably many do overdose this often. But this is a particularly high risk sub-population from an overdose perspective, not representative of the entire IDU population.

While this high overdose rate might be expected to also be reflected in local ambulance call-out statistics, this assumes that a significant proportion of all heroin overdoses result in an ambulance call-out. The MSIC Evaluation Report cited one study (Darke et al 1996) from which it was estimated that 51% of heroin overdoses resulted in ambulance call-out. However this study recruited a stratified sample of IDUs which had quite a different overdose risk profile to the MSIC population, in 1994, which was another era in terms of drug using patterns and heroin overdose prevention strategies in place.

Like other studies in this regard, it relied on retrospective self-report by IDUs, which has limitations. Many drug users do not realise that they have overdosed because they have necessarily experienced a decreased level of consciousness, and have often also used the benzodiazepine group of drugs (eg temazepam), which specifically affect short term memory. It also seems likely that under-reporting would greatest for overdoses that did not result in an ambulance call-out, this perhaps being a less memorable event. I suspect that the actual non-fatal heroin overdose rate in the community is higher than that ever previously reported.

Mathematical calculations of heroin overdose rates per heroin injection may tell us something about a particular time and place, but have limited predictive value. This is because the number of heroin injections

is only one of the risk factors involved. While there is likely to be a relationship between the two, it is not necessarily linear, because of the range and variability of the other risk factors (such as drug purity, other drug and alcohol use, IDU tolerance and risk profile) affecting the incidence of drug overdose across time, geographical areas, and subpopulations of IDUs. For example the rate of deaths from heroin overdose started to decrease in late 1999 whereas the number of needle syringes dispensed in NSW continued to increase until late 2000.

For the same reason such rates can't be back-projected. For example your estimate that there is one heroin overdose death per 190,000 heroin injections elsewhere in the Kings Cross community when applied to the nation would mean that in 1999 when there were more than 1,000 deaths from heroin overdose in Australia, there would have been more 190 million heroin injections. Yet only about 31 million needle syringes were dispensed nationally, only 53% of which were used to inject heroin that year.

You may have a sincere concern that the MSIC is not only not meeting its aim of reducing the morbidity and mortality associated with drug overdose when they occur in un-supervised settings, but is actually increasing individual's level of drug use and in so doing, the drug industry, but I reassure you that there is no evidence of this. The number of drug users and the number of needle syringes dispensed in the area decreased significantly. More IDUs reported that they had decreased their frequency of injection since attending the MSIC than the reverse. IDUs were not observed to be more intoxicated during the period. In fact they exhibited increased symptoms of heroin withdrawal than usual due to its low purity and availability during the heroin shortage. Drug-related crime (including drug supply) decreased in Kings Cross during the evaluation period, in line with the rest of NSW.

Finally, as I concluded in Canberra, there is clearly much scope for further investigation to improve our understanding of this important public health issue. I hope that the MSIC will provide a setting in which to progress this.

Yours sincerely
Ingrid van Beek.

From: Gary Christian
Sent: Wednesday, 22 October 2003 8:51 PM
To: update@ilanet.net.au
Subject: Reply to Ingrid Van Beek's Reply - Massive Overdose N umbers in MSIC

Updaters

Below is a reply to Dr Ingrid Van Beek's letter which I posted over a week ago on Update.

Notably, in this reply,

1. Ingrid's assertion that more than 10 overdoses per year per client might be considered unextraordinary for her MSIC clientele is shown to be totally at odds with the MSIC's own data which shows that only 12% (median 1 per client) of the Centre's clients had overdosed in the 12 months prior to registration, and 44% (median 3 per client) had ever overdosed.

2. Ingrid's explanation of many unrecognised, unrecalled overdoses by heroin users is shown to destroy the very basis on which the 'lives saved' estimates were made in the MSIC evaluation, reducing the estimates of 4-9 lives saved per year to only a fractionof one life saved, a conclusion already made by Drug Free Australia from Kings Cross mortality data.

3. The assertion that there are many more overdoses in the community (based on MSIC observations) than previously realised is shown to be an argument from silence which can have no value in evidence-based science.

4. Ingrid's questioning of the Darke et al. ratios of fatal to non-fatal overdoses is shown to be ill-founded, as is shown by comparable studies.

Regards

Gary Christian
CHIEF OPERATIONS OFFICER
ADRA Australia

ADRA Australia
146 Fox Valley Road
Wahroonga NSW 2076

22 October 2003

Dr Ingrid Van Beek
Medical Director
Sydney Medically Supervised Injecting Centre

Dear Ingrid

Re: Massive Rate of Overdose in the Injecting Room

In my last letter to you dated 27 September 2003 I noted that the injecting room's overdose rate of one overdose for every 105 heroin injections indicated such a massive over-representation of overdose that, ifgeneralised to the rest of Australia's heroin using population, would create a bizarre world in which every heroin user would be expected to have an average of 10.44 overdoses annually, thus resulting in 515,000 (1) and 773,000 (2) non-fatal overdoses in Australia per year instead of the currently estimated 15,000. (3)

EXPLANATION CONTRADICTED BY CENTRE'S OWN CLIENT PROFILE

In your recent reply you stated that the discussed 10.4 average (4) annual overdoses per MSIC client derived from your Centre's high overdose rate could well be considered quite unextraordinary for your clientele.

But the overdose history of your centre's clientele directly contradicts this explanation. The MSIC evaluation report recorded the following (5):

Overdosed in last 12 months: 12% (median 1 overdose per client)

Ever overdosed: 44% (median 3 overdoses per client)

Over the average 12 years (6) of illicit drug use by injecting room clients, a median average of 3 overdoses per client is a long way short of 10.4 overdoses each per year. In 12 years, injecting room clients, overdosing at the rate they do in the injecting room, should be expected to amass an average 125 overdoses each. And yet the injecting room's own entry survey says they averaged just three.

Therefore, on the injecting room's own data, clients had an injecting room overdose rate most likely 30 to 40 times (7) higher than their overdose rate prior to using the injecting room. This is notably similar to the Drug Free Australia observation that the injecting room evaluation's own data and assumptions yielded an overdose rate 36 times higher than the rest of Kings Cross.

And this would also provide independent confirmation of the ratio of heroin overdose fatalities to non-fatal overdoses calculated by Darke et al. (8)

LATEST EXPLANATION CONFIRMS NOT ONE LIFE SAVED

The injecting room response to Drug Free Australia's criticism of its overdose numbers is to venture that the Centre's heroin using clients have actually been experiencing one overdose for every 105 injections throughout their heroin using career. The injecting room is proposing that due to a lack of recall associated with various overdoses these same users simply do not realise that their overdose rate is really 30 ? 40 times higher than what they have self-reported in the registration survey.

Assuming that this explanation was true, the current national estimate of 15,000 non-fatal overdoses per year would immediately and necessarily be scrapped for a new figure of 515,000 and 773,000 non-fatal overdoses nationally every year, overdose totals 34-52 times higher than the present estimate.

But this massive inflation of non-fatal overdose estimates for Australia would come at a terrible price. Any and all overdose mortality estimates (such as those by Darke et al which was the pivot-point for the injecting room evaluator's calculations of 'lives saved') based on the ratio between known fatal and non-fatal overdoses, would necessarily have to be reduced.

Where it was now considered that non-fatal overdoses were 34-52 times higher than previously recognised estimates, ratios of fatal to non-fatal overdose would now have to be reduced by a factor of 34-52. And applied to the injecting room evaluation report, the 4-9 lives saved each year are reduced to a mere fraction of one single life that could be considered saved by the presence of the MSIC, precisely the same conclusion reached by the Drug Free Australia from comparisons with Kings Cross overdose fatalities during the MSIC evaluation period.

INJECTING ROOM HYPOTHESIS IS UNVERIFIABLE CONJECTURE

We, the authors of the Drug Free analysis of the MSIC evaluation report, do believe that the injecting room provided objective, verifiable evidence that there was one overdose for every 105 injections in the injecting room during the evaluation period.

But it must also be understood that the injecting room's hypothesis of numerous unrecognised, unobserved and unrecalled overdoses is merely an argument from silence, an argument which is in this case totally refractory to verification.

To further explain, any hypothesis requires some kind of founding observation to be a hypothesis. If it is countered that staff observations of high overdoses in the injecting room constitute such a founding observation, it must be emphasised that high overdose numbers in the injecting room is precisely the phenomenon to be explained, creating an untenable circularity. The supposed high rates of overdose per client, unseen and unrecalled, have clearly never been observed by injecting room staff, and are merely supposition and conjecture, a belief perhaps, but never open to verification or falsification.

Alternatively the high number of overdoses in the injecting room admits of a vastly more verifiable explanation. The injecting room evaluation report records NSW surveys (9) in which 3 and 5 percent of those surveyed stated they would use heroin if medical staff were present as insurance against the risk of overdose. Notably, 26 out of 28 respondents in the second of these surveys had not used heroin before.

While recognising that the injecting room did not permit entry to first-time injectors, it is nevertheless abundantly clear that the presence of medical staff is considered as insurance against high-risk experimentation with heroin. Overdose as a result of users trying to rediscover the rush of their first experience with heroin is well established in the literature as well as anecdotally. It is both verified and well established. We cannot accord the same to an argument from silence.

I trust this better explains our concerns.

Yours sincerely

Gary Christian
(Drug Free Australia)

Appendix A

MSIC Client Profile Almost Identical to 1994 Cohort of Darke et al.

With 59% (10) of MSIC clients being regular heroin users, we can correct for the fact that the heroin using sub-group are the ones most likely to be presenting with a history of overdose. The corrected overdose percentages for the MSIC, in the table beneath, are compared to the overdose percentages in the 1996 study by Darke et al. which formed the basis of the injecting room evaluation report's 'lives saved' estimates. Other similar studies listed beneath show that the injecting room clients are certainly not at higher risk of overdose than other representative studies.

Study Overdosed	Last 12 mths	Ever Overdosed
MSIC at enrolment (corrected for heroin user sub-group only)	20%	56%
Darke et al.(1996) (11)	20%	68%
McKetin, Darke et al. (2000) (12)	20% Adelaide 28% Sydney 36% Melbourne	51%
Bennett & Higgins (1999) (13) (British study)	30%	58%

It must be noted that the Darke et al. 1996 study of a cohort of Sydney users has an overdose profile remarkably close to the MSIC profile. Having already independently confirmed that Darke et al.'s estimates are in the same ballpark as those suggested by the MSIC data, we have to reject the criticism of the Darke et al. study recorded in your last response.

1. Calculated on Australia's estimated heroin using population averaging 2 injections per day (730 injections per year with one overdose every 105 injections = 6.95 overdoses for each of Australia's estimated 74,000 daily heroin users)

2. Calculated on Australia's estimated heroin using population (74,000 users) averaging 3 injections per day (as per the MSIC evaluation report's own estimate of heroin user daily frequency being 'at least' 3 injections per day ? page 58)

3. Warner-Smith M.; Lynskey M.; Darke S.; Hall, W. ANCD Research Paper 'Heroin Overdose ? Prevalence, Correlates, Consequences and Interventions
ANCD Canberra (2001) p.12
4. Calculated at one overdose per 105 injections for a user averaging 3 injections per day (as per the MSIC evaluation report's own frequency estimate) over 365 days (365 x 3 / 104.86)
5. par 1 p 16
6. par 2 p 8
7. It is noted that while the median average for overdoses in the last 12 months was 1, there was a range of 1 ? 31 overdoses for the same clientele. Unfortunately the MSIC evaluation report does not give enough information to precisely calculate the total number of overdoses experienced in the previous 12 by newly registered injecting room clients. If the MEAN average was 1 overdose per person, the expected 21715 overdoses for the 2080 MSIC heroin users (calculated at 10.44 overdose per year per person) would be 48 times higher than the 454 overdoses represented by this mean average. Thus, taking account of a umber of MSIC clients having multiple overdoses in the 12 months prior to registration, it seems conservatively fair to say that if all MSIC heroin users consistently overdosed at injecting room overdose rates they would be expected to overdose 30 to 40 times more often than reported at registration.
8. Darke, S., J. Ross et al. (1996). 'Overdose among heroin users in Sydney, Australia: I. Prevalence and correlates of non-fatal overdose'. Addiction 91: 405?411.
9. p 157 par 2 and 158 Table 8.4
10. 55% of MSIC users are heroin users, while another 4% are heroin and cocaine users.
11. Darke, S., J. Ross et al. (1996). 'Overdose among heroin users in Sydney, Australia: I. Prevalence and correlates of non-fatal overdose'. Addiction 91: 405?411.
12. McKetin, R., S. Darke et al. (2000). Australian Drug Trends 1999: Findings from the Illicit Drugs Reporting System (IDRS). Sydney: National Drug and Alcohol Research Centre. Monograph 43.
13. Bennett, G. and D. Higgins (1999). 'Accidental overdose among injecting drug users in Dorset, UK'. Addiction 94: 1179?1190.

Received by e-mail 24/10/2003

Gary, you do not seem to have connected aspects of my reply to you.

Expressed more succinctly, I suggested that elsewhere in Kings Cross there may have been more heroin overdoses occurring (perhaps up to twice as many, not 36 times) among fewer heroin injecting episodes (perhaps around 1,000 instead of 6,000 a day. This would render a rate of heroin overdose in the MSIC somewhere closer to three times that of elsewhere in Kings Cross. This difference is about what might be expected, given the higher drug overdose risk profile of the street-based IDU sub-population targeted by the MSIC compared to the rest of the IDU population. But I reiterate that there needs to be further research to verify this suggestion.

There was no evidence that drug users injected more heroin at the MSIC than they did elsewhere as you hypothesise. This seems particularly implausible given that this phenomenon has never been reported anywhere in the scientific literature to date despite 60 supervised injecting facilities now operating worldwide for up to 17 years. But again, further research into the impact of a safer environment on injecting practice would be welcomed by me.

Regards Ingrid

From: update-bounces@adca-lists.org.au [mailto:update-bounces@adca-lists.org.au] **On Behalf Of** Bernadette Keeffe
Sent: Thursday, 20 July 2006 5:25 PM
To: update@adca-lists.org.au
Subject: [Update] CORRECTION OF MISINFORMATION MSIC

"It's the misinformation that makes us mad!"

CORRECTION OF MISINFORMATION COMMUNICATED ABOUT THE MEDICALLY SUPERVISED INJECTING CENTRE IN KINGS CROSS, ON 2GB RADIO BY MAJOR BRIAN WATTERS – FORMER CHAIR OF THE AUSTRALIAN NATIONAL COUNCIL ON DRUGS (ANCD)

Please see the following transcript of Major Watters' interview with 2GB's Jason Morrison on Wednesday July 12, 2006 followed by the correct information.

Major Watters: "Hi Jason; glad you're a voice of commonsense in this thing.

Today they had this big self-congratulatory get together in Parliament House, these people. Interesting that people like me weren't invited – they were all the stooges together, slapping each other on the back to say how good this is".

Fact: Uniting*Care* (the arm of the Uniting Church of Australia that holds the license to operate the Medically Supervised Injecting Centre) hosted a symposium at NSW Parliament House on 12 July to report back on its first 5 years of operation. The current Chair of the ANCD was invited along with the other members of the ANCD and all state politicians in NSW - who could hardly be described as "stooges" for the MSIC.

Major Watters: It's the misinformation that makes me mad. They're all on about the drops in deaths but the fact is that's a result of the heroin drought, which was a result of Federal Government policy. There's been a dramatic drop in deaths, quite irrespective of the injecting room.

In 2000 - 24 people died in Cabramatta. In the next 6 months that dropped to five. At the same time in Kings X it went from 13 to 24 - the number of deaths doubled after the room opened".

Fact: There were approximately 50 heroin-related deaths per annum in the Kings Cross area in the late 1990s, prior to the establishment of the MSIC in May 2001. In the MSIC's first 18 months of operation this decreased to 11 deaths per annum. [MSIC Evaluation Committee (2003) Final Report].

Major Watters: "In Cabramatta the number of needles dispensed fell from 194,000 to 46,000. It used to be the drug capital of Australia. Kings Cross? We can't get the figures. They won't give them to us.

Fact: There has been a 40% reduction in the number of needle syringes dispensed through the various needle syringe programs in Kings Cross (including those used at the MSIC), since 2000. The reduction in needle syringes dispensed in Kings Cross has exceeded that of the rest of NSW where it decreased by 30%. [Medical Director's Report. Face-Up Newsletter, July 2006]

Major Watters: "Ambulance callouts – Cabramatta dropped 385 to 30. Kings Cross – for the same period they went up to 223."

Fact: In 1999 there were 677 ambulance callouts in Kings Cross compared to104 ambulance callouts to heroin-related overdoses in 2004 [source: NSW Ambulance Service] representing an 84% decrease. Ambulance call outs to heroin-related overdoses in NSW decreased approximately 63% post-heroin shortage. [Degenhardt, L., Conroy, E., Gilmour, S., Hall, W. *The effect of a reduction in heroin supply on fatal and non-fatal drug overdoses in New South Wales, Australia*. MJA 2005; 182 (1): 20-23].

The MSIC acknowledges the major contribution of the national heroin shortage to this decrease in ambulance callouts to heroin-related overdoses, however posits that the successful treatment of some 1600 overdose cases on-site at the MSIC during its first 5 years, is likely to have contributed to this greater decrease in callouts to overdose cases in the Kings Cross compared to the rest of NSW. [Medical Director's Report. Face-Up Newsletter, July 2006]

From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] **On Behalf Of** Bernadette Keeffe
Sent: Tuesday, 25 July 2006 9:51 AM
To: drugtalk@adca-lists.org.au
Subject: [Drugtalk] "It's the misinformation that makes us mad"

Dear Mr Christian

Would you please elaborate further re your query: why the ambulance call-out comparisons of the first 18 months of injecting room operation do not apply to the time since October 2002?

Meanwhile would you please note that the new estimate for the IDU population in Kings Cross during the 12 months to 31 October 2002 is 1100, instead of the 4 000 IDUs estimated in the 2003 Final MSIC Evaluation Report - not 2 000 IDUs as you cite in the following: The Drug Free Australia determination of overdoses at 36 times the rate of overdoses on the street is indeed measured using the evaluation's estimate of 2,000 users in Kings Cross each day, (injecting an average of 'at least' 3 times a day resulting in 6,000 injections per day in Kings Cross - p 58 of the evaluation).

Regarding your efforts to estimate lives saved at the MSIC using drug overdose/ambulance callout rates etc:

It needs to be appreciated that not every heroin injecting episode among every IDU carries the same risk of heroin overdose. Individual IDUs' risk also varies over time and individual IDUs' decision to utilise the MSIC on a particular occasion may be influenced by a range of factors, which may include their risk of overdose at that time.
For example: it has been estimated that injecting in a public place increases the risk of overdose threefold compared to other situations. More social marginalised IDUs are also considered to be at higher risk heroin overdose. It is well established that the MSIC has engaged the most socially marginalised of the IDU population and that having a history of public injecting is a predictor of frequent attendance at the MSIC.

Please also note that the impact of the MSIC's intervention in relation to drug overdose, which includes post-overdose counselling at the time and again at their next visit about the risk factors involved, is likely to extend beyond the MSIC setting - IDUs being better informed to prevent subsequent overdoses in all situations, not just when they inject at the MSIC.

It should also be noted that the number of ambulance callouts wherein naloxone is administered is an underestimate of the incidence of non-fatal overdose in the community, and that IDUs under-report past overdose, being drug-affected decreasing recall ability.

Finally: the ambulance callout data reported by the MSIC were provided by the NSW Ambulance Service and NSW Health. Would Major Watters please disclose the source of the information he rang in to 2GB, in particular in relation to his statement: "in Kings Cross it went from 13 to 24 - the number of deaths doubled after the [injecting] room opened".

-----Original Message-----
From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au]**On Behalf Of**
Gary Christian
Sent: 25 July 2006 15:19
To: drugtalk@adca-lists.org.au
Subject: Re: [Drugtalk] "It's the misinformation that makes us mad"

Bernadette

I will reply to you more fully later, but I need to correct your assertion about the 2000 users in Kings Cross.

On page 58 par 4 of the injecting room report it clearly says that there are 6,000 injections per day by 2000 heroin users averaging 3 injections per day.

I think you will find that what I said was correct on this point.

Regards

Gary Christian
(Drug Free Australia)

From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] **On Behalf Of** Bernadette Keeffe
Sent: Wednesday, 26 July 2006 1:30 PM
To: drugtalk@adca-lists.org.au
Subject: [Drugtalk] FW: "It's the misinformation that makes us mad"

Dear Mr Christian

We think you will find that in the preceeding paragraph (par 3) on page 58 it states: "...On this basis, it is estimated that approximately 12% of NSW heroin users were regularly in the Kings Cross area to inject prior to the operation of the MSIC, **corresponding to more than four thousand heroin injectors...**"

The next paragraph to which you refer (par 4) then goes on to state: "Approximately half of the 2080 (55%) MSIC clients reported heroin as their main drug injected in the month prior to registration. Using this and the previous estimate [> 4 000 IDUs] **it is likely that half the IDU in the Kings Cross area are regular heroin injectors**, and it is plausible that 2 000 IDU are regularly injecting heroin in the Kings Cross area..."

So please note that the more accurate estimate of 1 100 IDUs in Kings Cross recently reported here is for **all** IDUs in Kings Cross at that time - not just regular heroin injectors, so using the same methodology, this would translate into **1,650 (and not 3,300 as applied to your various calculations today) heroin injections per day**.

Further in relation to your posting today - you appear to ignore our previous advice that the overdose risk profile of the IDUs who attend the MSIC 220 times a day is substantially higher than that of the total population of registered IDUs to date.

While you frequently quote various statements from the MSIC's initial 18-month evaluation regarding the inability to detect differences in ambulance callouts etc that could be specifically attributed to the MSIC, you omit the many references throughout the report to the task of determining the impact of the MSIC in this regard being significantly confounded by the major impact of the national heroin shortage of that time.

Finally, in response to your statement: "So obscenely high overdoses = a lot of heroin being bought from the local dealers to fund those overdoses, making the injecting room an excellent accessory to the drug trade. How else do you explain the huge number of overdoses? - There is no evidence that the MSIC has aided the drug trade in Kings Cross: all categories of drug-related crime including drug seizures have decreased 30 - 40% since before the MSIC was established. There is also no evidence that drug use has increased among IDUs since the MSIC - needle syringe distribution rates in Kings Cross decreasing 40% since 2000.

That the MSIC continues to successfully treat a significant number of drug overdose cases, among its many other efforts to prevent and reduce injecting-related harm, is testament to its ability to engage a particularly marginalised, high risk sub-population of IDUs who would otherwise suffer overdose alone in less safe, back-street circumstances - something we as health practitioners think would be obscene to knowingly allow to occur.

From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] **On Behalf Of** Gary Christian
Sent: Friday, 4 August 2006 5:18 PM
To: drugtalk@adca-lists.org.au
Subject: Re: [Drugtalk] FW: "It's the misinformation that makes us mad"

Bernadette

Here is my definitive answer on your responses re injecting room failure. They are necessarily brief.

1. It is statistically impossible for the injecting room to save even 1 life per annum

As previously outlined, only 1% (see Wayne Hall's figures in his paper on the number of dependent heroin users in Oz) of heroin users die each year of heroin overdose. Because dependent heroin users CONSERVATIVELY inject at three times a day (see MSIC Evaluation p 58) the injecting room would have to host the injections of 100 users every day at least 3 times a day before it could say that it saved the life of the 1% who would have died. Therefore the injecting room is incapable of saving a life until it reaches a capacity of 300 injections per day. It has averaged 194 injections per day since October 31, 2002. By the way, (this is the Peter Muhleisen rider) this uses the precise methodology used by German injecting rooms to prove their effectiveness (at an unspecified cost to the German public). The injecting room spends $2.5 million per annum to save less than one life - a terrible cost for little benefit.

2. Surveys have demonstrated that an injecting room's safety does indeed increase experimentation with heroin

The survey recorded at Table 8.4 of the MSIC Evaluation shows that if injecting rooms were made freely available to all comers, they would more than double heroin use. 3.6% of NSW residents (n=2100) said they would use heroin if an injecting room was made available. Most of these would have used for the first time. The last Household Survey indicated 1.6% of Australians had previously experimented with heroin, showing injecting rooms would double heroin use if made available unrestricted to the public. This is damning of injecting rooms in that it shows that their safety gives licence to experimentation with a deadly drug.

3. Users are not often in the injecting room

Clients have 3-6 injections per day, but then the injecting room could only cater for less than 100 users per day in Kings Cross if at full capacity and each was ALWAYS injecting safely (otherwise their other injections are unsafe anywhere else - most injectors die at home afterall). So injecting rooms clients can't possibly be there much of the time or else the injecting room would have 100 clients rather than 9,000. So on utilitsation rates the ijecting room is a failure, and why doesn't it operate at capacity anyway?

4. The injecting room clients are less at risk of overdose than other studied populations in Australia

There shouldn't be too many overdoses because the injecting room clientele, as recorded on p 16 of the MSIC Evaluation shows:

Study	Ever Overdosed	Overdosed in

		Last 12 Months
MSIC	44%	12%
Australian IDRS study 1999	51%	29%
Sydney study 1996	68%	20%
British study 1999	58%	30%

Compared to rates in ANCD Research Paper 1 on Heroin Overdose p 10

We are told by the MSIC Evaluation and Ingrid Van Beek (letter posted to Update in 2003) that users are more at risk of overdose, but they clearly are not. The injecting room is still maintaining this line as they did at the time the evaluation was released. We could not believe injecting room personnel or evaluators then so why would we believe that the injecting room now has higher risk clientele than anywhere else as explanation of the obscenely high overdose rate?

5. There are only 1,100 IDU living in the Kings Cross area and 55% of these are heroin users

This argument is adduced to lower the disproportion of overdoses in the injecting room against those on the street. I would have to question the capture/recapture figure here. Afterall, the MSIC Evaluation p 17 records 862 clients living in 2010 and 2011 alone. What of the other thousands from the other areas close to the city. With 9,000 clients on the books I am staggered that there is only 238 other IDU out of what must be at least 3-4,000 current clients in the Sydney area coming into the Cross each day. I am not sure what the public will think of this claim.

6. The overdose numbers are absolutely massive

Even if we accept the figure of 1,100 IDU we can see from the stats on p78 Table 4.8 that 70-80% of local users were always heroin users (down to 55% for the evaluation period due to the heroin drought, but the graph on p22 of the evaluation shows that injecting heroin was back to 80% by October 31, 2002). With that figure in mind the most conservative over-representation of overdose in the injecting room is a mid-boggling 14 times higher than street rates (even allowing for roughly 50% of street overdoses being 'forgotten' as per the Evaluation's calculations on p 59) and more than 7 times higher when judged in terms of Narcan administrations (where the client would do more than merely forget the overdose if the Narcan did not intervene, and where we fairly well know the rate of Narcan administrations by ambulance call-out). And if Peter Watney is correct about the paramedics gratuitously administering the Narcan when it is not necessarily needed, this creates an even higher comparison rate of Naloxone-intervened overdoses in the injecting room, making it look even worse.

Also remember that the rate of overdoses in the injecting room is 42 times higher than the client's own overdose rate before registering at the MSIC, and 49 times higher than the national estimates of overdose rates. Yes we can allow for forgotten overdoses, but remember that the lives saved calculations in the MSIC were all calculated on 'known' rates of overdose, not forgotten ones. If overdoses are forgotten by the users, then scrap the lives saved calcs on pp58-59 of the evaluation (which should be scrapped anyway - see my point 1).

7. That's a lot more heroin bought from the dealers to service all those overdoses

The MSIC Evaluation supposed on p62 that clients were experimenting with higher overdoses of heroin. This was their own explanation for the high overdose rate. (Their other explanation on that page is demonstrably wrong as per my point 4 above). Alcohol use is implicated in many overdose deaths in Australia, but because the MSIC eliminates this factor in its overdoses, then it must be higher doses of heroin for clients than last night's dose on the streets. This must be expanding the drug dealers business more than modestly, and is supported by point 2.

8. Public amenity did not improve one iota

Needles dispensed by pharmacies and NSP's dropped by 20% between July 2000 and July 2002 and yet all measures of public amenity in the injecting room evaluation only show a matching 20% drop in line with the needles dispensed. So the heroin drought is clearly responsible, and is still responsible for any drop in percentages quoted presently by the MSIC. Heroin user numbers in Australia have gone from 74,000 in 1997 to 25,000 now, so a 40% drop in anything heroin related would have to be slated to the drought, not the MSIC.

9. The MSIC did create a honey-pot effect

Users from all around Kings Cross centred their loitering on the MSIC. p 146 of the report clearly says that public complaints of dealing and loitering coincided with MSIC opening hours only, and p 147 says that the station did not figure as a meeting place before the MSIC opened. It has indeed been 'like bees to the honey'.

There is a whole list of things it failed to improve - HIV, Hep B, Hep C, injecting with other's equipment etc etc all found in the evaluation.

So no, Andrew Byrne or MSIC staff are not telling us the truth when they speak of the 'success of the injecting room'.

Regards

Gary Christian
(Drug Free Australia)

-----Original Message-----
From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] On Behalf Of Collete Mcgrath
Sent: Tuesday, 8 August 2006 2:27 PM
To: drugtalk@adca-lists.org.au
Subject: Re: [Drugtalk] "It's the misinformation that makes us mad"

The MSIC has tried to provide some insights into the nature of heroin overdose risk and how relocating the most high risk injecting episodes to its clinical setting would reduce the morbidity and mortality that could have occurred had these same episodes occurred in less safe, unsupervised situations elsewhere in Kings Cross. But the epidemiology of heroin overdose is complex and there are limits to what can be communicated in postings of this sort, especially when minds are set.
For this reason the MSIC will refrain from further postings on this matter, however invites all sincerely interested Drugtalkers to communicate directly with us should they have any doubts about being told the truth when we speak of the 'success of the injecting room'.

Meanwhile the MSIC still awaits the truth from Major Watters regarding the source of the information he recently rang in to report on 2GB, in particular in relation to his statement: "... in Kings Cross it went from 13 to 24 - the number of deaths doubled after the [injecting] room opened".

Re: [Drugtalk] "It's the misinformation that makes us mad" 5/08/2006 8:26:00 PM

From: Gary Christian
To: 'drugtalk@adca-lists.org.au' [drugtalk@adca-lists.org.au]
Cc:
Bcc:
Attachments:

Bernadette

Just taking up a couple of other points in your reply of a week or so ago.

You assert:

QUOTE

Individual IDUs' risk also varies over time and individual IDUs' decision to utilise the MSIC on a particular occasion may be influenced by a range of factors, which may include their risk of overdose at that time.

UNQUOTE

The main predictors of overdose, as per the ANCD Research Paper 1 - 'Heroin Overdose' are 1. a period of abstinence lowering tolerance to heroin 2. use of alcohol and benzodiazapenes with heroin

With 1. there can only be som many injecting room users to whom this would apply, and users are unlikely to go through short cycles of abstinence and reuse
With 2. the injecting room excludes users who are intoxicated by alcohol

Therefore your assertion is questionable.

You also assert:

QUOTE

it has been estimated that injecting in a public place increases the risk of overdose threefold compared to other situations.

UNQUOTE

This does not accord with the client's own data. MSIC clients, at registration, indicated that 36% of their last overdoses were in a public place (MSIC Evaluation p 16). However the same ANCD Research Paper p 19 gives good data on Kings Cross deaths showing that your assertion might well apply to Cabramatta but certainly not to Kings Cross. In Kings Cross 19% die in public places, while 36% have their non-fatal overdoses in public places. This disproportion suggests that injecting in public places does not increase

the risk of fatal overdose for Kings Cross users at all - rather it is the injections elsewhere that are more likely to be fatal. See the ANCD Research Paper quote below:

QUOTE

Darke, Ross et al. (2000a) noted that among the 191 fatalities in Kings Cross and immediate surrounds 47 per cent died in home environments, 25 per cent in hotel rooms and 19 per cent in public places. Among the 144 cases in Cabramatta and surrounds, 65 per cent occurred in a public place, 27 per cent in homes and 4 per cent in hotel rooms. It is probable that this geographic clustering of deaths in public places is related to the pronounced presence of the heroin market in these two areas. The high rate of death in a public place in the Cabramatta region is likely to reflect the nature of heroin transactions in the area, in that many heroin users resident outside the area travel to the region specifically to purchase heroin, and hence consume it in public rather than waiting until they return home. By contrast, Kings Cross appears to have a resident population of heroin users, as is reflected in the proportion of overdoses that occur in private homes. A number of cheap hotels also exist in Kings Cross which offer users a private place to consume heroin purchased in the area.

UNQUOTE

Regards

Gary Christian
(Drug Free Australia)

-----Original Message-----
From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] On Behalf Of Collete Mcgrath
Sent: Tuesday, 19 September 2006 12:20 PM
To: drugtalk@adca-lists.org.au
Subject: [Drugtalk] FW: "It's the misinformation that makes us mad"

Drugtalkers need to be aware that while epidemiologist Professor D'arcy Holman may not have been able to falsify DFA's calculations on the data in the MSIC's Evaluation Report on its first 18 months' operation - it is our understanding that Holman did not verify that these data were correct or support DFA's interpretation of its subsequent calculations.

As previously posted here: further data analysis undertaken subsequent to the initial MSIC evaluation report, using validated capture-recapture methodologies has estimated that there were approximately 1100 IDUs in Kings Cross area during the 12 months to October 2002. This is significantly fewer IDUs than the 4000 IDUs cited in the Final Evaluation Report (extrapolated from previous research undertaken by Hall et al in 1996). Drug talkers should note that Mr Christian has not adjusted DFA's calculations accordingly.

We also request that Mr Christian provide evidence to support his statement:
"...and the public was told time and time again by the injecting room staff that it was saving hundreds of lives." The MSIC has never stated this in any forum, whereas it is on the record as having agreed that the mortality rate may have been in the vicinity of 1 per 25 heroin overdose cases had these occurred in unsupervised (community) circumstances.

Meanwhile the MSIC notes that Major Watters has yet to disclose the source of the information he rang in to state on 2GB radio, in particular in relation to his statement: "... in Kings Cross it went from 13 to 24 - the number of deaths doubled after the [injecting] room opened". We ask again for Major Watters to disclose the source of this information or otherwise retract it.

Colette McGrath
Clinical Services Manager
Sydney MSIC

-----Original Message-----
From: drugtalk-bounces@adca-lists.org.au
[mailto:drugtalk-bounces@adca-lists.org.au] On Behalf Of Gary Christian
Sent: Wednesday, 20 September 2006 3:18 PM
To: drugtalk@adca-lists.org.au
Subject: Re: [Drugtalk] FW: "It's the misinformation that makes us mad"

Collette

Holman verified our calculations from the MSIC evaluation's own data.

If you want to take issue with your own evaluation, I have no problem with that, but it still doesn't alleviate any problems for the injecting room. It still cannot claim to save one single life per annum until it reaches 300 injections per day - that is set in concrete. The overdose rates are still massively high, no matter how much you capture/recapture lower numbers of drug users in the Cross (which don't accord with the number living in the Cross who registered in 2001-2.

And the media comments. Of course the MSIC was responsible for the myth that each overdose is equal to a life saved.

2.1 Media Record 1
PM Archive - Thursday, 21 June , 2001 00:00:00
Reporter: Rachel Mealey
MARK COLVIN: The organisers of Australia's first legalised heroin injecting room claim that FOUR LIVES WERE SAVED IN THE FIRST MONTH OF OPERATION. They say the facility's a success and sight (sic) evidence that more than half the drug using population of Sydney's Kings Cross have injected in the room. But their claims come amid a storm of criticism after it was revealed that the facility has already overspent its budget by two and a half million dollars.
http://www.abc.net.au/pm/s316825.htm

2.2 Media Record 2

Darlinghurst's controversial injecting room has extended its operating hours to meet client demand, the centre's medical director, Dr Ingrid van Beek, confirmed yesterday.
The news followed an admission at a parliamentary committee hearing on Wednesday by the Special Minister of State, Mr Della Bosca, that the injecting room's budget had more than doubled, from an initial $1.8 million to $4.3 million.
But the Uniting Church's Rev Harry Herbert said yesterday the original
$1.8 million figure was wrong. ``[The original estimate] was done a long time ago ... probably whoever was responsible for it didn't have all the information, all the facts at the time," he said. ``I don't think it ought to be called a blowout."
Dr van Beek conceded, however, there had been unexpected costs over the past 18 months, largely due to delays in opening.
A legal challenge launched by the Kings Cross Chamber of Commerce had also added up to $40,000 to the Uniting Church's costs, Mr Herbert said, and this figure could creep higher, pending an appeal lodged

by the chamber in the Supreme Court.
In Parliament yesterday, the Premier predicted long-term success for the injecting room, defending it from opposition claims the experiment was failing. ``This is not the answer. It's a better way of managing an inherently awful situation," Mr Carr said.
The centre has recorded more than 500 injecting episodes in its first month of operation. In one four-hour period more than 60 clients used the premises. Four overdoses have been recorded on site. In each case the user had arrived at the centre alone, which is a known risk factor in drug overdose death, Dr van Beek said.
``POTENTIALLY WE'VE SAVED FOUR LIVES IN THE FIRST MONTH."
Kelly Burke - SMH 22/6/2001 p 3

2.3 Hansard Record 1

"In the first month of operation, FOUR LIVES WERE SAVED, people who would otherwise have probably overdosed; and 42 people, those in the depths of the addiction cycle, were referred for further treatment services and counselling."
John Della Bosca, NSW Special Minister of State, NSW Legislative Council Hansard 4 July 2001
http://www.parliament.nsw.gov.au/prod/parlment/hanstrans.nsf/v3ByKey/LC2
0010704

2.4 Media Record 3

Kings Cross heroin injecting centre hailed a "success"
The World Today Archive - Wednesday, 15 August , 2001 00:00:00
Reporter: Joe O'Brien
ELEANOR HALL: If the debate over dealing with drug addiction has heated up this week, those behind Australia's first legal heroin injecting centre are today proclaiming its success.
A newspoll meanwhile - published in The Australian - shows that almost half of us have been won over to the cause of heroin trials - a substantial increase on the position four years ago when the Prime Minister first vetoed plans for a trial in the ACT.
Since its controversial opening three months ago, the Sydney Kings Cross centre, has provided hundreds of users with clean safe facilities and referred them to rehabilitation and welfare agencies. AND THE CENTRE SAYS ITS STAFF HAS SAVED MORE THAN A DOZEN LIVES FROM OVERDOSES.
Supporters say it's evidence that other communities should consider adopting similar trials.
http://www.abc.net.au/worldtoday/s346896.htm

2.5 Hansard Record 2

"To date, the trial injecting room has reported that there were 2,729 registered clients and 250 overdoses. Therefore, because of the available trained medical staff 250 LIVES WERE SAVED. There were 446 referrals into drug treatment, which could be contrasted with what occurs on the streets."
The Hon Bryce Gaudry MP, NSW Legislative Assembly Hansard 29 May 2002

http://www.parliament.nsw.gov.au/prod/parlment/hanstrans.nsf/V3ByKey/LA2
0020529

2.6 Media Record 4
Injecting centre to get thumbs up
By Steve Dow and Frank Walker
June 15 2003
The Sun-Herald
A final report on the controversial Kings Cross injecting centre is expected to declare it a resounding success that has SAVED HUNDREDS OF LIVES.
The report, by an independent evaluation committee headed by Professor Richard Mattick, director of the National Drug and Alcohol Research Centre, will go to the Government in the next few weeks.
It has found that over 18 months the centre handled 424 drug overdoses -
337 of them from heroin - and referred 1385 drug users to rehabilitation or welfare.
Special Minister of State John Della Bosca said there would be a full debate once the report was released.
"I don't want to give my personal thoughts on how it has gone at this stage," he said.
The injecting room trial began two years ago amid a storm of protest.
Critics said it would act like a honey pot, attracting addicts and dealers to Kings Cross, and send a message that it was OK to be an addict.
http://www.smh.com.au/articles/2003/06/14/1055220810539.html

It's a bit of a scandal, isn't it?

Regards

Gary Christian

(Drug Free Australia)

-----Original Message-----
From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] On Behalf Of Collete Mcgrath
Sent: Thursday, 21 September 2006 2:14 PM
To: drugtalk@adca-lists.org.au
Subject: [Drugtalk] FW: FW: "It's the misinformation that makes us mad"

There is only one direct quote among Mr Christian's "evidence" that MSIC was "responsible for the myth that each overdose is equal to a life saved": Dr van Beek said "Potentially we've saved four lives in the first month" and the MSIC doesn't resile from the fact that indeed, every overdose case can POTENTIALLY result in death [i.e. if assistance is not provided in a timely way]. This is necessarily different to stating that each overdose IS equal to a life saved as alleged.

While the MSIC cannot be held responsible for how media and politicians express various information in this regard, it supported a clarification explicitly stating that the MSIC had not saved "hundreds of lives" published in response to the 15 June 2003 Sun Herald article cited. As already posted - the MSIC is also on the record elsewhere in this regard including in Dr van Beek's own book "In the Eye of the Needle - a Diary of a Medically Supervised Injecting Centre". Mr Christian has also been in attendance at one of her public presentations wherein she also stated this quite categorically.

Posted on behalf of Dr vanBeek

Colette McGrath
Clinical Services Manager
Sydney Medically Supervised Injecting Centre

Re: [Drugtalk] FW: FW: "It's the misinformation that makes us mad"

21/09/2006
11:01:00 PM

From: Gary Christian
To: 'drugtalk@adca-lists.org.au' [drugtalk@adca-lists.org.au]
Cc:
Bcc:
Attachments:

Collette

Is there any reason for me to disbelieve the following report?

Injecting centre turns nine

Australia's only supervised injecting facility recently passed the halfway mark in its 18-month lifespan as a trial facility. To mark the occasion, the centre's medical director, Dr Ingrid Van Beek, and leading drug law reform advocate, Dr Alex Wodak, both travelled to Canberra to present a series of briefings to local, interstate and federal parliamentarians.

The visit concluded with a public forum which presented a detailed range of findings to the audience of academics, health planners, drug and alcohol organisations and interested community members.

Careful not to promote the centre at this stage as anything other than a solution to a local problem (ie. preventing fatal drug overdoses in Kings Cross), Dr Van Beek presented compelling evidence that in its first nine months, the centre has saved more than 100 lives. Early intervention has meant that potentially fatal overdoses which would otherwise have occurred in the surrounding streets and laneways were successfully treated on-site.

Not only have lives been saved, but the rigorous research program attached to the centre will draw a detailed picture of one of the world's largest ever cohorts of injecting drugs users – almost 2000 users in total.

http://www.hepatitisc.org.au/resources/documents/36_01.pdf

Regards

Gary Christian
(Drug Free Australia)

Re: [Drugtalk] FW: FW: "It's the misinformation that makes us mad" 26/09/2006 2:39:00 PM

From: Gary Christian
To: 'Collete Mcgrath' [cmcgrath@sydneymsic.com]
Cc:
Bcc:
Attachments:

Colette

Do you have a copy of any disclaimers by the injecting room pre-July 9 2003 that backs your assertion in this e-mail? Could you point me to where I would find it.

Much appreciated.

Gary Christian
(Drug Free Australia)

From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] **On Behalf Of** Gary Christian
Sent: Sunday, 1 October 2006 2:16 PM
To: drugtalk@adca-lists.org.au
Subject: Re: [Drugtalk] "It's the misinformation that makes us mad"

Bernadette

I believe we can put to rest Ingrid Van Beek's original assertion, reflected once again in your posting below, that the extraordinary number of overdoses in the injecting room are mainly the result of overdoses not being recorded in the community due to poor recall by heroin users.

This view posits significant numbers of overdoses which are not ever observed by paramedics or even other illicit drug users, and which are simply not remembered or even recognised by the person who has overdosed.

It must be emphasised that the comparison between the injecting room and the street done by Drug Free Australia, which found the injecting room 36 times higher than street rates of overdose, calculated an almost equal number of unobserved community overdoses as those attended by paramedics. So our calculation allowed for 51% paramedic-attended overdoses and 49% unattended. This 51/49 ratio was used by the injecting room evaluation in its own calculations. So DFA calculations did indeed account for the phenomenon you describe here.

However, if the injecting room were to claim that there were still more unrecalled overdoses than accounted for in our 51/49 ratio, then we would have to question this. Afterall Darke's 1996 study on heroin overdose expressly states that:

QUOTE

It would seem that a large proportion of deaths attributed to overdose occur in the presence of other heroin users,

UNQUOTE

If a large proportion of fatal overdoses are in the presence of other users, why would we believe that enormous numbers of non-fatal overdoses are not in the presence of other users. At the rate of overdose in the injecting room, we had previously calculated that there would be in excess of 500,000 non-fatal overdoses, while current estimates are roughly 15,000 per year. Again I think we can close the books on this little myth perpetuated by the injecting room. There is absolutely no reason to believe that there are extremely high numbers of overdoses suffered while alone. It simply does not find support from the evidence.

Regards

Gary Christian
(Drug Free Australia)

-----Original Message-----
From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] On Behalf Of Collete Mcgrath
Sent: Thursday, 8 February 2007 4:18 PM
To: drugtalk@adca-lists.org.au
Subject: [Drugtalk] MSIC response to DFA press release

Posted on behalf of the MSIC
Posted on behalf of Sydney Medically Supervised Injecting Centre

Drug Free Australia (DFA) has released the following misinformation to AAP under the title: "What's really going on in the KINGS CROSS INJECTING ROOM?"

Please see the following corrections.

DFA INFORMATION

Drug Free Australia's "report" reveals at least 8% injectors are using ICE Drug Free Australia (DFA) has uncovered evidence that the Kings Cross Injecting Room is allowing people to shoot up ICE.

This facility was put in place to supervise people injecting heroin, this taxpayer-funded trial has completely missed its target.

FACT

A range of drugs has been injected at the facility since 2001. This information is reported to the NSW Health Department on a quarterly basis.

Trend data in this regard are also provided to the National Drug and Alcohol Research Centre, the Medically Supervised Injecting Centre (MSIC) contributing as a sentinel site to its national drug surveillance system.

These data are also communicated to the local community through the MSIC's regular Newsletters, which are posted on its website at www.sydneymsic.com <http://www.sydneymsic.com>, and have often been reported in the media. The independent evaluation team also reports on the range of drugs being used at the MSIC over time to NSW Health and in various papers published in the scientific literature.

The MSIC was established to reduce all injecting-related harms - not just those associated with heroin use. Injecting as a way to self-administer drugs, is associated with significantly greater risks of harm, including drug-dependence, overdose and blood borne infections, quite regardless of the actual drug being used.

While sometimes coined "the heroin injecting room" by media - the MSIC has actively discouraged this, always referring to it as the "medically supervised injecting centre". All relevant legislation and policy documentation also use this correct terminology.

The MSIC is funded through the confiscated proceeds of crime.

DFA INFORMATION

Research just completed by Drug Free Australia points to numerous other irregularities and gross misinformation that demonstrates conclusively that it has consistently failed to meet the objectives upon which it was first established.

FACT

MSIC Objective 1: to reduce the morbidity and mortality otherwise associated with drug overdose

Results: 2,034 drug overdose cases have been successfully treated by registered nurses at the MSIC, none requiring emergency ambulance transportation to hospital; no fatalities to date; 84% decrease in ambulance callouts to overdose cases in the Kings Cross area since the MSIC was

established: a 21% greater decrease than elsewhere in NSW.

MSIC Objective 2: to reduce the transmission of blood borne infections including HIV and hepatitis B and C.

Result: Injecting drug users (IDUs) have been provided with clean injecting equipment and specific advice to reduce injecting risk behaviour on 371,240 occasions since 2001.

MSIC Objective 3: earlier and greater engagement with high-risk, street-based injecting drug users (IDUs)

Result: among the 9,500 individual IDUs who have registered to use the MSIC to date most of whom had previously injected drugs in Kings Cross, the majority had never accessed any of the other health services targeting drug users in the area. Having injected in public situations is a predictor of more frequent use of the MSIC, which is in turn a predictor of successful referral from the MSIC to a drug treatment program.

MSIC Objective 4: to enhance IDU access to relevant health and social welfare services including drug treatment and rehabilitation programs

Result: IDUs have been referred to other relevant services on more than 6,000 occasions to date - more than 2,500 of these were to drug treatment and rehabilitation programs.

MSIC Objective 5: to reduce street-based injecting and discarded injecting equipment in public places, and thereby improve public amenity

Result: On average 230 injecting episodes occur at the MSIC each day - episodes that would otherwise occur in less safe, often public places.

Serial random telephone surveys of local residents confirm that there has been a significant reduction in public injecting and associated injecting paraphernalia in Kings Cross since the MSIC opened.

DFA INFORMATION

In 2006 only a little over a third of injections in the injecting room were heroin, with 8% of current injections being the substance Ice. Our research reveals that, in fact, only 38% of injections in the facility in 2006

were heroin injections. Other substances that make up the other 62% included methamphetamines and cocaine.

FACT

While heroin remains the drug of choice for most drug users in the area and has been injected on 65% of all visits to the MSIC to date, other drugs including cocaine and methamphetamines may be substituted when heroin availability is low. "Ice", which is the crystalline form of methamphetamine, represents a proportion of all methamphetamine-injecting episodes at the MSIC.

The use of all forms of methamphetamine at the MSIC peaked in September 2003 when it reached 11% of all visits. It has gradually decreased since this time, representing 7% of all visits in the last 3 months.

DFA INFORMATION

Ice, though highly destructive in the medium to long term, does not present any significant risk of overdose.

FACT

There is a significant risk of methamphetamine "overdose" (more often referred to as "toxicity") when used heavily over time. Potentially fatal manifestations of methamphetamine overdose include cardiac arrhythmias (fast and/or irregular heart beat) and cardiac arrest ("heart attack"), rapidly escalating hypertension (high blood pressure), seizures (fits) and cerebrovascular accident ("stroke"). The MSIC has developed clinical protocols to treat all of these conditions.

Methamphetamine may also induce psychosis, which can be a risk to the individual and others' safety. By relocating drug users who would otherwise inject this same drug in back streets nearby, to a clinical facility, the MSIC is uniquely positioned to identify, contain and treat those with the very early signs of methamphetamine-induced psychosis, thereby preventing its escalation and consequent public order problems when this occurs in unsupervised circumstances.

The MSIC also works closely with mental health, police and other emergency services in the area to ensure a coordinated response to such problems should they arise. However, there have been no cases at the MSIC to date where emergency referral has been needed.

DFA INFORMATION

With the rationale for the injecting room being supervision in the event of life-threatening heroin overdose, the injecting room is not being used for its announced purpose, says DFA spokesperson, Gary Christian.

FACT

Among the 2,032 overdose cases successfully treated to date, more than 90% were heroin-related; 87 heroin-related overdose cases were treated at the MSIC in the last 3 months.

DFA INFORMATION

This blatant lack of accountability, makes one wonder what else is going on in the facility. It is time to close the injecting room, said Mr Christian.

It is an experiment that is in total breach of Australia's United Nations obligations, and as a trial it should have been closed in 2003 once the negative evaluation evidence was presented.

FACT

The MSIC is arguably amongst the most accountable health organisations ever established. All of its internal management protocols were carefully examined and approved by both of its licensing authorities: the Director-General of NSW Health and the NSW Police Commissioner prior to being granted a licence to operate. These cannot be changed without prior approval from these authorities. Their delegates visit the MSIC without notice on a regular basis to ensure compliance with these protocols. The service is required to report its clinical activity to NSW Health to the "Government Monitoring Committee" - made up of a range of relevant stakeholders - every 3 months. The MSIC continues to be subject to external evaluation by a team of highly respected public health researchers.

All countries with supervised injecting facilities (which include Switzerland, Germany, the Netherlands, Spain, Canada, Norway and Luxembourg) are signatories to all UN drug control treaties (although some have not yet ratified the 1988 Convention). While the International Narcotics Control Board (INCB) of the United Nations Office of Drugs and Crime (UNODC) has contended that drug injection rooms contravene these treaties "by publicly inciting or inducing as well as aiding and abetting, facilitating or counselling the illicit use of drugs for personal use", a report prepared by the UNODC's own Legal Affairs Section for the INCB in 2002 concluded that:

"It would be difficult to assert that, in establishing drug injection rooms, it is the intent of parties to actually incite or induce the illicit use of drugs, or even more so, to associated with, aid, abet or facilitate the possession of drugs. On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug [users], thereby reducing risk of infections with grave transmittable diseases and, at least in some cases, reaching out to them with counselling and other therapeutic options."

DFA INFORMATION

That evidence is conclusive concerning its failure, and whichever government wins the NSW election on March 24, it should divert the funds to drug prevention and effective rehabilitation, which will really save lives.

FACT

The MSIC does not divert funding from drug prevention and rehabilitation programs and supports their further expansion. The MSIC urges all state politicians to approach the decision regarding its future in a non-partisan way, to consider the objective evidence and reserve their decision until the final evaluation report is tabled in NSW Parliament for consideration later this year.

Re: [Update] Sydney Medically Supervised Injecting Centre 9/02/2007 9:41:00 AM

From: Gary Christian
To: 'update@adca-lists.org.au' [update@adca-lists.org.au]
Cc: 'Collete Mcgrath' [cmcgrath@sydneymsic.com]
Bcc:
Attachments:

Colette

I am replying to your MSIC post on Update, knowing that Update is not a forum for debate, but because the discussion between the MSIC and Drug Free Australia is not only of national significance, but also international significance, we believe our reply is justifiable on Update.

I will reply to each point you make here in turn.

1. **Heroin Injections in Room at 38%**

   a. DFA contends that a review of all literature produced by the injecting room, including its 2003 evaluation, reveals that the focus regarding overdose/toxicity is on heroin overdoses pre-MSIC versus heroin overdoses post-MSIC (there are no such comparisons for cocaine and amphetamine) and that therefore the public perception that HEROIN overdose is its dominant rationale for existence matches the MSIC's own evident focus re its original purpose
   b. DFA contends that cocaine and amphetamine injection was moreso a pragmatic response by the MSIC to changed drug use behaviours resulting from the heroin drought, which intervened 6 months before the MSIC opened in May 2001, rather than an original publicised focus

2. **Mortality – Statistically IMPOSSIBLE for MSIC to Save Even One Life per Year**

Drug Free Australia acknowledges that the number of overdose interventions in the injecting room have been very high, but also asserts that these overdoses have little bearing on real mortality for the following reasons:

   a. The overdose rate in the 2003 evaluation was one for every 106 heroin injections, while the streets outside the centre (with the very same MSIC clients, who injected 34 of every 35 heroin injections on the street) experienced a rate of overdose of one in every 3,800 injections. This suggests that the safety of the facility artificially increases the risks of overdose in the MSIC. We note that the rate of overdose for the 5 years has changed little. On these grounds we can give no credence to overdose numbers as an indicator of success re mortality
   b. It is statistically impossible for the injecting room to save even one life per year. Using the very same methodology used to defend German injecting rooms we know that 1% of heroin users die each year from heroin overdose. For the injecting room to claim just ONE life saved, it would need to have 100 dependent heroin users injecting an average 3 or more injections per day (cumulatively 300 heroin injections per day) before it could claim it had saved the life of the one heroin user who would have died from overdose. But the injecting room has averaged less than

160 heroin injections per day in 5 years, and now has less than 80 per day. Not one life can possibly be defended statistically

c. DFA is concerned that the injecting room influenced public opinion in support of the injecting room by equating each overdose intervention with a life saved. This is simply not true. On page 2 of our new publication (go to http://www.drugfree.org.au/home) we demonstrate the false perceptions created were never corrected by the MSIC, despite it being D&A common knowledge that 24 of 25 overdoses are never fatal. Thus the mortality issue in the injecting room is in very muddy water
d. The 2003 estimate of 6 lives saved made a most fundamental error in their calculations – they based their calculations on an uninterrogated total number of overdoses in the MSIC, and failed to correct for the over-representation of overdose due to the safety of the MSIC as against the street. The result was 0.18 lives saved in 18 months. DFA asked eminent epidemiologist Dr D'Arcy Holman to falsify these calculations, but he verified they were correct in 2003
e. DFA is concerned by MSIC claims about decreased ambulance callouts since 1999. These were the result of the heroin drought, not the presence of the MSIC, as was concluded by the MSIC evaluation document pp 60-62

3. **Blood-Borne Diseases Did not Decrease After MSIC**
   a. Drug Free Australia would direct readers' attention to the 2003 evaluation which showed that there were no decreases in BBV's in the Kings Cross/Darlinghurst area post MSIC. HIV increased, Hep B stayed the same, and Hep C increased – see p 71ff of MSIC Evaluation. With almost 900 MSIC clients within walking distance of the facility, the public might expect some perceptible change
   b. Comparisons between MSIC clients and nearby needle-exchange clients showed no less risky behaviours amongst MSIC clients see pp 92-4 of MSIC Evaluation

4. **Clients More at Risk?**

   a. DFA contends that MSIC clients are less at risk than other previously-studied user populations. Go to the detailed evidence 70 pager also found at http://www.drugfree.org.au/home for all the info on this.

Study	Ever Overdosed	Overdosed in Last 12 Months
MSIC	44%	12%
Australian IDRS study 1999	51%	29%
Sydney study 1996	68%	20%
British study 1999	58%	30%

5. **Referrals to Treatment and Rehab**

   a. Drug Free Australia commends the MSIC on its increased emphasis on referral to treatment and rehab. However the MSIC has not published the percentage of MSIC clients assisted with referrals to treatment or rehab, rather just the raw number of referrals. As is evident from the

MSIC evaluation, despite the referrals being 34% of client numbers, only 12% of clients were referred to treatment or rehab, indicating multiple referrals per client. DFA assumes that the 2,500 referrals to date includes doubling, such as detox and rehab being counted as 2 referrals but for one client.

6. **Improvement in Public Amenity Due to Heroin Drought, not MSIC**

   a. Drug Free Australia is concerned by MSIC claims that public amenity has been improved by the MSIC presence. We note that on page 122 of the MSIC evaluation there is a 19% decrease in needles distributed from needle exchanges and pharmacies in Kings Cross between July 2000 and July 2002. The average decrease in needle counts for July 2000 to July 2002 was roughly the same, indicating that the drought was entirely responsible, not the MSIC – see our 70 pager for full analysis
   b. It is acknowledged that the MSIC does remove 200 injections per day from the streets of Kings Cross, but DFA could spend $10,000 a year hiring a room at the Tudor Hotel next door to do the same. The MSIC is spending $2.5 million of taxpayer funds for nursing staff and resuscitation equipment for the 80 or so heroin injections happening in the facility. This explains our concern about only 38% of injections being heroin – the rest could be far more cheaply hosted elsewhere if need be

7. **Low Risks with Methamphetamine**

   a. ABS statistics for 2004 indicate low risk of amphetamine toxicity versus opiates (61 deaths for ALL ATS (which would include ice) versus 431 deaths for opiates)
   b. While the MSIC has recorded a substantial percentage of amphetamine injections, it has not recorded a substantial percentage of amphetamine toxicity, thus our claim that 'ice' does not present SIGNIFICANT risks for overdose

It is for these reasons that Drug Free Australia has called on whatever government wins the March 24 election to close the MSIC.

Regards

Gary Christian
Director,
Drug Free Australia

-----Original Message-----
From: drugtalk-bounces@adca-lists.org.au [mailto:drugtalk-bounces@adca-lists.org.au] On Behalf Of Collete Mcgrath
Sent: Tuesday, 27 February 2007 4:19 PM
To: drugtalk@adca-lists.org.au
Subject: [Drugtalk] MSIC RESPONSE

Sorry about the previous posting it was unclear , please take note in particular of the areas the MSIC wished to highlight in bold with thanks and apologies re the double posting

Colette McGrath
Clinical Services Manager

In response to Mr Christian's posting hereunder, a reality check is indeed needed.

From: "Gary Christian" <>
To: <drugtalk@adca-lists.org.au>
Subject: Re: [Drugtalk] FW: Ho hum.
Date: Mon, 26 Feb 2007 15:52:16 +1100

Greg, Paul & Marg
Interesting situation here.
Out in the rest of society, people will ALL agree that the phrase 'the potential to double' and the alternate phrase 'has doubled' do not mean the same thing.
Yet here in this cosy, virtual world of Drugtalk, two contributors have declared they are exactly the same phrase and meaning, simply because they say so.
Reality check, gentlemen!

The MSIC would like to draw Drugtalkers' attention to its posting of September last year in response to Mr Christian's own apparent difficulty in appreciating the meaning of "potentially".

Subject: RE: [Drugtalk] FW: "It's the misinformation that makes us mad"

There is only one direct quote among Mr Christian's "evidence" that MSIC was "responsible for the myth that each overdose is equal to a life saved": Dr van Beek said "Potentially we've saved four lives in the first month" and the MSIC doesn't resile from the fact that indeed, every overdose case can POTENTIALLY result in death [i.e. if assistance is not provided in a timely way]. This is necessarily different to stating that each overdose IS equal to a life saved as alleged.

While the MSIC cannot be held responsible for how media and politicians express various information in this regard, it supported a clarification explicitly stating that the MSIC had not saved "hundreds of lives" published in response to the 15 June 2003 Sun Herald article cited. As already posted - the MSIC is also on the record elsewhere in this regard including in Dr van Beek's own book "In the Eye of the Needle - a Diary of a Medically Supervised Injecting Centre". Mr Christian has also been in attendance at one of her public presentations wherein she also stated this quite categorically.

Despite this, Mr Christian's recently distributed "report" entitled The Kings Cross Injecting Room: the Case

for Closure" states: "The Injecting room's own public relations unit continually stated that each overdose intervention in the injecting room was a life saved…" citing as "evidence"
the exact same quote: "Potentially we've saved four lives in the first month".

The MSIC would also like to draw Drugtalkers' attention to Mr Christian's apparent continuing inability to adapt his overdose calculations after mistakes in his reading of the 2003 evaluation report, which these were based on, are pointed out to him.

Specifically, you will note in the postings pasted hereunder, that despite the MSIC twice informing Mr Christian that the 2003 report had estimated that there were 4,000 IDUs (and not 2,000) he continues to quote the report as stating that it estimated that there were 2,000 IDUs in Kings Cross.

Further, Mr Christian does not appear to recognise that IDUs are a highly transient population. Unlike the capture-recapture methodologies used to estimate size of dynamic populations, Mr Christian does not account for the significant migration of IDUs in and out of the Kings Cross area over time when he refers to the MSIC's client registration data as proof that there must be more than 1,100 IDUs in Kings Cross at any one time. For example,
8,912 individual IDUs were registered at the MSIC during its first 5 years, whereas only about 900 individuals use the service in any given month.

Re: [Drugtalk] MSIC RESPONSE 28/02/2007 6:50:00 AM

From: Gary Christian
To: 'drugtalk@adca-lists.org.au' [drugtalk@adca-lists.org.au]
Cc:
Bcc:
Attachments:

Collete

Some words in response.

1. The Drug Free Australia position on the continued public announcements that equated each overdose in the injecting room with another life saved is that these frequent announcements by independent parties were never corrected by the injecting room when they knew full well that most overdoses are not fatal. Why wasn't the misinformation, particularly if it was the mere misconception of others, corrected? There is an issue here of complicity in other people's spin (to use the most charitable word).

2. Drug Free Australia has definitively NOT made any error in its statements about there being 2,000 HEROIN injectors in Kings Cross every day. Page 58 par 4 says:

QUOTE

Approximately half of the 2080 (55%) MSIC clients reported heroin as their main drug injected in the month prior to registration. Using this and the previous estimate it is likely that half the IDU in the Kings Cross area are regular heroin injectors, and it is plausible that 2,000 IDU are regularly injecting heroin in the Kings Cross area. Allowing for an average of at least three injections per day per regular heroin user, there would be 6,000 injections of heroin per day in the Kings Cross area.

UNQUOTE

The evaluators derived this figure by noting that 55% of the 3,782 clients that injected all drugs in the room (ie 2,080 clients) was roughly half the MSIC's clientele. They then applied this rough approximation to the 4,000 IDU (of all types of drugs - page 58 par 3) and determined that there were 2,000 HEROIN injectors in the Cross on a daily basis. Drug Free Australia has not claimed anything that the evaluation did not itself claim.

3. Drug Free Australia calculations indicating that clients averaged just one in every 35 of their injections in the room did indeed factor in transience of clientele. The one in 35:

a. excludes clients registering from overseas, interstate, and any area outside SE Sydney, Sydney North and Central Sydney
b. excludes 50% of clients from postcodes 2010 and 2011 (23% of total), where resident turnover is 50% every 4 years (as per MSIC's own published observations)

Our assumption about the MSIC estimate of 1,100 clients being questionable is based on the MSIC's own assumption that there is 50% TURNOVER of users in the Cross, rather than a 50% exodus. We have noted that 870 clients in the MSIC evaluation lived in the 2010 and 2011 postcodes, and we find it hard to believe that only 200 odd extra clients access the Cross each day from other areas.

The effect of a smaller heroin using population in Kings Cross does indeed reduce the massive overdose rate presented by the injecting room when comparisons are done with street rates of overdose in Kings Cross. But we have to remember that the other measures remain very high, particularly the comparison with client rates of overdose before they registered. On this measure, where the injecting room is 42 times higher than previous rates of overdose, there is little reason to reduce the result of 42 times higher on the account of forgotten overdoses. As posted on this list a number of times, overdoses are more usually in the presence of other people whether that be family members or other users.

The reason DFA did a number of comparisons, including against national estimates, is to demonstrate that no matter what the measure, the overdoses rates in the injecting room remain massive.

Regards

Gary Christian
(Drug Free Australia)