The Kings Cross Injecting Room

The Case for Closure – Detailed Evidence

This document sets out detailed evidence backing each page of the Drug Free Australia 12 page booklet titled 'The Kings Cross Injecting Room - the Case for Closure', starting with more detailed citations backing the statements on the cover of the DFA booklet.

This report uses data from the injecting room's own evaluation, released July 9 2003 as well as data to December 2006. Because the data is mostly statistical in nature, it is easily mathematically checked and verified or falsified. Drug Free Australia has used the injecting room's data, with the identical methodologies used by its so-called 'independent' evaluation in formulating the conclusions in this booklet. Where data is quoted from the 2003 evaluation, screen copies from the actual 2003 evaluation document are reproduced in this document.

Statistical work was done by a Drug Free Australia team including Dr Joe Santamaria (previously Department Head of Community Medicine, St Vincent's Hospital, Melbourne); Dr Stuart Reece (Addiction Medicine specialist, Brisbane); Dr Lucy Sullivan (Social Researcher formerly of the Centre for Independent Studies, Sydney); Dr Greg Pike, (Director of Southern Cross Bio-ethics Institute, Adelaide) and Mr Gary Christian, (Welfare industry Senior Manager, Sydney).

I. COVER

Key quotes concerning the injecting room

1.1 Self-condemnation via Supporters

Posting on Update Drug & Alcohol national listserver 21/7/2006 by Andrew Byrne, Injecting Room Community Consultative Committee:

"The latest information is that heroin availability has declined dramatically since January this year and just as common now are prescribed pain killers morphine/oxycodone (31%). These have shown to produce a far lower overdose rate (less than half that of street heroin). Also, for the first time in 20 years, brown heroin (38%) from Afghanistan has appeared on the Sydney market. 'Crystal meth' or 'ice' is still popular (6%) and cocaine is used by 21% of attendees."

1.2 Condemnation in Daily Telegraph

"The Sunday Telegraph can reveal that ice addicts make up eight per cent of users at the Medically Supervised Injecting Centre, . . ."
Sunday Telegraph Dec 10 2006

1. 3 Condemnation by the United Nations

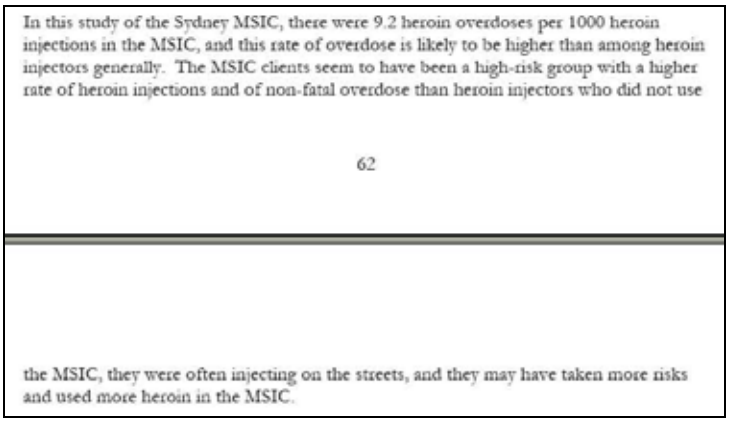
"The Board regrets that local authorities in the Australian State of New South Wales have permitted the establishment of a drug injecting room, setting aside concerns expressed by the Board that the operation of such facilities, where addicts inject themselves with illicit substances, condones illicit drug use and drug trafficking and runs counter to the provisions of the international drug treaties."
United Nations International Narcotic Control Board, in its 2001 report, paragraph 559

1.4 Condemnation via the Injecting Room's Own Report

"In this study of the Sydney MSIC there were 9.2 heroin 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."

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 62 par 6 (actual copy from the report reproduced below)



In this study of the Sydney MSIC, there were 9.2 heroin 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 and of non-fatal overdose than heroin injectors who did not use

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the MSIC, they were often injecting on the streets, and they may have taken more risks and used more heroin in the MSIC.

THE CASE FOR CLOSURE

In 1999 the NSW Government's Drug Summit recommended the trial of a safe injecting room on three grounds:

1. it should decrease overdose deaths,
2. it should provide a gateway to treatment and
3. it should reduce the problem of discarded needles and users injecting in public places

Further:

It should provide safety to injectors living with the threat of overdose

But it:

1. demonstrably failed to save even one life
2. had very poor referral rates to treatment or rehab
3. it in no way reduced the problem of discarded needles and therefore of public injection
4. demonstrated that safety was not a concern for clients

Objections to the injecting room were that it would:

1. increase drug taking
2. increase drug trafficking
3. create a honey-pot effect for drug dealers around the injecting room

THE EVIDENCE HEREIN INDICATES THE INJECTING ROOM DID ALL THREE

This document seeks to reproduce or otherwise direct its reader to all relevant evidence cited in the Drug Free Australia publication on the failure of the Kings Cross injecting room

Where the analysis examines the statistical claims of the injecting room's evaluation report, step by step methods of calculation are reproduced for ease of verification

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II. WAS THE PUBLIC MISLED?

The injecting room's own public relations unit continually stated that each overdose intervention in the injecting room was a life saved. This resulted in increased public support which went from 68% in 2000 to 78% in 2002. The fact is that their own advisors found that just one in 25 overdoses is ever fatal yet the following was reported:

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/LC20010704

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 Media Record 4

DOOR LEADS AWAY FROM DEATH IN GUTTER
West Australian, Fri, 10 Aug 2001

TWENTY DRUG ADDICTS who would probably have overdosed in a King's Cross gutter ARE ALIVE after being revived at Australia's first legally sanctioned injecting room.
The 20 success stories have become statistics of a new kind - figures used to show why the contentious drug injecting centre has a place in the battle plan against the scourge of drugs. After 12 weeks of operation, it has more than 800 users registered, up to 100 people a day using its facilities and about 200 addicts who have signed on for health and welfare programs, including rehabilitation.
And then there is the one statistic that counts above all else - no deaths. Centre director Ingrid van Beek said the figures were better than expected, given the intense scrutiny under which it opened.
http://www.mapinc.org/drugnews/v01.n1468.a02.html

2.6 Media Record 5

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

2.7 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/LA20020529

2.8 Media Record 6

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

III. 10 CRUCIAL THINGS YOU NEED TO KNOW

Summary

(detailed evidence addressing each point from page 11 on)

1. Only 38% of injections in the injecting room in 2006 were heroin injections. Substances such as cocaine and 'ice', highly destructive in the longer term but not presenting high risks of immediate overdose, are commonly injected, as is prescription morphine.

2. The International Narcotics Control Board (INCB) specifically singled out the Kings Cross injecting room trial as being in breach of the International Conventions against illicit drug use. This trial does not utilise legal heroin but rather depends on clients illegally procuring heroin, illegally transporting heroin, and illegally using heroin. Furthermore, if the injecting room trial had been valid, the 2003 evaluation should have marked the end of the trial. Results should have been forwarded to the INCB and the injecting room closed.

3. On average one out of every 35 injections per user was in the injecting room, despite the public being told that every heroin injection is potentially fatal. So under-utilised is the injecting room that it has averaged just 200 injections per day despite having the capacity to host 330 per day.

4. Based on the overdose figures published by the Medically Supervised Injecting Centre (MSIC) the overdose rate in the injecting room was 36 times higher than on the streets of Kings Cross.

5. The high overdose rate was attributed by the MSIC's own evaluation report to clients taking more risks with higher doses of heroin in the injecting room. More injected heroin means more heroin sold by Kings Cross drug dealers.

6. Currently a disturbing 1.6% of Australians have used heroin. However surveys show that 3.6% of NSW respondents say they would use heroin if an injecting room

was available to them, most for the first time, potentially doubling the number who would use the drug.

7. The government-funded estimate of 4 lives saved per year failed to take the enormously increased overdose rate into consideration. Adjusted for the high rates of overdose, the injecting room saved statistically 0.18 lives in its 18 month evaluation period.

8. Only 11% of injecting room clients were referred to maintenance treatment, detox or rehab. 3.5% of clients were referred to detox and only 1% referred to rehabilitation. None of Sydney's major rehabs such as Odyssey House, WHOS or the Salvation Army ever sighted one of the referrals.

9. The injecting room did not improve public amenity. The injecting room quite evidently drew drug dealers to its doors. Reductions in the number of public injections and discarded needles in Kings Cross decreased only in line with reduced distributions of needles due to the heroin drought. Recent reports indicate increases in publicly discarded needles.

10. The 'independent' government-funded evaluation of the injecting room, released July 9 2003 and from which much of the data in this report is drawn, was done by a research team of five, three of whom were colleagues in the same NSW University medical faculty as the Medical Director of the injecting room. A fourth researcher was one of those who, during the 1999 NSW Drug Summit, shaped the proposed injecting room trial. Drug Free Australia has questioned the independence of this evaluation team.

HAD THE NSW GOVERNMENT BEEN TOLD THESE REALITIES, IT WOULD HAVE BEEN OBLIGATED TO CLOSE THE INJECTING ROOM DOWN.

THE INJECTING ROOM EVALUATION FAILED TO DRAW ATTENTION TO ANY OF THE ABOVE

A DETAILED EXPOSITION OF EACH OF THE ABOVE POINTS FOLLOWS – text from DFA booklet in BLUE

DETAILED EVIDENCE

3.1 ONLY 38% INJECTIONS ARE HEROIN

Only 38% of injections in the injecting room in 2006 were heroin injections. Substances such as cocaine and 'ice', highly destructive in the longer term but not presenting high risks of immediate overdose, are commonly injected, as is prescription morphine.

Posting on Update Drug & Alcohol national listserver 21/7/2006 by Andrew Byrne, Injecting Room Community Consultative Committee:

> "The latest information is that heroin availability has declined dramatically since January this year and just as common now are prescribed pain killers morphine/oxycodone (31%). These have shown to produce a far lower overdose rate (less than half that of street heroin). Also, for the first time in 20 years, brown heroin (38%) from Afghanistan has appeared on the Sydney market. 'Crystal meth' or 'ice' is still popular (6%) and cocaine is used by 21% of attendees."

3.2 INCB DECLARES ROOM'S ILLEGALITY

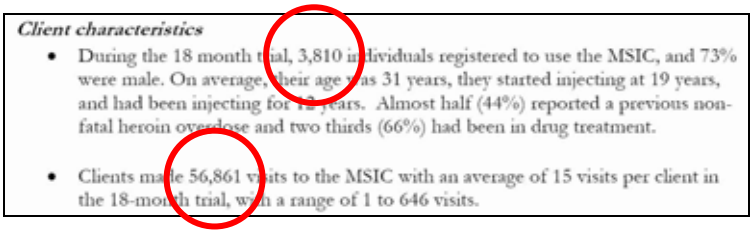
The International Narcotics Control Board (INCB) specifically singled out the Kings Cross injecting room trial as being in breach of the International Conventions against illicit drug use. This trial does not utilise legal heroin but rather depends on clients illegally procuring heroin, illegally transporting heroin, and illegally using heroin. Furthermore, if the injecting room trial had been valid, the 2003 evaluation should have marked the end of the trial. Results should have been forwarded to the INCB and the injecting room closed.

> "The Board regrets that local authorities in the Australian State of New South Wales have permitted the establishment of a drug injecting room, setting aside concerns expressed by the Board that the operation of such facilities, where addicts inject themselves with illicit substances, condones

illicit drug use and drug trafficking and runs counter to the provisions of the international drug treaties."
United Nations International Narcotic Control Board, in its 2001 report, paragraph 559

3.3.1 ONLY 1 IN EVERY 35 INJECTIONS INSIDE THE INJECTING ROOM

On average one out of every 35 injections per user was in the injecting room, despite the public being told that every heroin injection is potentially fatal.



Client characteristics

- During the 18 month trial, 3,810 individuals registered to use the MSIC, and 73% were male. On average, their age was 31 years, they started injecting at 19 years, and had been injecting for 12 years. Almost half (44%) reported a previous non-fatal heroin overdose and two thirds (66%) had been in drug treatment.
- Clients made 56,861 visits to the MSIC with an average of 15 visits per client in the 18-month trial, with a range of 1 to 646 visits.

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p XI par 2,3

Month	Days	Registered	Adjusted	Cumulative Registered	Injections @ 3 a day
May-01	31	290	163.85	163.85	15238
Jun-01	30	198	111.87	275.72	24815
Jul-01	31	333	188.145	463.865	43139
Aug-01	31	211	119.215	583.08	54226
Sep-01	30	230	129.95	713.03	64173
Oct-01	31	231	130.515	843.545	78450
Nov-01	30	188	106.22	949.765	85479
Dec-01	31	263	148.595	1098.36	102147
Jan-02	31	206	116.39	1214.75	112972
Feb-02	28	170	96.05	1310.8	110107
Mar-02	31	203	114.695	1425.495	132571
Apr-02	30	166	93.79	1519.285	136736
May-02	31	209	118.085	1637.37	152275
Jun-02	30	171	96.615	1733.985	156059
Jul-02	31	186	105.09	1839.075	171034
Aug-02	31	227	128.255	1967.33	182962
Sep-02	30	168	94.92	2062.25	185603
Oct-02	31	160	90.4	2152.65	200196

TOTALS	3810	2152.65	
TOTAL INJECTIONS FOR REGISTERED CLIENTS			2,008,182
TOTAL INJECTIONS IN MSIC			56,861
RATIO OF INJECTIONS IN ROOM		1:	35

The above spreadsheet 1. adjusts for monthly registrations 2. excludes clients registering from overseas, interstate, and any area outside SE Sydney,

Sydney North and Central Sydney 3. excludes 50% of clients from postcodes 2010 and 2011 (23% of total), where resident turnover is 50% every 4 years

The spreadsheet above estimates from Figure 2.1 on page 14 of the evaluation report the registrations for each month.

Figure 2.1: Number of new clients registered per month

34 out of their every 35 injections were unsupervised, at a friend's place or squat, at a dealer's home, on the street, in a car, in a public toilet or in an illegal shooting gallery *despite access to the room.*

3.3.2 INJECTING ROOM UNDER-UTILISED

So under-utilised is the injecting room that it has averaged just 200 injections per day despite having the capacity to host 330 per day.

Posting on Update Drug & Alcohol national listserver 21/7/2006 by Andrew Byrne, Injecting Room Community Consultative Committee:

> "On average about 200 visits occur each day and some days there are more than 300 injecting episodes in the centre."

2.4.3 Interpretation and implications

The large number of MSIC client registrations and visits suggest that there is considerable demand for a service of this kind in Kings Cross. With extended hours of operation it is likely that the MSIC can increase its current capacity. MSIC service utilisation after weekday operating hours were extended to 12 hours per day showed the MSIC could accommodate up to 330 visits per day (Kimber & Mattick, 2003)

3.4 MASSIVE RATES OF OVERDOSE IN THE INJECTING ROOM

Based on the overdose figures published by the Medically Supervised Injecting Centre (MSIC) the overdose rate in the injecting room was 36 times higher than on the streets of Kings Cross.

Text below is reproduced from page 8 of the DFA Injecting Room booklet . . .

The injecting room had an extraordinary rate of overdose – 9.6 overdoses for every 1,000 injections. But its evaluation report curiously failed to compare these injecting room overdose rates with other known rates of overdose.

There are three comparisons that can be done:

1. Comparison with overdoses in the rest of Kings Cross
2. Comparison with injecting room client overdose rates before they entered the MSIC
3. Comparison with Australian estimates of national rates of overdose

3.4.1 36 Times Higher than Streets of Kings Cross - Summary

By using precisely the same methodology as the MSIC evaluation team it is first noted that the evaluation document recorded 431 ambulance attendances for overdose in Kings Cross (Table 3.5 p 52) during the 18 months of evaluation.
Applying the observation that "Darke et al. (1996) showed that an ambulance attends in 51% of non-fatal overdose events . . ." (p 59 par 3) it could be expected that Kings Cross had a total of 845 non-fatal overdoses on its streets during the same period.
The report calculated that "Allowing for an average of at least three heroin injections per day per regular heroin

users, there would be 6,000 injections of heroin in the Kings Cross area per day." (p 58 par 4) For the 544 days of the evaluation period, there were thus 845 non-fatal overdoses for 3,264,000 heroin injections, or a rate of 0.26 non-fatal overdoses per 1000 injections as compared to 9.6 per 1000 in the injecting room. 36 times higher in the injecting room.
(Calculations checked by Dr Joe Santamaria, former Head of the Melbourne St Vincents Hospital Department of Community Health AND Dr D'arcy Holman, one of Australia's most internationally renowned epidemiologists from the University of Western Australia)

DETAILED CALCULATIONS

This uses PRECISELY the same methodology as the MSIC evaluation team. The evaluation document noted that there were 431 ambulance attendances for overdose in Kings Cross (Table 3.5 p 52) during the 18 months of evaluation.

Table 3.5: Kings Cross area: Ambulance attendances during MSIC hours

	Total number of ambulance attendances for overdose	Number of attendances during MSIC opening hours	Percent of attendances in MSIC opening hours	Statistical significance
Pre MSIC (May 1999 – October 2000)	1,059	355	33.5%	χ^2_1=1.8, p=0.18
Post MSIC (May 2001 – October 2002)	431	129	29.9%	No significant change

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Applying the observation that "Darke et al. (1996) showed that an ambulance attends in 51% of non-fatal overdose events . . ." (p 59 par 3) it could be expected that Kings Cross had a total of 845 non-fatal overdoses on its streets during the same period.

> Combining these two figures, the relative rate of death per ambulance attendance is 0.0812 or 8.12% of total NSW ambulance attendances. If we assume that all of the 329 cases of heroin overdose which occurred at MSIC had occurred in the community and had an ambulance called, approximately 27 deaths (329 X 0.0812 = 26.71) may have been averted. This is likely to be an overestimate as many overdoses are known to occur in the community but do not have an ambulance attend. Darke et al. (1996) showed that an ambulance attends in 51% of non-fatal overdose events and Darke et al. (in press) reported an estimate of 4.1 fatal overdoses for every 100 non-fatal overdoses in the community, overall (i.e., 0.041 or 4.1%). Therefore, using this figure of 4.1%, approximately 13 deaths (329 X 0.041 = 13.49) may have been averted in the 18-month trial period.

The report calculated that "Allowing for an average of at least three heroin injections per day per regular heroin users, there would be 6,000 injections of heroin in the Kings Cross area per day." (p 58 par 4)

> • 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 2000 IDU are regularly injecting heroin in the Kings Cross area. Allowing for an average of at least three heroin injections per day per regular heroin users, there would be 6,000 injections of heroin in the Kings Cross area per day.

For the 544 days of the evaluation period, there were thus 845 non-fatal overdoses for 3,264,000 heroin injections, . . .

Days of evaluation period	x	Injections per day in Kings Cross	=	Total injections for Kings Cross for evaluation period
544	x	6,000	=	3,264,000

. . . or a rate of 0.26 non-fatal overdoses per 1000 injections as compared to 9.6 per 1000 in the injecting room.

Estimated overdoses	/	Total injections for Kings Cross /1,000	=	Rate of overdose per 1,000 injections
845	/	3,264,000 (/1,000)	=	0.26/1,000

36 times higher in the injecting room.

Rate of overdose per 1,000 injections – Injecting Room	/	Rate of overdose per 1,000 injections – Kings Cross	=	Comparative rate of overdose
9.6/1,000*	/	0.26/1,000	=	36 times higher than Kings Cross

(Calculations verified by Dr Joe Santamaria, former head of the Melbourne St Vincents Hospital Department of Community Health)

* 9.6 overdoses per 1,000 injections is the correct figure, as correctly recorded at p 23 par 1 of the injecting room evaluation report

3.4.2 At Least 40 Times Higher than MSIC Client's Previous History - Summary

Registration questionnaires, which all clients completed upon first entering the injecting room, indicated an average 3 overdoses per client (p 16 par 1) over an average 12 years of illicit drug abuse (Table 2.1 p 15). This averages one non-fatal overdose for every 4 years of drug abuse. Using the evaluator's own conservative estimate of 3 injections per day there would be one overdose for every 4,380 injections every 4 year period. This would represent a rate of 0.23 overdoses per 1000 injections as compared to 9.6 per 1000 in the injecting room.

DETAILED CALCULATIONS

Registration questionnaires, which all clients completed upon first entering the injecting room, indicated an average 3 overdoses per client (p 16 par 1)

Previous non-fatal heroin-related overdose was reported by 44 % of clients; with a median number of three episodes reported. At least one heroin-related overdose in the 12-months before registration was reported by 12% of clients with a median of one episode (range 1-31 episodes). The mean age of first overdose was 23 years (SD=7). On average female clients were 1.8 years younger than males at the time of their first overdose (22 vs 23 years, 95% CI 1.5-3.2, p<. 01). At the time of their last overdose, 74% of clients reported being attended by ambulance and 68% reported being administered naloxone (Table 2.4).

Table 2.4: Overdose history

Overdose history	Number of clients = 3,782
Ever overdosed	44 %
Overdosed in past 12 months	12 %
Attended by ambulance at last overdose	74 %
Administered naloxone at last overdose	68 %
Last overdose occurred in public place [1]	36 %

1 = Street, park, beach or public toilet.

over an average 12 years of illicit drug abuse (Table 2.1 p 15).

Table 2.1: Demographic characteristics

Characteristic	Number of clients = 3,782
Average age in years (SD)	31years (8)
Average age started injection (SD)	19 years (6)
% English speaking background	93 %
% Indigenous background	9 %
% Completed high school	28 %
% Social security main source of income	57 %
% Unstable accommodation [1]	11 %
% Imprisoned in previous 12-months	26 %
% Injection daily in previous month	42 %
% Sex work in previous month	10 %
% Injected in a public place in previous month	39 %

1 = Includes living on the street, shelters and abandoned buildings.

This averages one non-fatal overdose for every 4 years of drug abuse.

Average years of illicit drug use for clients	/	Median number of overdoses	=	Average number of years between overdoses
12	/	3	=	4

Using the evaluator's own conservative estimate of 3 injections per day there would be one overdose for every 4,380 injections every 4 year period.

Number of days between averaged client overdoses	x	Median number of overdoses	=	Number of injections per overdose for injecting room clients
(4 x 365) 1,460	x	3	=	4,380

This would represent a rate of 0.23 overdoses per 1000 injections as compared to 9.6 per 1000 in the injecting room.

Single overdose	/	Number of injections per overdose for injecting room clients before entering injecting room /1000	=	Rate of overdose per 1,000 injections
1	/	4,380 (/1,000)	=	0.23

More than 40 times higher in the injecting room.

Rate of overdose per 1,000 injections – Injecting Room	/	Rate of overdose per 1,000 injections – clients before entering the injecting room	=	Comparative rate of overdose
9.6/1,000	/	0.23/1,000	=	42 times higher than Kings Cross

Answers to possible objections to this mode of calculation

A possible objection to this second mode of calculation might be this:

That the 44% of injecting room clients who recorded past overdoses may not have all been heroin users. If some had previously overdosed on amphetamine, then it would be unfair to compare past overdoses of heroin AND amphetamine with only heroin overdoses in the injecting room.

In response to such an objection we would note that the rate of 9.6 heroin-related overdoses per 1,000 injections in the injecting room was applied to all the heroin users at the centre, a sub-group which made up 60% of the entire client number. This same sub-group would have been mostly responsible for the previous overdose figure of 44%.

It is therefore evident that not all heroin users entering the centre had ever had an overdose before, and should mostly not be expected to overdose in the centre. THE CLIENTS WITH NO HISTORY OF OVERDOSE SHOULD REASONABLY BE EXPECTED TO REDUCE THE OVERALL RATE OF OVERDOSES PER 1,000 INJECTIONS IN THE INJECTING ROOM, indicating that without these non-overdosing clients the rate of overdose would have even been higher than 9.6/1000, an already extraordinary figure.

3.4.3 49 Times Higher than Estimated National Overdose Averages

The official well-known estimate of dependant heroin users within Australia in 1997 was 74,000. With these users injecting at a conservative estimate of three times per day there would be 81,030,000 heroin injections per year from this group. There were 600 fatal overdoses in 1997 plus an estimated 15,000[1] non-fatal overdoses. 15,600 overdoses for every 81,030,000 injections yields a rate of overdose of 0.19 overdoses for every 1000 injections, compared to 9.6 per 1000 in the injecting room.

DETAILED CALCULATIONS

The official well-known estimate of dependent heroin users within Australia in 1997 was 74,000.

[1] Warner-Smith M.; Lynskey M.; Darke S.; Hall, W. ANCD Research Paper 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions ANCD Canberra (2001) p.12

The prevalence of heroin dependence in Australia

A variety of estimation methods have been used to determine the number of heroin users in Australia, based on Australian Bureau of Statistics overdose mortality data, methadone client database and arrest data. A convergence of estimates from these sources gives a best estimate of 74 000 dependent users (range from 67 000 to 92 000). This figure (for 1997) represents a doubling of the 34 000 estimated in 1984–87 and a 25 per cent increase on the estimate of 59 000 in the period 1988–93, and gives a population prevalence of opioid dependence in Australia of 6.9 per 1000 adults aged 15–54 years (range from 4.6 to 8.2).

ANCD Research Paper No 1 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions' p vii

With these users injecting at a conservative estimate of three times per day there would be 81,030,000 heroin injections per year from this group.

Estimated dependent heroin users in Australia	x	Heroin injections per user per year @ 3 injections per day	=	Total injections per annum for dependant heroin users in Australia
74,000	x	1095	=	81,030,000

There were 600 fatal overdoses in 1997 . . .

Year	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Deaths	347	302	316	243	327	357	406	550	526	600	737

. . . plus an estimated 15,000 non-fatal overdoses.

> The three estimates of non-fatal overdose prevalence extrapolated from Darke, Ross et al. (1996b), Thackaway and Poder (2000), Degenhardt, Hall et al. (2000), overdose fatality data, and estimates of the prevalence of heroin dependence are in broad agreement. These three methods suggest that the current total prevalence of fatal and non-fatal overdose in Australia lies in the range of 10500 to 20500 annually, with a best estimate of 15000.

ANCD Research Paper No 1 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions' p 12

15,600 overdoses for every 81,030,000 injections yields a rate of overdose of 0.19 overdoses for every 1000 injections,

Total estimated overdoses for Australia (1997)	/	Total injections per annum for dependant heroin users in Australia /1000	=	Rate of overdose per 1,000 injections
15,600	/	81,030,000 (/1,000)	=	0.19

compared to 9.6 per 1000 in the injecting room. 49 times higher than the national overdose estimates.

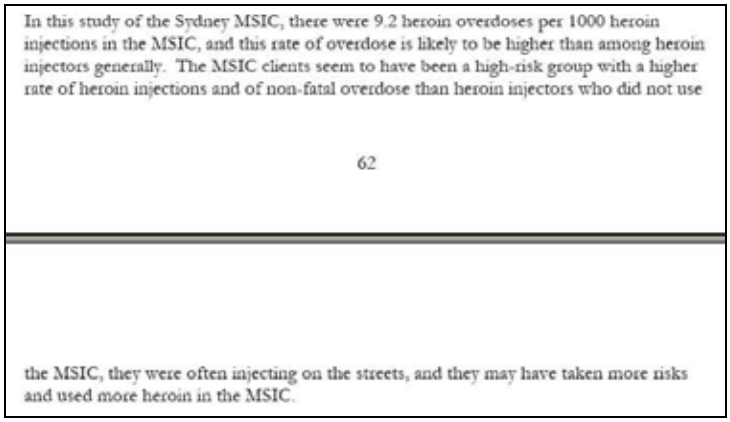
Rate of overdose per 1,000 injections – Injecting Room	/	Rate of overdose per 1,000 injections – National estimates	=	Comparative rate of overdose
9.6/1,000	/	0.19/1,000	=	49 times higher than Kings Cross

3.5 MORE OVERDOSES = MORE HEROIN SOLD BY KINGS CROSS DEALERS

The high overdose rate was attributed by the MSIC's own evaluation report to clients taking more risks with higher doses of heroin in the injecting room. More injected heroin means more heroin sold by Kings Cross drug dealers.

"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."

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 62 par 6 (actual copy from the report reproduced below)



In this study of the Sydney MSIC, there were 9.2 heroin 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 and of non-fatal overdose than heroin injectors who did not use

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the MSIC, they were often injecting on the streets, and they may have taken more risks and used more heroin in the MSIC.

3.6 SIGNIFICANTLY INCREASING THE ILLICIT DRUG TRADE

Currently a disturbing 1.6% of Australians have used heroin. However surveys show that 3.6% of NSW respondents say they would use heroin if an injecting room was available to them, most for the first time, potentially doubling the number who would use the drug.

Note that the above-mentioned survey was specifically completed for the government-funded injecting room evaluation. Here is some background on the survey from the injecting room's own evaluation report.

Telephone interviews were carried out with three sub-groups: businesses located in Kings Cross; residents in Kings Cross; and residents in New South Wales. The baseline surveys were carried out in August and September 2000 for the NSW residents' survey and October 2000 for businesses and residents in Kings Cross; seven to nine months before the MSIC opened and 15 and 17 months after the decision was announced approving the establishment of the MSIC in Kings Cross. The follow-up surveys were carried out two years later in 2002 in the same months respectively, 15 and 17 months after the MSIC opened in Darlinghurst Rd, Kings Cross.

Telephone numbers for businesses were randomly selected from the electronic business telephone database (postcode area 2011). Telephone numbers for the resident surveys were generated randomly by the NSW Department of Health. Telephone numbers for Kings Cross residents included residences in the Kings Cross postcode area and the north side of Oxford Street in the Darlinghurst area.

Trained interviewers conducted the telephone interviews using the CATI system (Hunter Valley Research Foundation). The questionnaire required ten minutes, on average, to complete. Information was obtained on respondents' opinion of the Kings Cross MSIC, the location of supervised injecting centers in general, the advantages and disadvantages of MSICs and agreement with other selected drug policy initiatives.

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 154 pars 1-3

The results are an absolute scandal but draw no comment from the evaluators, which might raise questions about their independence (a point taken up elsewhere in this document).

A small proportion of resident respondents from Kings Cross or NSW also reported that they would be more likely to inject heroin if they had access to a supervised injecting centre; 4% (2000) and zero (2002) for Kings Cross ($p<0.001$) and 5% (2000) and 3% (2002) for NSW respondents ($p=0.01$). Only two of the 28 NSW respondents in 2002 who reported that they would be more likely to inject heroin also reported a history of injecting drug use. The most frequently reported reason for potential use of the MSIC was safety (Table 8.4).

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Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 157 par 2

Further detail is given about the surveys on the next page of the evaluation report.

Table 8.4: Number (percentage) of Kings Cross and NSW residents reporting that they would use the MSIC and the reason for use

Characteristics	Kings Cross		NSW	
	2000 n=515	2002 n=540	2000 n=1018	2002 n=1070
Would use a SIC	19 (4%)	0 (0%)	47 (5%)	28 (3%)
Reason for MSIC use				
Safety	12 (2%)	-	19 (2%)	18 (2%)
Hypothetical	5 (1%)	-	2 (<1%)	8 (1%)
Not IDU	2 (1%)	-	0 (0%)	1 (<1%)
Anti-drugs	0 (0%)	-	1 (<1%)	1 (<1%)
Not asked the reason [1]	-	-	25 (3%)	-

1 = Most of the first 25 NSW resident respondents who reported that they would be more likely to inject heroin if they had access to a SIC were aged over 50 years, therefore a question was added to determine whether people responding in the affirmative would actually commence drug injection.

This unquestionably demonstrates that the injecting room does indeed encourage experimentation with high-risk substances and increases illicit drug use. Currently only 1.6% of Australians have experimented with heroin.

Taken together with the extraordinary rate of overdose in the injecting room, it might suggest that injecting room clients are using medical staff in the room as insurance against the risks of experimenting with higher doses of heroin. And the survived higher dose today becomes the drug dealer's bigger sale tomorrow and the next day, and the next . . .

3.7.1 NOT ONE LIFE SAVED PER YEAR

The government-funded estimate of 4 lives saved per year failed to take the enormously increased overdose rate into consideration. Adjusted for the high rates of overdose, the injecting room saved statistically 0.18 lives in its 18 month evaluation period.

IMMEDIATE FALSIFICATION OF EVALUATION ESTIMATE

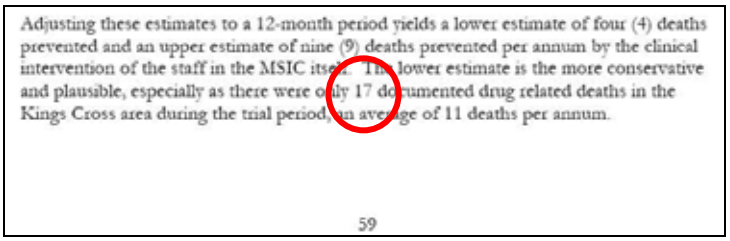
In Australia, about 1 in every 100 heroin addicts die each year from heroin overdose. The injecting room would need host 300 injections per day (that is enough injections for 100 heroin addicts injecting 3 times per day) before they could claim they had saved the life of the one of those 100 who would have died. But the injecting room averages less than 200 injections per day, many of which are not even heroin. This is not even enough to claim that they save one life per year.

3.7.2 ONLY 0.18 LIVES SAVED IN 18 MONTHS

Data from the 2003 evaluation indicates statistically only 0.18 lives were saved in the 18 month evaluation period.

DETAILED CALCULATIONS

The fatal overdose rate for Kings Cross is easily calculated. Out on the streets there were 17 fatal overdoses . . .



Adjusting these estimates to a 12-month period yields a lower estimate of four (4) deaths prevented and an upper estimate of nine (9) deaths prevented per annum by the clinical intervention of the staff in the MSIC itself. The lower estimate is the more conservative and plausible, especially as there were only 17 documented drug related deaths in the Kings Cross area during the trial period, an average of 11 deaths per annum.

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. . . for the estimated 3,264,000 injections that took place.

Days of evaluation period	x	Injections per day in Kings Cross	=	Total injections for Kings Cross for evaluation period
544	x	6,000	=	3,264,000

This is one fatal overdose for every 190,000 heroin injections.

Total injections for Kings Cross for evaluation period	/	Total overdose deaths in Kings Cross – evaluation period	=	Number of heroin injections per fatal overdose in Kings Cross
3,264,000	/	17	=	190,000

Yet the injecting room only had 35,000 heroin injections over its first 18 months, . . .

- Clients made 56,861 visits to the MSIC with an average of 15 visits per client in the 18-month trial, with a range of 1 to 646 visits.
- Heroin was the drug most frequently injected at the MSIC (61% of visits) followed by cocaine (30% of visits).

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p xi

Total visits to injecting room during evaluation period	x	Percentage of visits for heroin injection	=	Maximum number of heroin injections in injecting room
56,861	x	61%	=	34,969

not even one-fifth of the number of injections per fatal overdose on the streets.

Number of heroin injections per single fatal overdose in Kings Cross	/	Total visits to injecting room during evaluation period	=	Possible lives saved In injecting room - by comparison with fatal overdoses in Kings Cross
190,000	/	<34,969	=	0.18

3.7.3 $20 MILLION TO SAVE JUST ONE SINGLE LIFE

- At rates of initial use during its first 18 months, the injecting room would take 8 years

Number of heroin injections per single fatal overdose in Kings Cross	/	Total visits to injecting room during evaluation period	=	(A) Possible lives saved In injecting room - by comparison with fatal overdoses in Kings Cross
190,000	/	<34,969	=	0.18

See page 26 for background to these figures

Single life to be saved	/	(A) Statistical number of lives saved during 18 month evaluation period	=	(B) Number of 18 month periods to save one single life in the injecting room
1	/	0.18	=	5.56

(B) Number of 18 month periods to save one single life in the injecting room	x	Number of months in the 18 month evaluation period	=	Number of months to save one single life in the injecting room
5.56	x	18	=	100 months (8.33 years)

. . . and $20 million to statistically claim it had saved just one single life

On the proviso that the injecting room evaluation report estimated $2.4 million a year to operate an injecting room:

Table 9.10: MSIC set-up and operating costs

	Current operation	Future operation	Future operation at a new location
Operating costs	$2,130,000	$2,337,000	$2,337,000
Set-up costs (amortised)	$96,000	n.a.	$99,000
Total	**$2,226,000**	**$2,337,000**	**$2,435,000**

In the first year of operation of the Kings Cross MSIC, total costs of $2.2 million were incurred. These costs would rise to $2.3 million per annum for subsequent operation of this MSIC and to $2.4 million per annum for future MSICs operating in a manner similar to the Kings Cross MSIC.

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Number of years to save one single life in the injecting room	x	Cost of injecting room operation per annum	=	Cost of saving just one life in the injecting room
8.33	x	$2,400,000	=	$20,000,000

3.8 ONLY 11% OF CLIENTS REFERRED TO TREATMENT, DETOX OR REHAB

Only 11% of injecting room clients were referred to maintenance treatment, detox or rehab. 3.5% of clients were referred to detox and only 1% referred to rehabilitation. None of Sydney's major rehabs such as Odyssey House, WHOS or the Salvation Army ever sighted one of the referrals.

Because only 15% of clients were referred to a service of any kind (see page 98 of the MSIC evaluation) it is evident that there were multiple referrals for each client. It is assumed here that some clients referred to a residential rehabilitation centre were referred to a detoxification program first.

8% of clients were referred to maintenance treatments . . .

Table 5.7: Type of referral by the number of cards provided and returned

Referral type	All referrals	Referral card provided	Referral card returned	Percent returned (%)
Drug treatment				
Buprenorphine maintenance	179	100	12	12
Detoxification program	134	48	9	19
Methadone maintenance	125	88	21	24
Drug and alcohol counselling	107	51	5	10
		98		
Residential rehabilitation	43	12	2	17
Other	13	1	0	0
Sub total	601	*300*	*49*	*16*

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre pp 98,9

Number referred to buprenorphine & methadone maintenance	/	Number of injecting room clients	=	Percentage of clients referred to treatment
304 (x100)	/	3,810	=	8%

. . . and only a mere 4.7% were referred to detox or rehabilitation

Number referred to detox & rehab	/	Number of injecting room clients	=	Percentage of clients referred to treatment
177 (x100)	/	3,810	=	4.7%

with none of the major rehabs such as Odyssey House, WHOS or the Salvation Army sighting one of the referrals according to Drug Free Australia's Major Brian Watters, then Chairperson of the Prime Minister's Advisory of Illicit Drugs who personally checked with the CEO's of each of these organisations.

3.9 PUBLIC AMENITY NOT IMPROVED

The injecting room did not improve public amenity. The injecting room quite evidently drew drug dealers to its doors. Reductions in the number of public injections and discarded needles in Kings Cross decreased only in line with reduced distributions of needles due to the heroin drought. Recent reports indicate increases in publicly discarded needles.

NSW PARLIAMENT SAID PUBLIC AMENITY WOULD IMPROVE – IT DIDN'T

Here is what the NSW Parliament was told about the injecting room, and the expected changes to the visible drug problems of Kings Cross it would make.

"Although people might not like it in their neighbourhood—I know that older people in particular find the whole injecting drug scene very confronting and distressing—the majority of people in my electorate are tolerant and are prepared to give the trial a fair go. **The hope is that amenity will improve**—a reduction in street injecting and syringes in public places—that the centre will save lives and that it will help the marginalised drug-using minority to get their lives back together."
NSW Parliamentarian - Clover Moore 29 May 2002

"Providing a clinical place for people to inject under medical supervision is a means of saving lives, providing an entry point to treatment, **and improving public amenity**. I am advised that the centre has indicated that in its first 11

months there were more than 400 referrals into treatment and more than 200 overdoses but no deaths."
Premier Bob Carr – NSW Legislative Assembly Hansard 2002 p 1978

THE REALITY

A review of the survey results of Kings Cross businesses and residents shows a decrease in the nominated public amenity indicators of no greater than 20% between 2000 and 2002. This is despite a heroin drought intervening in October 2000 which decreased the number of needles and syringes distributed by 20% between 2000 and 2002.

We can conclude that the injecting room had no perceivable effect on public amenity – decreases in sighted injections and discarded syringes decreased only in line with the decreased number distributed.

Page 122 of the MSIC Evaluation shows the number of syringes per month distributed in Kings Cross

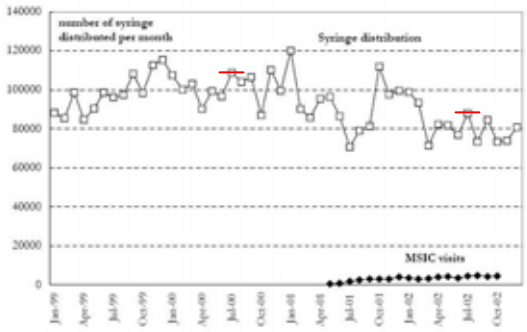

Figure 6.6: Syringe distribution from major NSP and pharmacy services in the Kings Cross/Darlinghurst area and MSIC visits, January 1999 – December 2002

Compare the lower distribution of needles with the decreases in sightings of public injection and discarded needles:

PUBLIC AMENITY

Public Nuisance from illicit drug use in Kings Cross

Local Resident Surveys	*2000*	*2002*
Reported public annoyance	87%	86%
More than one annoyance	39%	41%
Discarded syringes	38%	35%
Negative image	31%	33%
Crime and Personal Safety	26%	24%
Public injection	10%	8%

Local Business Surveys	*2000*	*2002*
Reported public annoyance	93%	92%
Discarded syringes	35%	31%
Negative image	34%	36%
Crime and Personal Safety	18%	33%
Public injection	9%	9%

Approaches to Buy Drugs

Local Resident Surveys	*2000*	*2002*
Ever asked to buy drugs	44%	44%
Asked to buy drugs in last 24 hrs	8%	9%
Asked to buy drugs - last mth	28%	29%

Local Businesses	*2000*	*2002*
Ever asked to buy drugs	46%	49%
Asked to buy drugs in last 24 hrs	14%	11%
Asked to buy drugs - last mth	33%	34%

Public Injection Perception

Local Residents	*2000*	*2002*					
Ever Seen Public Injecting	60%	61%	2000		2000	2002	2002
In last 24 hours	3%	2%	Median		Range	Median	Range
In past month	33%	28%		3	1-88	2	1-30

Local Businesses	*2000*	*2002*					
Ever Seen Public Injecting	62%	65%	2000		2000	2002	2002
In last 24 hours	7%	5%	Median		Range	Median	Range
In past month	38%	32%		3	1-120	4	1-90

Discarded Syringe Perception

Local Residents	*2000*	*2002*

Local Streets and Parks	84%	86%	2000	2000	2002	2002
Last 24 hours	27%	18%	Median	Range	Median	Range
Past month	67%	58%	8	1-360	5	1-600
Local Businesses	*2000*	*2002*				
Local Streets and Parks	90%	87%	2000	2000	2002	2002
Last 24 hours	34%	27%	Median	Range	Median	Range
Past month	72%	64%	12	1-600	12	1-800

PUBLICLY DISCARDED SYRINGE COUNTS

	Jul-00	Jul-02	
1. KRC Needle Exchange counts	60	55	
2. Researchers	2000	2001	2002
250-500 metres from MSIC	7	4	3
All locations	Same for 2000 as for 2002		
3. South Sydney Council	Jul-00	Jul-01	Jul-02
All locations	48	49	40
Fitzroy Gardens	61	81	24
Victoria Street	71	49	40
Bayswater Road	23	36	38
Macleay Street	28	38	30
Kellet Street	51	50	63
Darlinghurst Road	50	47	45

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3.10 INDEPENDENT EVALUATION NOT INDEPENDENT

The 'independent' government-funded evaluation of the injecting room, released July 9 2003 and from which much of the data in this report is drawn, was done by a research team of five, three of whom were colleagues in the same NSW University medical faculty as the Medical Director of the injecting room. A fourth researcher was one of those who, during the 1999 NSW Drug Summit, shaped the proposed injecting room trial. Drug Free Australia has questioned the independence of this evaluation team.

Three of the five researchers are colleagues of the Medical Director of the injecting room, indeed all part of the same medical faculty at NSW University. The report was led by NDARC, which has a history of supporting drug legalisation agendas such as heroin prescription trials, injecting rooms, medical use of cannabis and decriminalisation of cannabis.

It is also notable that NSW University offered to run the injecting room before Uniting Care was given the responsibility.

The Evaluation Committee was comprised of (alphabetically):

John Kaldor, Professor of Epidemiology, Deputy Director, National Centre in HIV Epidemiology and Clinical Research, University of New South Wales.

Helen Lapsley, previously Senior Lecturer, School of Public Health and Community Medicine, University of New South Wales.

Richard P. Mattick, Professor and Director, National Drug and Alcohol Research Centre, University of New South Wales.

Don Weatherburn, Director, New South Wales Bureau of Crime Statistics and Research.

Andrew Wilson, previously New South Wales Chief Health Officer, New South Wales Department of Health, chaired the Committee until 2001.

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Detail of these pages can be read by setting your viewer to 200% or higher


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Professor Richard Mattick
Head, National Drug and Alcohol Research Centre


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IV. Statistically Impossible to Save Just One Life per Year

4.1 STATISTICALLY IMPOSSIBLE TO SAVE ONE LIFE PER YEAR

Only two statistics need be known to demonstrate that the injecting room cannot possibly save even one life statistically per year.

Statistic 1
Less than 1% of dependent heroin users die from overdose each year in Australia

> "Multiplier methods used the number of national opioid overdose fatalities and NSW methadone maintenance therapy (MMT) clients. For mortality, we used both the conventional multiplier of 100 (which assumes an annual overdose mortality rate of 1%) and a multiplier of 125, derived from a meta-analysis of cohort studies of treated heroin users (which suggests an annual mortality rate of 0.8%)."
>
> **'How many dependent heroin users are there in Australia?' -** Wayne D Hall, Joanne E Ross, Michael T Lynskey, Matthew G Law and Louisa J Degenhardt; *MJA* 2000; 173: 528-531

Statistic 2
A dependent heroin user averages 'at least' three heroin injections per day.

- 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 2000 IDU are regularly injecting heroin in the Kings Cross area. Allowing for an average of at least three heroin injections per day per regular heroin users, there would be 6,000 injections of heroin in the Kings Cross area per day.

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 59)

Taking these two statistics together, it is clear that the injecting room would need to host 300 injections per day (ie enough injections for 100 heroin addicts injecting 3 times per day) before they could claim they had saved the life of the one (1%) of those 100 who would have died.

But the injecting room has only averaged 156 heroin injections per day since its evaluation period ended.

At the 5 year mark of April 2006 the injecting room had hosted 309,529 injections of various illicit or licit substances.
http://www.sydneymsic.com/files/MSIC%20-%20the%20first%205%20years%20ppt.ppt#363,30,Public amenity)

There were 56,861 injections in the first 18 months, when the injecting room was not yet running to its current daily rate of injections, so to be scrupulously fair calculations should be done on the 3.5 years since. Injections for the 3.5 years from October 31, 2002 to April 30, 2006 would be thus:

Total injections in 5 years	-	Injections during 18 Month evaluation period	=	Total injections since evaluation period
309,529	-	56,861	=	252,668

The number of days in those 3.5 years should take account of the fact the injecting room closes for 4 public holidays each year (thus around 1263 days in the 3.5 years).

Injections since evaluation period	/	Days MSIC open since end of evaluation period	=	Injections per day since end of evaluation period
252,668	/	1263	=	200

However, 75-80% of injections were heroin injections, as recorded in the injecting room's own newsletter for 2005 p 4 (we note that the percentage would have been even lower by 2006).

> Drug Trends
> "Heroin continues to be the most frequently injected drug at the MSIC constituting about 75 - 80% of all MSIC visits."
> http://www.sydneymsic.com/newsletters/FaceUpJune2005.pdf

Injections per day since end of evaluation period	*	Percentage heroin injections	=	Injections per day since end of evaluation period
200	*	78%	=	156

4.2 High Cost for Little Benefit

The injecting room costs $2.5 million a year to operate.

Table 9.10: MSIC set-up and operating costs

	Current operation	Future operation	Future operation at a new location
Operating costs	$2,130,000	$2,337,000	$2,337,000
Set-up costs (amortised)	$96,000	n.a.	$99,000
Total	**$2,226,000**	**$2,337,000**	**$2,435,000**

In the first year of operation of the Kings Cross MSIC, total costs of $2.2 million were incurred. These costs would rise to $2.3 million per annum for subsequent operation of this MSIC and to $2.4 million per annum for future MSICs operating in a manner similar to the Kings Cross MSIC.

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That is enough money for the NSW government to fund 109 drug rehabilitation beds or supply more than 700 dependent heroin users with life-saving Naltrexone implants for an entire year.

Taking the $23,000 per year offered by the NSW Government to fund a rehabilitation bed for an entire year, 109 beds could be funded with the $2.5 million it now costs to run the injecting room. Naltrexone implants with Rapid Detox costs $3,500 in a year.

4.3 Injector Safety Not Enhanced

Heroin addicts inject at least three times a day, or around 1,100 times in a year. If a heroin user wanted to avoid a fatal overdose she would have every injection inside the injecting room. But clients average just 2-3 visits per month, leaving themselves open to a fatal overdose for 34 out of 35 of their heroin injections.

See pages 12 & 13 of this document for full detail

4.4 Increased the Use of Heroin

The table below reproduces the results from two surveys commissioned by the injecting room evaluators, one in 2000 with 1018 respondents and the other in 2002 with 1070 respondents. In each case respondents were asked whether they would use an injecting room if made available. 3.6% replied they would.

Yet only 1.6% in the 2001 National Drug Strategy Household Survey indicated prior use of heroin. Alarmingly, 26 of the 28 who replied affirmatively in the 2002 survey had never tried heroin before. If more injecting rooms were opened this could lead to much higher heroin use.

Table 8.4: Number (percentage) of Kings Cross and NSW residents reporting that they would use the MSIC and the reason for use

Characteristics	Kings Cross		NSW	
	2000 n=515	2002 n=540	2000 n=1018	2002 n=1070
Would use a SIC	19 (4%)	0 (0%)	47 (5%)	28 (3%)
Reason for MSIC use				
Safety	12 (2%)	-	19 (2%)	18 (2%)

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 158

Alarmingly, 26 of the 28 who replied affirmatively in the 2002 survey had never tried heroin before. If more injecting rooms were opened this could lead to much higher heroin use.

A small proportion of resident respondents from Kings Cross or NSW also reported that they would be more likely to inject heroin if they had access to a supervised injecting centre; 4% (2000) and zero (2002) for Kings Cross ($p<0.001$) and 5% (2000) and 3% (2002) for NSW respondents ($p=0.01$). Only two of the 28 NSW respondents in 2002 who reported that they would be more likely to inject heroin also reported a history of injecting drug use. The most frequently reported reason for potential use of the MSIC was safety (Table 8.4).

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Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 157

V. Inject Anything You Want & an Evident Honey-pot Effect

5.1 Only 38% of injections are heroin

In 2006 only 38% of injections in the injecting room were for heroin. Yet the dangers of heroin overdose were the clear rationale given by its supporters for opening such a facility. Reports from the injecting room in 2006 show that 'ice', a highly destructive substance in the longer term but with much lower risks of overdose, is being consumed in the room. This drug is responsible for increasing numbers of violent attacks in the community.

Attendees use the following:
Heroin: 38%
Ice: 6%
Cocaine: 21%
Prescription Morphine: 31%

The injecting room is clearly a facility that doesn't meet its own publicised reason for being. It supports the use of any drug as often as you like. That just doesn't make sense.

See page 11 of this document for full detail

5.2 Running at 2/3rds capacity

Despite almost 900 injecting room clients living within walking distance of the facility,

> Most MSIC clients at registration reported residential postcodes from within NSW metropolitan health areas, with the largest proportion of clients residing in the South Eastern Sydney Health Area (42%) where the MSIC is located. Clients from South Eastern Sydney Health Area also accounted for the majority of visits (62%) to the MSIC during the evaluation period (Table 2.6). Approximately one quarter of MSIC clients (23%) reported their residential postcode was a Kings Cross area postcode (2010 or 2011) and these clients accounted for 38% of all visits to MSIC.

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 17

Total clients for injecting room	*	Percentage from 2010 & 2011 postcodes	=	Clients within walking distance of MSIC
3,810	*	23%	=	876

the injecting room has averaged just 200 injections per day, despite a capacity for 330 injections per day.

See page 13 of this document for full detail

The high overdose rates and the low utilisation rates might suggest that clients are not using the injecting room for day-to-day safety, as per the injecting room's originating rationale. Rather, clients may be infrequently using the safety of the room for a different purpose - experimention with high doses of heroin.

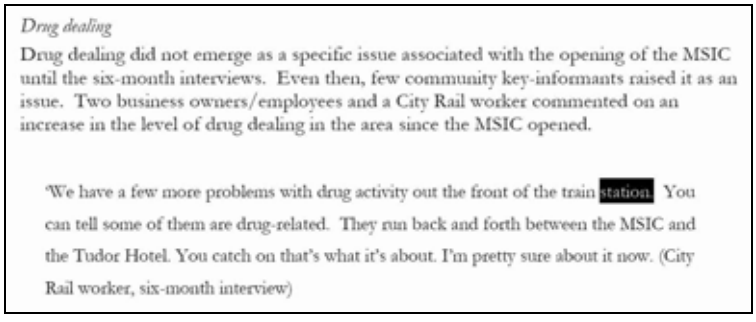
5.3 An Evident Honey-Pot Effect?

The injecting room is 25 metres opposite the entrance to the Kings Cross train station on Darlinghurst Road.

The following was stated in the injecting room's own government-funded evaluation of 2003.

Below are copies directly from the injecting room's own evaluation report which show the train station, which had not previously been a location for drug-dealing, had become a major site of dealing.

Drug dealing, 6 months after the opening of the MSIC, was already identified as an issue on p144 par 4.



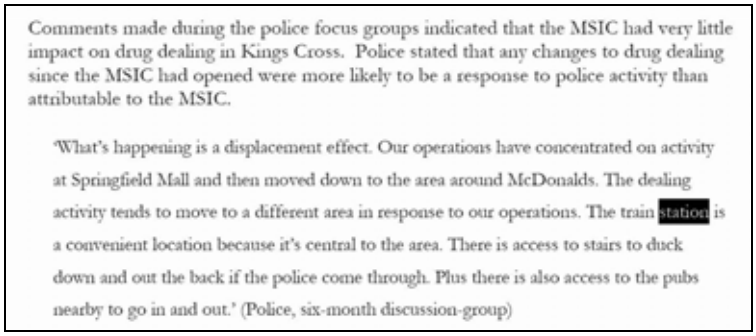
Drug dealing

Drug dealing did not emerge as a specific issue associated with the opening of the MSIC until the six-month interviews. Even then, few community key-informants raised it as an issue. Two business owners/employees and a City Rail worker commented on an increase in the level of drug dealing in the area since the MSIC opened.

'We have a few more problems with drug activity out the front of the train station. You can tell some of them are drug-related. They run back and forth between the MSIC and the Tudor Hotel. You catch on that's what it's about. I'm pretty sure about it now. (City Rail worker, six-month interview)

Police comments six months after the MSIC opened indicated they did not believe the MSIC was the cause of drug-dealing newly observed at the train station p 144 par 8. BUT AT THE 12 MONTH MARK THEY HAD

CHANGED THEIR VIEW (see the Evaluation report's p 146 on next page)



Comments made during the police focus groups indicated that the MSIC had very little impact on drug dealing in Kings Cross. Police stated that any changes to drug dealing since the MSIC had opened were more likely to be a response to police activity than attributable to the MSIC.

'What's happening is a displacement effect. Our operations have concentrated on activity at Springfield Mall and then moved down to the area around McDonalds. The dealing activity tends to move to a different area in response to our operations. The train station is a convenient location because it's central to the area. There is access to stairs to duck down and out the back if the police come through. Plus there is also access to the pubs nearby to go in and out.' (Police, six-month discussion-group)

If the police did not at first blame the MSIC for drug-dealing at the train station directly opposite its front door, they certainly were admitting it was the MSIC 6 months later, with a rise in loiterers during the times the MSIC was open (p 146 par 7).

This report acknowledges that there is no evidence that new drug dealers were attracted to Kings Cross by the injecting room, in that the average of 106 injections in the room out of 6,000 on the streets should not reasonably have attracted more dealers.

Loitering

Interviews conducted three months after the opening of the MSIC elicited very few mentions of loitering. Subsequent interviews at six and twelve months revealed a concern among community key-informants of an increase in loitering outside the front and back of the MSIC and the Darlinghurst Road entrance to Kings Cross train station (opposite the MSIC). Persons making these observations included all four business owners, both business patrons, both street cleaners, both City Rail workers, two local residents and a health worker. At least some of this loitering was considered by key-informants to be related to IDU and the MSIC.

> 'Seems to be a lot more drunks and dodgy types at the train station. I've seen a few people out the back [of the MSIC] near the Icebox. I'm not positive, but I think it could be [due to] the MSIC.' (Resident, six-month interview)

> 'People are hanging around the front and back [of the MSIC]. Some are homeless or sex workers but it's putting business people off.' (Street cleaner, twelve-month interview)

> 'We've got problems at the entrance [of the train station] with people just hanging around. We've got members of the public complaining about drug users, homeless and drunks hanging around the entrance on Darlinghurst Road.' (City Rail worker, twelve-month interview)

At the six-month focus group, police expressed scepticism about the possibility that loitering in the vicinity of the MSIC and at the entrance to the train station was associated with the MSIC. Other factors, such as budget accommodation, were thought to contribute to the presence of IDU in the area.

> 'The community doesn't always realise that many of the IDU that are hanging around the streets are there because they live in the cheap hotels nearby. That's why you see them in those areas.' (Police, six-month discussion-group)

By the twelve-month discussion-group the response of the police toward the increase in loiterers at the train station had changed somewhat. The police who participated in the twelve-month discussion-group commented that they had received complaints from the public and the City Rail staff about the increase in the number of people loitering at the train station. They noted that, while other factors, such as police operations, would have contributed to the increase in loitering outside the train station, there was a notable correlation between the loitering and the MSIC opening times. The increase in loitering at the train station was considered to be a displacement of existing users and dealers from other locations in the area rather than due to new groups of users coming into the area.

Interestingly, p 147 pars 1,2 tell us that there had not been any issue of drug-dealing at the train station before the MSIC opened its doors. Thus the evaluation report has demonstrated that the MSIC had indeed attracted drug-dealers to within 50 metres of its front doors.

'Their numbers are going up there at the train station. They see it as a social thing while waiting to get in [the MSIC]. It's a natural progression from them getting into the routine of the MSIC's operation like what occurs when a methadone unit opens. The train station never featured as a meeting place before. It used to be Springfield Mall and Roslyn Street.' (Police twelve-month interview)

'We're tasking now to the lead up of the opening hours [of the MSIC]. It's a morning tasking due to more congregating near the train station. We have to move them along. Hours of closing we don't really need to task because they don't hang around.' (Police twelve-month interview)

On p 149 par 2, the evaluators believe "it is difficult to determine the degree to which the increase in . . . drug related activities outside the train station was associated with the MSIC." BUT THE EVIDENCE FROM PAGES 146 AND 147 OF THE EVALUATION (ABOVE) SHOWS AN UNDENIABLE ASSOCIATION.

Focus groups with local police confirm the findings of the quantitative analysis of crime data, that there has not been any increase in acquisitive crime associated with the MSIC. While an increase in drug transactions immediately outside the front or rear of the MSIC did not emerge as an issue in the key-informant interviews, there was concern regarding drug-related behaviour and loitering at the entrance to the train station located directly across the road from the MSIC. A range of key-informants observed an increase in the number of people congregating outside the train station. While not all the loiterers appeared to be IDU, drug-related activities by some of the loiterers were observed. It is difficult to determine the degree to which the increase in IDU and drug-related activities outside the train station was associated with the MSIC. The police discussion group members cautioned that a combination of factors is likely to have contributed to the increase in drug-related activity and loitering in this location. These factors include the design of the train station with two entrances/exits that facilitated evasion from police, a displacement effect from police operations that targeted sites further up Darlinghurst Road that had previously been used for drug-related activities, and the presence of telephones and street seating facilitating drug transactions and socialising. Nevertheless, it is impossible to dismiss the suggestion that the loitering at the train station is a least partially related to the MSIC, given the comments by police at the final focus group, that IDU congregate outside the train station while waiting for the MSIC to open.

Again, the evaluators appear to try to find every reason to deny a honey-pot effect for the MSIC, against the evidence (p 150 par 1).

an area bounded by two businesses on either side, at the front and at the back, of the MSIC. The possibility exists that there was an increase in drug-related activity in Kings Cross that was not picked up by the data presented here. This problem was highlighted to some degree by comments made by police about an increase in loitering outside the Kings Cross train station, an area not covered by the loitering counts. While the key-informant data provide a valuable supplement to the quantitative data, it must be understood that the responses provided by the key-informants cannot be considered to be representative of all local persons or free from personal biases. Key-informants had a wide range of views towards the MSIC, and these views are likely to have affected the key-informants' sensitivity to, and the salience of, various behaviours and events. The mere fact that key-informants were participating in the study is also likely to have affected their degree of scrutiny of the local area.

Again, on p 193 pars 6,7 the evaluators are denying the inevitable.

- **Loitering.** Quantitative evidence suggests that the number of loiterers in the vicinity of the MSIC was very low and there was no indication of an increase in drug-related loitering (See Chapter 7). There may even have been a decrease in such loitering, possibly as a result of the security guard posted outside the MSIC. Some evidence, on the other hand, suggested that there may have been an increase in drug-related loitering outside the front and back of the MSIC and at the Kings Cross railway station. In all, the evidence indicating either an increase or a decrease in loitering is not compelling.
- **Drug dealing.** Police evidence indicated that the MSIC had very little impact on drug dealing in Kings Cross. On the other hand, there appears to have been increased drug dealing activity at Kings Cross station, although it is difficult to determine whether this increase was causally linked to the operations of the MSIC (See Chapter 7).

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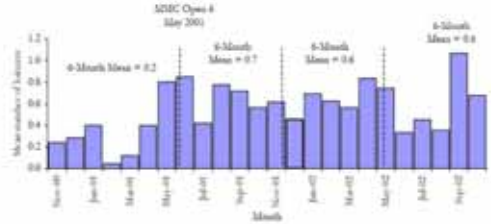
More dealing at its rear door on Kellet Street (see p 141 of MSIC Evaluation below). Local businesses describe a continual presence by drug dealers on Bayswater Road

Figure 7.4: Mean number of 'drug related' loiterers per count at back of MSIC, by month, November 2000 to October 2002

The mean number of total loiterers per count at the back of the MSIC, is presented by month in Figure 7.3, along with the mean number of total loiterers per count in each six-month period of the study. As with 'drug-related' loiterers, there appears to have been an increase in total loitering after the MSIC opened, which was sustained throughout the study period. Analysis of the mean number of loiterers per count, by week, using a Mann-Whitney test, indicates that there was a significant increase in loitering at the back of the MSIC following the opening of the MSIC ($Z = -4.6$, $p < 0.01$), from 0.27 to 0.64 persons per occasion of observation. Again, however, it is important to keep in mind that no loiterers were observed at the back of the MSIC on the majority of count episodes. One or more loiterers were observed at the rear of the MSIC on 27 per cent of the post-intervention counting episodes, an increase from 12 per cent prior to the MSIC commencing operation.



VI. DROUGHT REDUCED NEEDLES, NOT THE INJECTING ROOM

In the 'Interim Evaluation Report No. 2' for the Sydney Medically Supervised Injecting Centre, released in 2006, the conclusion of the report stated:

"Residents and business operators in the Kings Cross area perceived a decrease in the level of public drug use and publicly disposed syringes seen in the last month."

The conclusion was based on the finding that:

"58% of residents and 60% of business operators reported that they had ever seen public injecting in 2005. In both groups, the overall proportions were similar to 2000 but there were significant decreases in the proportions of residents who had seen public injecting or a discarded syringe in the past month."

However, data reproduced in the adjacent column from pages 116-122 of the injecting room's own government-funded evaluation of 2003 clearly shows a direct correlation between the decreases in needle distributions from needle exchanges and pharmacies in Kings Cross and decreases in sightings of public injection and discarded needle/syringe counts.

Surveys by the injecting room's evaluators were in July 2000 and July 2002, and the graph below shows a decrease from roughly 108,000 needles in the year 2000 to roughly 88,000 needles distributed in 2002, a decrease in distribution of 19%.

Surveys and syringe counts recorded in the injecting room's evaluation appear in the left hand table below. Surveyed reductions in discarded needles and sightings of public injecting before and after the injecting room opened are in line with the 19% reduction in distributions. Clearly the heroin drought is responsible for these reductions, not the injecting room as its staff have so often inferred.
In 2005, discarded syringes still rated as one of the top three annoyances for residents and businesses surveyed in the Kings Cross area.
See pages 31-34 of this document for full detail

VII. INJECTING ROOM SCORECARD

The injecting room's 2003 evaluation demonstrated a litany of failure. Various justifications for the introduction of an injecting room in Sydney were proposed which are assessed in the scorecard below.

(The scorecard below is more fully detailed than the FDA Injecting Room booklet scorecard on page 7).

a)	Number of overdose deaths in the area – no evidence of any impact	"A daily MSIC capacity to manage 200-300 injections is not likely to make impact on opioid overdose deaths in a location which has an average of many thousands of heroin injections per day, ..." p 62
b)	Ambulance overdose attendances in the area – no evidence of any impact	"Initial analyses of ambulance attendances at opioid overdoses across the years 1995-2002 provided no evidence that MSIC had decreased opioid overdose events occurring in the community." p 61
c)	Ambulance overdose attendance during hours the injecting room was open - no evidence of any impact	" . . . there was no alteration in the pattern of ambulance attendances when the MSIC was open each day compared to when it was closed each day. Thus there is no reason to believe that the MSIC caused a reduction in ambulance attendances to opioid overdoses in the Kings Cross area." p 60
d)	Overdose presentations at hospital emergency wards - no evidence of any impact	" . . . presentations at St Vincent's and Sydney Hospitals showed a further reduction in the level of presentations after the commencement of the MSIC . . . . It is likely, however, that this reduction also actually reflects the prolonged impact of the heroin shortage throughout 2001 and 2002 rather than reflecting an impact of the MSIC itself." p 60
e)	HIV infections amongst injecting drug users - worsened	"Very few HIV notifications among males were attributed to injecting drug use in 2001/2; zero in Kings Cross, 10 in Darlinghurst/Surry Hills . . . ." p 71
f)	Hep B infections - no improvement but did perform better than the rest of Sydney which worsened	"The number of notified cases of newly diagnosed HBV infection remained stable from 1998 to 2002 in the Kings Cross and Darlinghurst/Surry Hills postcode areas." p 71

g)	Notifications of newly-diagnosed Hep C: continued to worsen in Darlinghurst/Surry Hills and remained stable in King Cross despite the presence of the injecting room and other needle exchanges	"On average, notifications increased by 11% per year in Darlinghurst/Surry Hills . . . . In the Kings Cross postcode area the number of HCV notifications and the annual population rate remained stable throughout the period." p 71
h)	Frequency of public injection – moderate decreases or no improvement	"Among MSIC users, reporting of injection on the street (57% vs 46%, p=0.04) or public toilet (40% to 33%, p=0.06) decreased from 2001 to 2002 and reporting of injection in a squat remained stable (13% in both years). Daily or almost daily use of commercial shooting galleries was reported by 16% and 14% of MSIC users in 2001 and 2002." p 94
i)	New needle and syringe use - no advantage displayed by injecting room over the nearby needle-exchange	"Both MSIC and non-MSIC users reported similar rates of new needle/syringe use in the month before survey (79% and 74%, p=0.2). Reporting of use of new needles/syringes increased slightly among MSIC users from 2001 to 2002 although the difference was not statistically significant (75% to 82%, p=0.1)." p 92
j)	Re-use of someone else's syringe - no improvement	"Rates of reuse of someone else's syringe in the previous month were the same for both MSIC and non-MSIC users (17%)." p 93
k)	Re-use of injecting equipment other than syringes – worsened slightly or no improvement	"Among MSIC users, reported sharing of spoons (29% and 32%), filters (11% and 11%), the drug mix solution (10% and 13%) or tourniquets (14% and 16%) were similar in 2001 and 2002." p 93
l)	Tests taken for HIV and Hep C - worsened	"Around three-quarters of MSIC and non-MSIC users also reported HIV and HCV testing in the previous twelve months in both years (80% vs 72%, p=0.2; 80% vs 77%, p=0.6)." p 96
m)	Tests taken for Hep B – no sustained improvement or worsened	"Higher rates of HBV vaccination were reported from MSIC than non-MSIC users in 2001 (61% vs 48%, p=0.04) but not in 2002 (53% vs 59%, p=0.04)." p 98
n)	Referrals – extremely poor	Only 8% of clients referred to methadone and buprenorphine maintenance combined and only another 4.7% referred to abstinence-based detox or residential rehab. pp 98,99
o)	Publicly discarded syringes – levels of those found by various teams decreased only in accordance with the number of syringes being distributed by needle exchanges and	Figure 6.6 on page 122 shows needles distributed from needle exchanges and pharmacies decreasing from an average 100,000 – 105,000 per month before the heroin drought, to 80,000 per month after

	pharmacies – no improvement (see pages 31 - 34 of this report for explication)	the heroin drought. pp. 117-123 See closer analysis at end of this section
p)	Perception of public nuisance caused by drug use – decreased in line with heroin drought impact (see pages 31 – 34 of this report)	
q)	Public injections sighted – no improvement (see pages 31 - 34 of this report for explication)	Residents reported less, but only in proportion to the decrease in needles distributed by needle exchanges and pharmacies, businesses reported no improvement despite the heroin drought p. 116
r)	Acquisitive crime – no improvement	"However, the initial increases in acquisitive crime at the onset of the heroin shortage were soon followed by downward trends in acquisitive crimes. This pattern was found in both Kings Cross LAC and the rest of Sydney." ". . . acquisitive crime trends . . . were not related to the MSIC, . . ." p 147
s)	Drug dealing at rear door of MSIC - continual	"However, a visual inspection of data, coupled with the fact that there were one or more loiterers at the back of the MSIC more frequently after the centre opened, does suggest that there may have been a small increase in loitering at the back of the MSIC after it commenced operation." p 148
t)	Drug dealing at Kings Cross station - worsened	"A range of key-informants observed an increase in the number of people congregating outside the train station. While not all loiterers appeared to be IDU, drug-related activities by some loiterers were observed." p 149

VIII. MASSIVE RATES OF OVERDOSE – WHY?

See pages 14 - 22 of this document for full detail

IX. EXPOSING THE MYTHS ABOUT OVERDOSE & INJECTING ROOM

9.1 Myth 1 – All heroin overdoses are fatal

(used by the injecting room to get public support for its introduction)

"Darke et al. (1996) showed that an ambulance attends in 51% of non-fatal overdose events and Darke et al. (in press) reported an estimate of 4.1 fatal overdoses for every 100 non-fatal overdoses in the community, . . ."
Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 59

9.2 Myth 2 – Most heroin overdoses are in public places

(used by the drug legalisation lobby to justify the existence of injecting rooms)

"The majority of deaths occur in a private home. Studies typically report that approximately half of all overdose fatalities occur in the victim's own home, while one-quarter occur in the home of a friend or relative. This pattern also holds true for non-fatal overdose, with only 10 per cent of users reporting that their last overdose occurred on the street."
ANCD Research Paper No 1 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions' p xi

"However, some distinct regional differences have been noted in relation to location of death. 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 percent in public places."
ANCD Research Paper No 1 'Heroin Overdose' p 19

Myth 3 - Heroin overdoses are caused by street heroin cut with toxic contaminants

(used by drug legalisation lobby to justify a heroin prescription trial)

"Two popular misconceptions, among both heroin users and the wider community, are that the major causes of opioid overdose are either unexpectedly high potency of heroin or the presence of toxic contaminants in heroin. The evidence supporting these notions is, at best, sparse.

"If overdose were a simple function of purity, one would expect the blood morphine concentrations of fatal overdose victims to be significantly higher than living intoxicated heroin users. As described above, it has been found that many individuals who die of an opioid overdose have blood morphine concentrations at autopsy that are below the commonly accepted toxic dose." ANCD Research Paper No 1 'Heroin Overdose' p xiii

9.4 Myth 4 - The MSIC ensures no first time users or pregnant women use the facility

The injecting room uses a 20 minute interview at registration that relies on the self-reported disclosure of age, pregnancy or user status. If you are a good liar you could probably get in.

Myth 5 - The only way high-risk drug users can be reached by health professionals is via the injecting room

Extensive needle exchange services have operated for years in Kings Cross to provide non-judgmental access to needles and syringes and a chance for health workers to build relationships which will encourage users towards treatment.

Major Causes of Heroin Overdose

"The evidence of polydrug use in fatal overdose is consistent with the experience of non-fatal overdose victims, particularly in terms of alcohol and benzodiazepine use. Overall, overdoses involving heroin use alone are in the minority. ALCOHOL APPEARS TO BE ESPECIALLY IMPLICATED, WITH THE FREQUENCY OF ALCOHOL CONSUMPTION BEING A SIGNIFICANT PREDICTOR OF OVERDOSE." .

ANCD Research Paper No 1 'Heroin Overdose' p xi

A recent decrease in tolerance to opioids has been proposed as a possible explanation for
the low blood morphine levels typically seen in overdose victims.

ANCD Research Paper No 1 'Heroin Overdose' pxii

X. FREQUENTLY ASKED QUESTIONS

10.1 Doesn't the injecting room have high overdoses because it helps a high-risk sub-group?

This claim does not stand up to scrutiny as can be seen from other previous surveys of heroin user groups.1 The fact is that injecting room clients had 34 in every 35 of their injections outside the injecting room, where their high overdose rates should reasonably have been expected to be replicated. They weren't.

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%

Compare data from the injecting room evaluation report . . .

Previous non-fatal heroin-related overdose was reported by 44 % of clients; with a median number of three episodes reported. At least one heroin-related overdose in the 12-months before registration was reported by 12% of clients with a median of one episode (range 1-31 episodes). The mean age of first overdose was 23 years (SD=7). On average female clients were 1.8 years younger than males at the time of their first overdose (22 vs 23 years, 95% CI 1.5-3.2, p<. 01). At the time of their last overdose, 74% of clients reported being attended by ambulance and 68% reported being administered naloxone (Table 2.4).

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 16

. . . with data from the Australian National Council on Drugs, Research Paper no 1:

3.3 Non-fatal opioid overdose in Australia
http://www.ancd.org.au/publications/index.htm

"Non-fatal opiate overdoses are common among heroin users (Darke, Ross et al. 1996a). Non-fatal overdoses may be defined as instances where loss of consciousness and depression of respiration occur but are not fatal. While trends in fatal overdose have been well documented, data on non-fatal overdose are sparse. Studies that have investigated non-fatal overdose report that a large proportion of regular heroin users has experienced non-fatal overdose.

"The Illicit Drug Reporting System (IDRS) found that in 1999 51 per cent of a sample of 396 injecting drug users (IDUs) reported having experienced a non-fatal overdose at some time in their lives. Of this sample 29 per cent reported overdosing in the previous 12 months. Regional differences were noted in the proportion of users who reported experiencing an overdose in the previous 12 months. In Adelaide 20 per cent of users reported overdosing in the previous year, compared to 28 per cent of Sydney users and 36 per cent of Melbourne users (McKetin, Darke et al. 2000). The geographic variation in non-fatal overdose rates reported by the IDRS is also evident from other studies (Darke, Ross et al. 1996a; McGregor, Darke et al. 1998). The proportion of Sydney users in this study who reported having experienced non-fatal overdose in the preceding year is supported by a previous study of non-fatal overdose among Sydney heroin users (Darke, Ross et al. 1996a).

"Darke, Ross et al. (1996a) found that 68 per cent of a sample of 329 Sydney users reported having experienced an overdose at least once, with 20 per cent of the sample overdosing in the last year. In a similar study McGregor, Darke et al. (1998) found that 11 per cent of a sample of 218 Adelaide heroin users reported experiencing an overdose in the previous six months. The limited data on Australian non-fatal overdose concur broadly with overseas experience.

"A recent British study, for example, found that 58 per cent of 212 heroin users reported having ever overdosed, while 30 per cent had overdosed in the preceding 12 months (Bennett and Higgins 1999). These findings were higher than those of an earlier British study, which found that 22 per cent of 432 users reported having ever overdosed, 9 per cent in the preceding 12 months (Gossop, Griffiths et al. 1996). While it is possible that this difference reflects a true increase in nonfatal overdose rates in Britain, it is more likely to be attributable to differences between the two studies. Of particular note is the fact that a substantially greater proportion of subjects in the second study nominated smoking as their preferred route of administration, as opposed to injecting."

ANCD Research Paper No 1 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions' p 10

10.2 Is it true the injecting room had higher overdose numbers than the above-mentioned surveys because heroin users don't remember the majority of their previous overdoses?

This explanation for the high number of overdoses was first offered by the Medical Director for the injecting room, Dr Ingrid van Beek.

> 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 be 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.
>
> Letter to Gary Christian of ADRA Australia by Dr Ingrid Van Beek, 13 October 2003 – subsequently posted on Update Listserver 14/10/2003 04:20 PM
> (The Update listserver is the bulletin board for all Drug and Alcohol professionals and workers nationally)

This line of argument posits that heroin users are actually having far more overdoses than they report and that most of their overdoses are unrecognised or forgotten. But a 1996 review by Shane Darke of studies on the circumstances of fatal heroin overdoses found that between 58% and 79% of fatal overdoses are in the company of other people.

> "There is evidence that the majority of deaths attributed to overdose occur in the company of others (Drew, 1982; Manning et al., 1983; Walsh, 1991; Zador et al, 1996). Others were present at the time of death in 58% of cases reported by Zador et al., (1996). Similar studies have reported the presence of others in 61% (Walsh, 1991), 79% (Drew, 1982) and "more than half" (Manning et al, 1983)."
>
> Fatal Heroin 'Overdose': A Review, Darke, Shane and Zador, Deborah, "Fatal Heroin 'Overdose': A Review." Addiction. 1996; 91(12): pp. 1765-1772.

Another study by Shane Darke estimated that 49% of overdoses in the community are not attended by paramedics. Drug Free Australia has already calculated this percentage into its comparisons of injecting room overdoses with those in the community.

> Combining these two figures, the relative rate of death per ambulance attendance is 0.0812 or 8.12% of total NSW ambulance attendances. If we assume that all of the 329 cases of heroin overdose which occurred at MSIC had occurred in the community and had an ambulance called, approximately 27 deaths (329 X 0.0812 = 26.71) may have been averted. This is likely to be an overestimate as many overdoses are known to occur in the community but do not have an ambulance attend. Darke et al. (1996) showed that an ambulance attends in 51% of non-fatal overdose events and Darke et al. (in press) reported an estimate of 4.1 fatal overdoses for every 100 non-fatal overdoses in the community, overall (i.e., 0.041 or 4.1%). Therefore, using this figure of 4.1%, approximately 13 deaths (329 X 0.041 = 13.49) may have been averted in the 18-month trial period.

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 59

10.3 Why do I read that there is high public acceptance of the injecting room?

Nationally, acceptance of the injecting room is not that high. However it may be that those in favour have believed it is

saving hundreds of lives, as promoted, when this is clearly not the case. See pages 5 – 8 of this document.

10.4 I have heard that 12% of clients were referred to treatment or rehab. Is that a good or bad referral rate?

Drug Free Australia Fellow, Dr Stuart Reece, a doctor working in addiction medicine in Brisbane reports that he refers 91% of his drug-dependent patients to treatment or rehab. Referral can of course be accomplished by any health worker service, even a soup kitchen.

10.5 Weren't all 1,385 injecting room referrals to assistance that would help them stop using drugs?

Only 134 referrals were to detox and another 56 to rehab. Much higher was the number of referrals (227) for social welfare assistance, which might well be assumed to be predominantly Centrelink benefits. Other referrals were for legal matters (51), counselling for issues other than drugs (63), legal and advocacy issues (51), medical/dental (313), health education (86) and testing for blood-borne viruses and sexually transmitted diseases (40). There were 304 referrals to drug maintenance, and another 107 to drug and alcohol counseling. There is no record of follow-up of any referral.

Table 2.13: Number and type of referrals

Referral type	Number	%
Drug treatment		
Buprenorphine treatment	179	13 %
Detoxification program	134	10 %
Methadone maintenance	125	9 %
Drug and alcohol counselling	107	8 %
Residential rehabilitation	43	3 %
Narcotics Anonymous/Self-help	10	1 %
Naltrexone maintenance	3	<1 %
Sub-total for drug treatment	*601*	*43 %*
Health care		
Medical/dental consultation[1]	313	23 %
Health education	86	6 %
BBV/STD testing	40	3 %
Sub-total for health care	*439*	*32 %*
Social welfare		
Social welfare assistance	227	16 %
Other counselling	63	5 %
Legal/advocacy	51	4 %
Other	4	<1 %
Subtotal for social welfare	*345*	*25 %*
Total	**1,385**	**100 %**

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Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 23

XI. PREVENTION OR HARM MINIMISATION?

The $2.5 million per year currently being spent on the injecting room would fund 109 drug rehabilitation beds or supply more than 700 dependent heroin users with life-saving Naltrexone implants. This would represent many lives saved from heroin and heroin overdose. If Australia has successfully reduced its tobacco addiction problem via anti-smoking campaigns, it can also reduce its drug addiction problem via clear anti-drug messages on TV, radio and through Public Health.

11.1 The United Nations View

In the 2004 Report of the United Nations Office of Drug Control & Crime Prevention (ODCCP), Australia's statistics indicated the highest levels of illicit drug abuse amongst OECD countries, which may well be due to its long history of allowing harm minimisation policies to predominate over prevention policies. It had the highest levels of cannabis and amphetamine use, with the fifth highest use of cocaine.

Australia's more recent prevention messages and excellent work by the Federal police have seen solid reductions in illicit drug use in Australia, despite harm minimization still predominating. It is certain that these decreases have not been produced by harm minimisation but by prevention strategies.

11.2 Australia from 1985 to Now

Australia is considered to be one of the world's most advanced harm-minimisation countries. Adopted in 1985, harm minimisation pragmatically accepts that people will use illicit drugs and seeks to minimise the harms of doing so.

Consequently, harm minimisation characteristically places little emphasis on the prevention of drug use.

11.3 Sweden from 1967 to Now

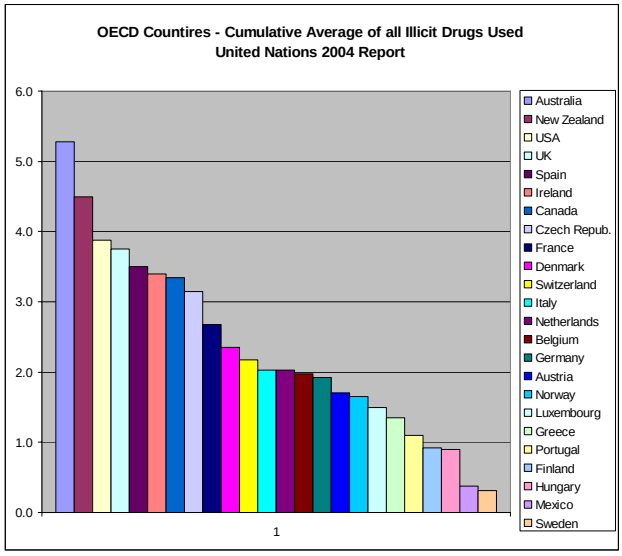
Sweden, a previously drug-liberal country with the highest European drug use levels, now has the lowest levels of drug use amongst OECD countries. Sweden's highly successful restrictive drug policy, unlike a zero tolerance approach which just pushes people into jails, puts a heavy emphasis on prevention of drug use with a minimal harm minimisation program. It has the support of 95% of its citizens.

11.4 Rehabilitation Successful

A key to the success of the Swedish model is mandatory drug rehabilitation for those found addicted to drugs. Swedish school education does not assume, as does Australian school education material produced by the Australian Drug Foundation, that illicit drug use is normal or should be socially accepted.

Prevention and early intervention programs send a clear message that the harms of illicit drug use are too great to be socially acceptable and that Australians adhere to the aim of a drug-free society.

Below is a chart of illicit drug use amongst OECD Countries showing Australia and Sweden at opposite ends of the drug-user spectrum.



11.5 Naltrexone Implants

So what about helping those stuck using heroin now? Studies show that up to 45% of methadone patients still use illegal heroin, and many stay on methadone for decades. Naltrexone, though, is a substance similar to Narcan in that it blocks the opioid receptors from responding to opiates.

Implants, which last up to 6 months each, feed Naltrexone into the blood, reducing cravings for opiates and preventing any chance of overdose. Trials with more than 2000 Naltrexone implants have thus far had excellent success.

XII. RECOMMENDATIONS

1. That the injecting room be closed and the funding redirected to establishment of more beds in rehabilitation centres which focus on ultimate abstinence from use of illicit drugs.

2. That the NSW Government follow the lead of the WA government and significantly fund naltrexone implants for those wishing to become abstinent (including drug-dependent prisoners).

3. That the NSW Government examine the Swedish model and its restrictive drug policies. This includes the adoption of strong policing of street selling and a replication of the Cabramatta model which resulted in a significantly lowered overdose rate (policing of supply and demand).

4. That the NSW Government examine abstinence-based rehabilitation programs which have shown considerable success, including Australian programs such as the Salvation Army and Drugbeat (South Australia), as well as international programs such as Hassela (Sweden), San Patrignano (Italy) and Daytop International or Phoenix House (United States).

PRIOR PRO DRUG LAW REFORM ASSESSMENTS PREDICTED IT WOULD HAVE NEGLIGIBLE IMPACT

In 2001, the ANCD published the most comprehensive study to date on heroin overdose in Australia. Notably, on page 47 it states:

"It is recognised that it is unlikely that this trial will have a significant impact on heroin overdose rates. There are a number of reasons for this. Firstly, the number of injecting events likely to occur in the facility, even while operating at full capacity, will represent only a small proportion of all injecting events in the State. Secondly, it is known that the majority of overdoses occur in a private home or hotel and there is no reason to believe that heroin users will choose to inject in an injecting centre rather than in their own home. Finally, the injecting centre will have limited hours of operation and therefore cannot influence overdoses that occur outside these hours. Of particular relevance is the fact that most overdoses occur between the hours of 6pm and midnight, outside of the proposed operating hours of the centre. These factors suggest that it is unlikely that the trial of a safe injecting centre will have a detectable effect on heroin overdoses." Warner-Smith M.; Lynskey M.; Darke S.; Hall, W. ANCD Research Paper 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions ANCD Canberra (2001) p 47

Note: Dr Wayne Hall has been at the Australian forefront of Australian calls for Drug Law Reform

APPENDIX

Darcy

Attached is our analysis of the injecting room evaluation report which is found at:

http://www.druginfo.nsw.gov.au/druginfo/reports/msic.pdf

The first 3 pages of our document (attached below) are what we would like verified, and the injecting room report's own calculations can be found on pages 58 and 59.

Regards

Gary Christian
CHIEF OPERATIONS OFFICER
ADRA Australia

Dear Gary

I have now examined the materials that you sent me about the injecting room report. My comments are as follows:

1. Your criticisms of the report are generally very well argued.

2. I think that it is unwise to make too much out of the higher overdose/injections ratio in the injecting room, due to likelihood of different bases for ascertainment of an 'overdose' in the injecting room scenario vs estimates in the general community (which are probably under-estimates). The hypothesis that injecting room users experiment with higher doses due to the immediacy of medical backup is an important concept and I wonder if you have any qualitative research information to support it. But as I say, I'd be very reluctant to put much faith in the data given the very different sources and methods of measuring 'overdose'.

Warm regards

D'Arcy

Professor C. D'Arcy J. Holman

Chair in Public Health and Head of School

School of Population Health, The University of Western Australia

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Phone 61-8-9380 1251 Fax 61-8-9380 1188 Secretary (Mrs Beth Bannerman) 61-8-9380 1318

Note:

The injecting room evaluation report provides good evidence, via the two NSW surveys which indicated 3.6% of respondents would use heroin if an injecting room was available, that the overdoses are most likely the result of experimentation with higher doses. It is also notable that experimentation with higher doses of heroin is the evaluation report's own explanation for the inordinately high number of overdoses.
Thus the report itself has demonstrably answered Dr Holman's questions.

DRUG LEGALISATION IN AUSTRALIA

On the 13th of May, 2001, the Daily Telegraph published Quantum research which asked the Australian public what they found to be most socially unacceptable. The results were:

- Child pornography 96%
- Use of hard drugs 92%
- Use of designer drugs 88%
- Racism 87%
- Public Drunkenness 80%
- Banks 63%

It is clear that the Australian public is neither enamoured with illicit drugs nor public intoxication. Australians do not want more drugs. And yet the drug legalisation lobby specialises in offering the public false choices – either legalise/decriminalise various types of drug use or live with escalating numbers of criminals and drug-related crime.

History

The current drug legalisation movement has its roots in the early 60's when counter-culture icons Ginsberg, Leary, Kesey and Haight-Ashbury took hold of popular consciousness in Western society, and the message that mind-altering drugs were both a God-given right and a spiritual imperative was accepted by the growing counter-culture movement.

Drug legalisation went political with the advent of NORML, an organisation which sought to legalise cannabis use. Today the drug legalisation movement is internationally funded by some of the world's wealthier men, such as Virgin's Sir Richard Branson and multi-billionaire George Soros, the

New York financier who has openly declared in his autobiography of 1995, "If it were up to me, I would establish a strictly controlled distributor network through which I would make most drugs, excluding the most dangerous ones like crack, legally available."

Drug Legalisation in Australia

The drug legalisation movement in Australia has a number of key platforms:

1. heroin legally available on prescription
2. legal heroin injecting rooms
3. marijuana decriminalisation
4. use of marijuana legalised for medical purposes
5. on-site RAVE-party testing for impurities in illegal party drugs

Australia's legalisation lobby has two camps. There are those that believe that most or all illicit drugs should be commercially available in the same way as alcohol or tobacco. Others believe that the above five agendas should only ever be implemented for the minimisation of harms to users.

What unites the two camps is the assertion that drug Prohibition creates such high prices for illicit drug that it makes profiteering for criminals too alluring. This argument is of course easily proven wrong. It is quite evident that Australia's drug problems stem from the pro-drug lobby which soothingly downplays the harms of the illicit drugs as acceptable harms if only used properly.

Demand for drugs, and the criminal supply to meet that demand is not caused by prohibition, which worked demonstrably well from 1912 to the mid-60's, but rather from those who vigorously promote drug use as exciting, enlightening or rebellious.

The growing volume of scientific evidence showing the enormous harms of illicit drugs has shown that prohibition was the best way to save lives and suppress criminal supply – afterall where there is no demand for drugs there is no room for criminal suppliers.

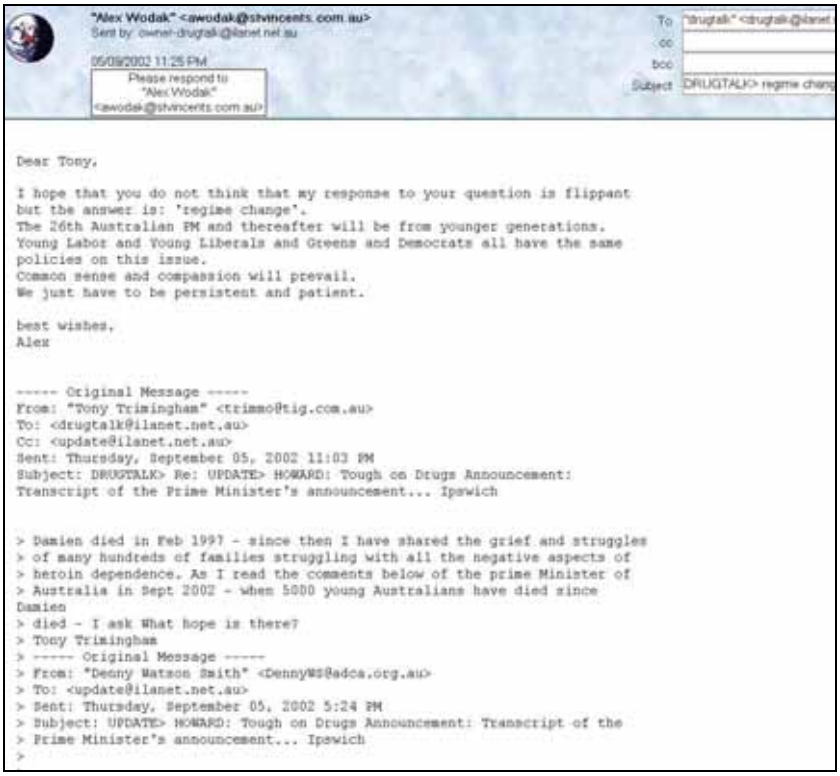
Australians are now at a crisis point. They must decide whether they want MORE drugs or LESS drugs. If it is less drugs, they will have to find the societal will to silence the pro-drugs lobby, something they have previously tolerated with catastrophic effect.

"Damien died in Feb 1997 - since then I have shared the grief and struggles of many hundreds of families struggling with all the negative aspects of heroin dependence. As I read the comments below of the prime Minister of Australia in Sept 2002 - when 5000 young Australians have died since Damien died - I ask What hope is there?"

Posting sent to Drugtalk national Drug & Alcohol listserver: September 05, 2002 11:03 PM by Tony Trimmingham – prominent drug legalisation proponent

"I hope that you do not think that my response to your question is flippant but the answer is: 'regime change'. The 26th Australian PM and thereafter will be from younger generations. Young Labor and Young Liberals and Greens and Democrats all have the same policies on this issue. Common sense and compassion will prevail. We just have to be persistent and patient."

Reply sent to Drugtalk national Drug & Alcohol listserver: 05/09/2002 11:25 PM by Dr Alex Wodak, President of Australia's most prominent drug legalisation Foundation



"Alex Wodak" <awodak@stvincents.com.au>
Sent by: owner-drugtalk@ilanet.net.au

05/09/2002 11:26 PM

Please respond to
"Alex Wodak"
<awodak@stvincents.com.au>

To: "drugtalk" <drugtalk@ilanet
cc:
bcc:
Subject: DRUGTALK> regime chang

Dear Tony,

I hope that you do not think that my response to your question is flippant
but the answer is: 'regime change'.
The 26th Australian PM and thereafter will be from younger generations.
Young Labor and Young Liberals and Greens and Democrats all have the same
policies on this issue.
Common sense and compassion will prevail.
We just have to be persistent and patient.

best wishes,
Alex

----- Original Message -----
From: "Tony Trimingham" <trimmo@tig.com.au>
To: <drugtalk@ilanet.net.au>
Cc: <update@ilanet.net.au>
Sent: Thursday, September 05, 2002 11:03 PM
Subject: DRUGTALK> Re: UPDATE> HOWARD: Tough on Drugs Announcement:
Transcript of the Prime Minister's announcement... Ipswich

> Damien died in Feb 1997 - since then I have shared the grief and struggles
> of many hundreds of families struggling with all the negative aspects of
> heroin dependence. As I read the comments below of the prime Minister of
> Australia in Sept 2002 - when 5000 young Australians have died since
Damien
> died - I ask What hope is there?
> Tony Trimingham
> ----- Original Message -----
> From: "Denny Watson Smith" <DennyWS@adca.org.au>
> To: <update@ilanet.net.au>
> Sent: Thursday, September 05, 2002 5:24 PM
> Subject: UPDATE> HOWARD: Tough on Drugs Announcement: Transcript of the
> Prime Minister's announcement... Ipswich
>

The message going to our young

The Soros-funded Australian Drug Foundation (ADF) has been responsible for much of the educational material being fed to our schools. They support drug legalisation in Australia. Bill Stronach, Executive Director of the ADF, boasted to a Washington drug legalisation conference in 1992, "we have focused, as an organisation, quite clearly strategically on the media. We have employed journalists not to churn out press releases but to get in there as subversives and work with their colleagues in the main stream press. So we have 24-hour availability to those journalists. . . . over the last eight months, over 50 per cent of the mainstream printed and radio and television reporting on alcohol and drug issues has been generated by the Foundation or filtered through it." "My own Foundation is currently working with the Victorian police force. We know that the police undertake 7,000 drug education sessions (in schools) a year. That's in a population of four and a bit million. So the Foundation and the police, over a fairly long period of time and difficult process, developed a training course to the extent now that Victorian police who go into schools, and this is built into the regulation, can only be those who have undergone the training course and are prepared to use the materials that are supplied to them."

It is notable that the injecting room evaluation team has given every appearance of advocacy for drug legalisation in the evaluation report. In a survey of Kings Cross residents and businesses, as well as a sample of NSW residents their agreement/disagreement with heroin on prescription and legalised heroin (see pages 174-6) was asked. Such drug normalisation survey questions are totally irrelevant to bodies wishing to support the international Conventions against illicit drug use.