DRUG FREE AUSTRALIA

NSW & VICTORIAN INJECTING ROOMS

...definitively enriching the drug trade, failure to meet objectives

Central Issues & Compiled Evidence

1. 99% of Australians do not approve heroin use, thereby indicating they would not approve any government interventions aiding and abetting increased opiate use
2. Staggering numbers of overdoses in Australia's injecting rooms are caused by users experimenting with drug cocktails or increased opiate doses. This inevitably entails purchasing more drugs which must inevitably enrich local drug dealers
3. Research data indicates injecting rooms do not improve local amenity
4. Research data indicates injecting rooms do not reduce blood-borne virus transmissions
5. Injecting rooms uniformly have very poor referral outcomes
6. Injecting rooms have demonstrated a clear honey-pot effect, attracting dealers to the streets outside the facility, prompting expensive preventative policing operations
7. Policing operations have been mostly responsible for reductions in ambulance callouts for overdose in local areas, not injecting rooms
8. For the cost of saving 1 life in an injecting room, many users can enter rehab, saving lives

The failure of NSW and Victorian injecting rooms

According to the last 2016 National Drug Strategy Household Survey of 25,000 Australians, **99% do not approve of regular heroin use.**[1]

While 55% of Australians surveyed support injecting rooms as an intervention[2] there has been a program of constant misinformation about injecting rooms by supporters fed to a gullible or complicit Australian media. If the same media reported the reality that injecting rooms are demonstrable accessories to the drug trade, condemnation would unquestionably be as high as the 99% disapproval rate of heroin use.

NORTH RICHMOND MSIR

Overdose rates

Overdose (OD) rate - **23.5 per 1,000 injections**[3]
Street OD rate - 0.2/1,000 injections (MSIC)[4]
MSIR OD rate – 102 times higher than normal street OD rates[5]

Testimony by ex-clients of the MSIC in rehab[6] is that the overdose rates are so extraordinarily high because clients **experiment with higher doses** of drugs in the facility[7]

Experimentation with higher doses inevitably means that **more drugs are purchased from local dealers** to service the inordinate overdose rates, lining drug dealers' pockets. This conclusion is inescapable and is damning for injecting rooms

This makes the MSIR **a government-funded accessory to the North Richmond drug trade**, where extra drugs purchased created OD rates 102 times higher than normal

KINGS CROSS MSIC

Overdose rates

Highest OD rate – 14.6/1,000 injections (2010)[8]
Pre-MSIC street rate – 0.2/1,000 injections[9]
MSIC OD rate – up to 63 times higher than clients' pre-MSIC rate of OD[10]

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NORTH RICHMOND MSIR

Public Amenity – MSIR Objectives (d) and (e)

The MSIR **failed** to improve public amenity with local residents reporting no reductions in discarded needles, and local businesses reporting increases[11]

Public injection was reported by less residents and businesses after the MSIR opened[12], but increases in discarded needles inevitably entails more public injections. Policing crackdowns, which appear to have moreso been during hours the MSIR was open, would likely have moved public injection to night-time when less people were around to see it

Reductions in Blood-Borne Virus Transmissions – MSIR Objective (f)

Failure to demonstrate that MSIR clients were less likely than other users to report using others' used injecting equipment[17]

Providing a gateway to drug treatment – MSIR Objective (b)

Failure to demonstrate any higher uptake of treatment services than other non-MSIR drug users

While 22%[19] of MSIR clients at intake expressed a desire for referral to treatment, only 8% were in fact referred[20]

Extensive policing to reduce honey-pot effect

Adding to the failure against objectives listed above, police complained of surging crime[24] around the MSIR, and residents of a honey-pot effect[25] where drug dealers were drawn to the streets directly outside the MSIR

The very high costs of the extensive policing added around these facilities around the time of their implementation **is a best-kept secret** concealed by injecting room evaluators/ reviewers from the media. Cost evaluations of injecting rooms worldwide never add these real and very high costs of policing to the costs of running these facilities

KINGS CROSS MSIC

Public Amenity – MSIC Objective 3

The heroin drought, which started 6 months before the MSIC opened[13], drastically reduced discarded needles across the entirety of Australia. The MSIC's 4th Evaluation[14] **failed** to demonstrate any reductions beyond those caused by the drought. The 2010 KPMG Evaluation[15] made no attempt to get relevant data and failed to mention changed policing[16] since 2001 which would undoubtedly affect needle counts

Reports by residents (1st Evaluation and KPMG Evaluation) of seeing less public injecting were unquestionably the result of the heroin drought and no account was taken by KPMG of changed policing since 2001

Reductions in Blood-Borne Virus Transmissions – MSIC Objective 4

Failure to demonstrate in any one of its many Evaluations any objective reductions in injectionrelated BBV transmissions[18]

Providing a gateway to drug treatment – MSIC Objective 2

Abnormally low levels of referral to treatment at only 11% of clients referred.[21] A Scottish study of methadone users found 57%[22] wanted to get clean, which would be similar to Australian heroin users. By comparison 22% of Victorian MSIR clients at intake expressed a desire for referral to treatment[23]

Extensive policing to reduce honey-pot effect

The 1st MSIC Evaluation had ample data demonstrating a visible honey-pot effect[26] where dealers were drawn to the doors of the MSIC. Not one of the many MSIC Evaluations even mentioned the ongoing implementation of sniffer dog policing one month after the MSIC opened which aimed to move drug dealers out of the Kings Cross postcode

The very high costs of the extensive policing added around these facilities around the time of their implementation **is a best-kept secret** concealed by injecting room evaluators/ reviewers. Cost evaluations of injecting rooms worldwide never include these real and very high costs of policing to the costs of running these facilities

NORTH RICHMOND MSIR

Policing operations reduced ambulance callouts – MSIR Objective (c)

Failed to reduce ambulance callouts. On any of the streets of Melbourne, the MSIR's 112,831[27] opiate injections in its first 18 months would have caused just 26 overdoses, (25 non-fatal and 1 fatal) according to the MSIC's 1st Evaluation.[28] 19, at most, would likely be attended by an ambulance[29]

Overdoses in the MSIR, which should have numbered no more than 26 anywhere else outside an injecting room, would reduce ambulance callouts in North Richmond by just 5%.[30] However the MSIR Review records the facility calling 30 ambulances to take their clients to hospital in 18 months[31], which means **it increased**, not decreased, **ambulance callouts**

The review egregiously claimed callout reductions of 36%,[32] which were clearly due to heightened police operations[33] around the MSIR

Save lives from fatal overdose – MSIR Objective (a)

On any of the streets of Australia, one heroin user will die for every 109,500 opiate injections.[41] The MSIR recorded around 75,000 opiate injections per year in its first 18 months of operation, **clearly not enough to save even one life in 18 months**[42]

For the $6 million[43] spent by the MSIR to save one single life, the Victorian government could provide 73 optimally-funded residential rehab beds for a full year.[44] **The same funding can save one life (which can nevertheless be lost tomorrow injecting elsewhere) or make many users drug-free**. The MSIR is multiplying policing expenditures with growing crime, while failing to stop overdoses by clients for the 58 in every of their 60 opiate injections they average OUTSIDE the MSIR.[45] Successfully rehabilitated users reduce the need for police expenditures and ambulance interventions as drug use is ceased altogether. Closure of the MSIR will immediately stop the mass experimentation with drugs currently happening, an experimentation which is likely to only promote more opiate-related deaths outside the facility.

KINGS CROSS MSIC

Policing operations reduced ambulance callouts

With less than 50,000 opiate injections per year[34] the MSIC would at best reduce overdoses in the Kings Cross community by 11 ambulance callouts per year[35]

The MSIC's 2007 4th Evaluation claimed 80% reductions in ambulance callouts in Kings Cross against reductions of 61% throughout NSW as caused by the national heroin drought.[36] This was a reduction 31% better than the rest of NSW during the hours the MSIC was open. During the hours it was closed there was a 69% better reduction in callouts,[37] demonstrating that the **sniffer dog policing** of Kings Cross, introduced within a month of the MSIC opening, [38] **was likely responsible**. NSW Parliament Hansard records that sniffer dog policing was active not only during the day, but highly active at night[39] into the hours shortly before dawn[40]

Save lives from fatal overdose – MSIC Objective 1

On any of the streets of Australia, one heroin user will die for every 109,500 opiate injections. The MSIC averaged around 51,000 opiate injections annually over its first 9 years of operation[46], **clearly not enough to save even one life in two years of operation**

For the $6 million spent by the MSIC to save one single life,[47] the NSW government could provide 73 optimally-funded residential rehab beds for a full year. **The same funding can save one life (which can nevertheless be lost tomorrow injecting elsewhere) or make many users drug-free**. The MSIC multiplies policing expenditures to stifle drug-related crime in Kings Cross, while failing to stop overdoses by clients for the 95% of injections they average OUTSIDE the MSIC. Successfully rehabilitated users reduce the need for police expenditures and ambulance interventions as drug use is ceased altogether. Closure of the MSIR will immediately stop the mass experimentation with drugs currently happening, an experimentation which is likely to only promote more opiate-related deaths outside the facility.

Endnotes

1. https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data

Table 9.7: Personal approval of the regular use by an adult of selected drugs, people aged 14 years or older, 2007 to 2016 (per cent)

	Persons			
Drug	2007	2010	2013	2016
Tobacco	14.4	15.3	14.7	15.7#
Alcohol	45.3	45.1	45.1	46.0
Cannabis	6.7	8.1	9.8	14.5#
Ecstasy	2.0	2.3	2.4	2.9#
Meth/amphetamine[(a)]	1.2	1.2	1.4	1.2
Cocaine/crack	1.4	1.7	1.6	1.7
Hallucinogens	1.7	2.4	3.1	3.7#
Inhalants	0.8	1.0	0.9	1.0
Heroin	1.0	1.2	1.2	1.1
Pharmaceuticals[(a)]	13.7	22.4	23.2	27.8#
Prescription pain-killers/analgesics[(a)]	n.a.	13.0	12.6	12.7
Over-the-counter pain-killers/analgesics[(a)]	n.a.	14.3	14.5	19.1#
Tranquilisers, sleeping pills[(a)]	4.1	6.4	8.2	9.3#
Steroids[(a)]	1.7	2.2	2.2	2.4
Methadone or buprenorphine[(a)]	1.0	1.2	1.3	1.3

Statistically significant change between 2013 and 2016.
(a) For non-medical purposes.
Note: The list of response options changed across survey waves. Comparisons should be interpreted with caution.
Source: NDSHS 2016

2. https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data

Table 9.22: Support[(a)] for measures relating to injecting drug use, people aged 14 or older, by sex, 2007 to 2016 (per cent)

	Males				Females				Persons			
Measure	2007	2010	2013	2016	2007	2010	2013	2016	2007	2010	2013	2016
Needle and syringe programs	63.8	65.2	64.6	64.8	70.2	71.8	69.6	68.9	67.0	68.5	67.1	66.9
Regulated injecting rooms	47.8	49.7	53.3	54.5	52.1	53.3	55.4	55.4	49.9	51.5	54.3	55.0
Methadone/Buprenorphine maintenance programs	65.0	66.2	63.6	65.1	70.5	72.3	70.5	70.6	67.7	69.3	67.0	67.9
Treatment with drugs other than methadone	66.2	67.5	63.7	65.4	70.9	71.3	68.4	68.7	68.5	69.4	66.0	67.0
Trial of prescribed heroin	32.2	34.6	35.2	36.5	33.6	35.0	32.9	33.6	32.9	34.8	34.1	35.1
Rapid detoxification therapy	76.7	75.9	67.2	67.5	80.9	80.0	71.7	71.3	78.8	77.9	69.4	69.4
Use of Naltrexone, a drug that blocks the effects of heroin and other opiates/opioids	73.5	75.1	66.4	65.8	76.0	75.8	69.5	66.7#	74.7	75.5	67.9	66.3#
The availability of take-home Naloxone, a drug that reverses the effects of a Heroin/Methadone/Morphine overdose	n.a.	n.a.	n.a.	56.1	n.a.	n.a.	n.a.	53.2	n.a.	n.a.	n.a.	54.7

Statistically significant change between 2013 and 2016.
(a) Support or strongly support (calculations based on those respondents who were informed enough to indicate their level of support).
Note: Question was modified in 2013. Measures taken to address problems associated with heroin use, was removed and measures taken to address problems associated with injecting drug use was reworded and new responses were added. Therefore comparisons to previous waves should not be made.
Source: NDSHS 2016

3. The MSIR review records that the facility had a total 116,802 supervised injections (p x) in its first 18 months, of which 96.6% (p x) were heroin injections which are subject to fatal overdose. This gives 112,831 heroin injections against 2,657 (p x) overdoses or 23.5/1,000 injections
4. Clients of the Kings Cross MSIC were considered by the 2003 1st MSIC Evaluation to be at higher risk of overdose than normal (p 62) and so the previous overdose rates of MSIC clients, as recorded when registering to use the facility, can well be used as normative for the MSIR. 44% (see p 8) of MSIC clients had overdosed before registering, with a heroin-use career spanning an average 12 years (see p 8) and a median average of three overdose episodes in the 12 years (see page 16). From this data, their average rate of overdose can be calculated. Using the MSIC Evaluation's own assumption of 'at least' three injections per day per dependent heroin user (see p 58), and keeping in mind that, for example, 8 injections per day for heroin users is not extraordinary, we can calculate the number of injections per user per year (3 x 365 = 1,095 injections per year), then calculate one non-fatal overdose every 4 years giving a rate of 1/4,380 injections (4 x 1,095 injections) or 0.23/1,000. The real rate would be quite a deal lower given that 3 injections per day is a low estimate, and this is the rate for only 44% high risk clients in the MSIC, where the other 56% have no overdoses but many injections
5. Their staggering overdose rate of 23.5/1,000 injections can be divided by the normative rate of overdose (see footnote 4) of 0.23/1,000 giving the result of 102 times higher than normal
6. See Hansard record of speeches by NSW MLC Gordon Moyes file:///C:/Users/gxian/Documents/Drugs/Interventions/Injecting%20Room/ADRAAnalysis/Lobbying/Full%20Day%20Hansard%20Transcript%20(Legislative%20Council,%2026%20June%202007,%20Proof)%20-%20NSW%20Parliament.htm and by NSW Andrew Fraser MP https://web.archive.org/web/20121102211713/https://www.parliament.nsw.gov.au/Prod/parlment/hanstrans.nsf/V3ByKey/LA20101021/$File/541LA217.pdf recording the observations of MSIC ex-clients on why the overdose rate is so imaginably high.
7. The 1st MSIC Evaluation (see p 62) noted that "In this study of the Sydney MSIC there were 9.2 heroin overdoses per 1000 heroin injections in the MSIC, and this rate of overdose is likely to be higher than among heroin injectors generally. The MSIC clients seem to have been a high-risk group with a higher rate of heroin injections than heroin injectors who did not use the MSIC, they were often injecting on the streets, and they may have taken more risks and used more heroin in the MSIC." The evaluators never bothered to measure this inordinately high rate of overdose against MSIC clients' own histories of overdose or rates of overdose derived therefrom. The rates were high because of unchecked MSIC client experimentation with more drugs and drug cocktails – see speech by NSW Upper House MLC Gordon Moyes file:///C:/Users/gxian/Documents/Drugs/Interventions/Injecting%20Room/ADRAAnalysis/Lobbying/Full%20Day%20Hansard%20Transcript%20(Legislative%20Council,%2026%20June%202007,%20Proof)%20-%20NSW%20Parliament.htm and by Andrew Fraser MP https://web.archive.org/web/20121102211713/https://www.parliament.nsw.gov.au/Prod/parlment/hanstrans.nsf/V3ByKey/LA20101021/$File/541LA217.pdf
8. See 2010 MSIC Evaluation by KPMG (p 154) for the overdose rates per year up to 2010
9. See endnote 4 above
10. The MSIC overdose rate of 14.6/1,000 injections can be divided by the normative rate of overdose (see footnote 4 of 0.23/1,000 giving the result of 63 times higher than normal.
11. p 76 of the MSIR review states that "Local people record no difference in seeing discarded injecting equipment" Also, "There was an increase in the median number of discarded syringes seen by business respondents during the trial (six to 10 per month)" (p 76)
12. DFA notes that the review's cited (small) reductions in reported sightings of public injecting (p xx) are clearly countered by increases in publicly discarded injecting equipment (p xx) which inevitably indicates INCREASED public injecting. Policing crackdowns during daytime obviously increased night-time injecting, when public injecting is less likely to be observed by local residents or businesses. This increase in public injecting is witnessed by the increases in ambulance callouts at night (p 71)
13. The heroin drought commenced December 2000 https://www.researchgate.net/publication/237404353_The_Australian_Heroin_Drought_and_its_Implications_for_Drug_Policy and the MSIC opened May 6, 2001. Australia has never recovered from the heroin drought
14. https://kirby.unsw.edu.au/report/sydney-medically-supervised-injecting-centre-msic-evaluation-report-4 see page 32ff
15. https://www.health.nsw.gov.au/aod/resources/Documents/msic-kpmg.pdf see p xi
16. Sniffer dog policing commenced 1 month after the MSIC opened (see speech by Clover Moore https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1323879322-25542/link/11) in the Kings Cross postcode and very successfully https://www.zdnet.com/article/sniffer-dog-avoidance-a-wireless-app-with-bite/ moved dealers out of the postcode into neighbouring postcodes, particularly next-door Darlinghurst
17. MSIR review (p 100) states that "There is not a significant difference between MSIR service users and other people who inject drugs in reporting that they had injected with someone's used needle/syringe in the previous month."
18. 2010 MSIC Evaluation by KPMG (p 4) records that ". . . it is not possible however to attribute any change in infection notifications to the operation of the MSIC" –DFA notes that the KPMG Evaluation, in assessing evidence regarding blood-borne virus transmissions, made no mention of the obvious heroin drought which was responsible for less needles being distributed by pharmacies and needle & syringe programs, and which remained active in 2010 and beyond. Nor did they make any mention of sniffer dog policing driving dealers, drug purchases and their associated overdoses to other areas of Sydney

19. MSIR review p 50
20. MSIR review p 55
21. See p 17 https://drugfree.org.au/images/pdf-files/library/Injecting_Rooms/DFA_Analysis_Injecting_Room_2010.pdf
22. https://www.tandfonline.com/doi/abs/10.1080/09687630600871987
23. MSIR review p 50
24. https://tpav.org.au/news/journals/2019-journals/june/safe-injecting-rooms
25. https://www.heraldsun.com.au/news/victoria/police-target-drug-traffickers-and-crime-in-richmond-during-operationapollo/news-story/c7b10e05340619b9282588ca81889bd9
26. 2003 1st MSIC Evaluation p 146ff
27. See endnote 3
28. The 2003 1st MSIC Evaluation (p58) cited the Darke et al. study which found that there 1 fatal overdose in every 24 overdoses, the remainder being non-fatal overdoses. On this data we can calculate the number of injections per overdose, given that there is solid Australian data indicating that one in every 100 dependent heroin users die each year from a fatal opiate overdose. If dependent heroin users are injecting 'at least' 3 times a day, as calculated by the 1st MSIC Evaluation (p58), there is one death for every 109,500 injections (3 injections per user per day x 365 days in a year x 100 users for which one injection will be fatal). There will be 24 overdoses per 109,500 injections, giving a rate of 1/4,563 injections, very similar to the previous overdose rates recorded by MSIC clients when registering to use the MSIC. Using the MSIC clients previous overdose rate of 1/3,480 injections we find that the 112,831 opiate injections in the MSIR SHOULD have only caused 26 overdoses, of which one would be fatal
29. Again we are being extremely generous – the Darke et al. study mentioned in endnote 28 found that an ambulance attended only 51% of their examined overdoses. We have more generously calculated according to the registration data of Kings Cross MSIC clients which had 74% of previous overdoses attended by an ambulance. Thus 19 of the 26 expected overdoses from 112,831 injections in the MSIR would have likely caused an ambulance callout. If we had calculated on Darke et al.'s 51% it would have been just 13 callouts that would be foregone by the presence of the MSIR
30. In the 18 months before the MSIR there were 382 ambulance callouts within a 1 km radius. If the (generous) 19 callouts are deducted, we would normally have expected the MSIR to reduce that number to 363 (388 minus 19 callouts), which is a 5% reduction
31. MSIR review p xi
32. MSIR review p 69
33. https://www.heraldsun.com.au/news/victoria/police-target-drug-traffickers-and-crime-in-richmond-during-operationapollo/news-story/c7b10e05340619b9282588ca81889bd9
34. The KPMG Evaluation recorded 604,022 injections (p ix) in 9 years, of which a maximum 76.5% (p 107) were opiate injections, averaging 51,275 opiate injections per year
35. With the 446,976 opiate injections over 9 years (see previous endnote) expected to produce an overdose for every 4,380 injections, (see endnote 4) the number of expected overdoses would be 102, or 11 per year over 9 years.
36. See the 2007 4th MSIC Evaluation p 24ff
37. In the Salmon et al. 2010 study on ambulance callouts, which replicated data from MSIC Evaluation 4 compare data on daytime callouts versus callouts outside MSIC operating hours (p 680)
38. NSW Parliament Hansard, "Police Sniffer Dogs" 23 October 2001 https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1323879322-25542/link/11
39. http://www.mapinc.org/drugnews/v01/n1987/a09.html?4817
40. See speech by Mrs A Megarrity https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1323879322-25542/link/11
41. See endnote 4
42. The MSIR review recorded 112,831 heroin injections during the first 18 months (see endnote 3), averaging 75,221 injections for the first 12 months (it was actually less than that due to a slow startup for the MSIR). The MSIR needed 109,500 injections to claim one life saved, and 75,000 injections does not even come close
43. https://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs_/Final_-_Victorian_Governement_Response_to_the_Parliamentary_Inquiry_into_Drug_Law_Reform__X1wNyVpZ.pdf records funding of $4 million per year which gives $6 million in 18 months
44. In August 2018 the NSW Legislative Council's Portfolio Committee No.2 (Health and Community Services) Report 49 recommended "That the NSW Government significantly increase funding to drug and alcohol related health services" (Recommendation 2). The NADA submission https://www.nada.org.au/wp-content/uploads/2019/03/NADA-Submission_-NSW-AOD-Beds_120319.pdf recommended $224.95 of funding per bed day for residential rehabs, which equals $82,106 per annum or 73 bed years for the $6 million to save one life in an injecting room. If patients are offered 6 months of rehab each over 140 users will have been assisted towards being drug-free, freeing them from the morbidity of non-fatal overdoses and freeing the community of crime and public nuisance
45. The MSIR review (p ix) indicates MSIR clients average 14 opiate injections per week which is 728 per year, or 60 per month on average. There were 112,831 heroin injections in 18 months recorded by the MSIR by the 3,936 clients, giving an average of 29 injections per client in 18 months or 19 per year, averaging a little over 1.5 injections per month. 58 of clients' average 60 injections per month were not in the MSIR.
46. The 2010 KPMG Evaluation recorded a total of 604,022 injections (p ix) in the 9 years evaluated, of which 76.5% were opiate injections (p 108). This gives 461,473 opiate injections, averaging 51,275 opiate injections annually.
47. In 2007 the MSIC cost $2.7 million to operate according to the 2007 4th Evaluation (p35). With current operating costs unable to be identified from MSIC records or State budgets, $3 million per year in 2020 is a very conservative estimate


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