DRUG FREE AUSTRALIA

Protect 100, or 950?
. . . this isn't a choice

Submission - proposed Melbourne injecting room

How many of these Kings Cross deaths since May 2001 were injecting room clients?

Injecting room statistics suggest a majority most likely were – see pages 14-16

6 months before the injecting room opens heroin drought hits in Dec 2000 and opiate deaths plummet Australia-wide by >60%

Injecting room opens May 6 2001, 6 months after the heroin drought, which continues to this day, commences

Opiate-related deaths

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	Total
Kings Cross	63 (13%)	42 (12%)	33 (11%)	10 (7%)	15 (10%)	26 (16%)	14 (10%)	7 (12%)	10 (12%)	13 (13%)	6 (9%)	239 (12%)
Rest of NSW	437 (87%)	303 (88%)	254 (89%)	136 (93%)	133 (90%)	134 (84%)	125 (90%)	52 (88%)	74 (88%)	90 (87%)	61 (91%)	1,799 (88%)
Total	**500**	**345**	**287**	**146**	**148**	**160**	**139**	**59**	**84**	**103**	**67**	**2,038**

What good is an injecting room saving a user's life today when tomorrow they die injecting elsewhere?

DRUG FREE AUSTRALIA

Executive Summary - Three Central Issues for Victorian Legislators

1. **It is the unpredictable nature of opiate overdose which makes opiate use so deadly. Consequently, a Melbourne injecting room would have to annually spend at least $30,000 per dependent opiate user to keep them completely safe from fatal overdose by supervising their every injection.**

   The Sydney injecting room (MSIC), which costs $3 million each year, has a maximum capacity of 300 injections per day. That is only enough to ensure that the average three injections per day for 100 dependent opiate users' are each safely supervised. This gives a ratio of $3 million for 100 users, or $30,000 funding per dependent opiate user.

   At a comparable $3 million per annum, Victoria will need to spend $30 million to keep 1,000 users completely safe. But that 1,000 is still only a fraction of Victoria's estimated 14,000 opiate users. This is an inordinate cost for little benefit.

2. **Only one in the above 100 mentioned in Section 1 above would have fatally overdosed without an injecting room, Australian statistics show. Consequently the ratio of deaths to injections is one in every 110,000 injections (ie 100 opiate users injecting 3 times daily for 365 days a year = 109,500 injections).**

   The Melbourne injecting room will need to host almost 110,000 opiate injections per year, or 300 injections per day, before it can claim it intervened in the one injection in 110,000 that would have been fatal.

   But the Sydney injecting room constantly runs at roughly half its opiate injection capacity, averaging

only 58,000 opiate injections per year – well short of the 109,500 to save one life.

Consequently, the cost of saving that one life per year in its injecting room would fund around 950 Naltrexone maintenance implants of the kind funded by the Western Australian government for the last two decades. Naltrexone implants block the effect of heroin so that an injection has no high, nor can it kill.

Of those 950 protected for a year, 9-10 (1%) would have otherwise died from a fatal overdose. For the one life saved in the injecting room, Naltrexone implant maintenance will save 9-10. This is a far better option for the Victorian government because the person whose life was saved in the injecting room today can die tomorrow injecting elsewhere. But this will not happen with a Naltrexone implant.

Upon the principle of distributive justice, the Victorian government should choose the programming that guarantees more lives saved for the same funding. 100 vs 950 protected. One life or 9-10? . . . this isn't a choice.

3. **At best, the Sydney injecting room hosts just 5% of Kings Cross/Darlinghurst injections but accounts for 77% of all the recorded overdoses in the Kings Cross/Darlinghurst area.**

400 overdoses are recorded on average in that facility each year. But the injecting room's own clients inject more often in the streets and houses outside the facility than in it, where the overdose rates outside should roughly match those inside the injecting room.

This massive number of overdoses indicates only one thing – experimentation with higher doses and different cocktails of drugs in the safety of the room.

Why would the Victorian government fund a facility, the safety of which encourages experimentation and greater drug use, adding significant harm to the Victorian community?

The evidence supporting each of these three central issues is found in the following pages.

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CENTRAL ISSUES FOR VICTORIAN LEGISLATORS - 1

Inordinate cost for little benefit

It is the unpredictable nature of opiate overdose which makes opiate use so deadly. Consequently, a Melbourne injecting room would have to annually spend at least $30,000 per dependent opiate user to keep them completely safe from fatal overdose by supervising their every injection.

The Sydney injecting room (MSIC), which costs $3 million each year, has a maximum capacity of 300 injections per day. That is only enough to ensure that the average three injections per day for 100 dependent opiate users' are each safely supervised. This gives a ratio of $3 million for 100 users, or $30,000 funding per dependent opiate user.

At a comparable $3 million per annum, Victoria will need to spend $30 million to keep 1,000 users completely safe. But that 1,000 is still only a fraction of Victoria's estimated 14,000 opiate users. This is an inordinate cost for little benefit.

The science – mostly long-term dependent users dying from overdose

In 2001 the Prime Minister's special advisory, the Australian National Council on Drugs (ANCD) in 2001 requisitioned an authoritative document on heroin overdose in Australia. (Go to https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Mono.46.PDF) It was produced as ANCD Research Paper No. 1 by the National Drug and Alcohol Research Centre (NDARC), a body which has always campaigned in favour of the Kings Cross injecting room. Their scientific review disclosed that,

> "Victims of overdose are predominantly single, unemployed men aged in their late 20s and early 30s, with a long history of heroin dependence." p vi

> "Tolerance to the respiratory depressive effects of opiates increases at a slower rate than tolerance to the euphoric and analgesic effects. This fact partially explains why long-term users are potentially at greater risk of overdose than novices and why most users report not experiencing their first overdose until a number of years after commencing regular heroin use." p xiii

> "Studies link mortality with longer heroin using careers (Davoli, Perucci et al. 1993; Eskild, Magnus et al. 1993). Darke, Ross et al. (2000a) found that, of 953 heroin-related deaths, 88 per cent were known heroin users, the overwhelming majority of whom were dependent (85 per cent of all cases). Less than 1 per cent of cases (seven individuals) were believed to be novice users." p 14

The same ANCD Monograph dispels some of the myths surrounding heroin overdose,

> "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." p xiii

> "The evidence of poly-drug use in fatal overdose is consistent with the experience of non-fatal overdose victims, particularly in terms of alcohol and benzodiazepine use. Darke, Ross et al. (1996a) found that two-thirds of most recent overdoses among a sample of Sydney heroin users involved the presence of another CNS depressant. Overall, overdoses involving heroin use alone are in the minority." p 17

The implications for opiate users are that their alcohol and poly-drug use threatens their life, and yet users' control of their alcohol use, particularly in social settings, is not always self-aware or premeditated. For this reason, there is a constant threat of overdose for any long-term opiate user who is using alcohol or other drugs.

The science – dependent users average three injections daily

The initial government-funded evaluation of the Kings Cross injecting room was completed 18 months after the facility commenced operation. (Go to https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf) It calculated estimates of the number of lives saved in that first 18 months by the facility. Involved with the calculations was their assertion that heroin users average 3 injections per day in Australia,

> " . . . it is plausible that 2000 IDU are regularly injecting heroin in the Kings Cross area. Allowing for an average of at least three injections per day per regular heroin users, there would be 6,000 injections of heroin in the Kings Cross area per day." p 58

The Canadian Government's review of the Vancouver injection facility in 2008 (Go to http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php#back) calculated that Canadian heroin users averaged four injections per day,

> "It has been estimated that injection drug users inject an average six injections a day of cocaine and four injections a day of heroin. The street costs of this use are estimated at around $100 a day or $35,000 a year." Background section – 4th paragraph

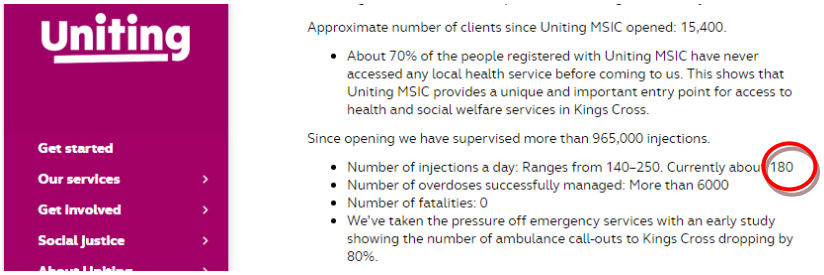
Dependent heroin users self-report injecting 2-12 times daily. (See https://drugs-forum.com/threads/how-many-times-a-day-do-other-daily-addicts-use.90306/).

The science – Sydney injecting room capacity of 300 injections daily

The initial government-funded evaluation of the Kings Cross injecting room recorded that the facility has a capacity of around 300 injections per day. (Go to https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf)

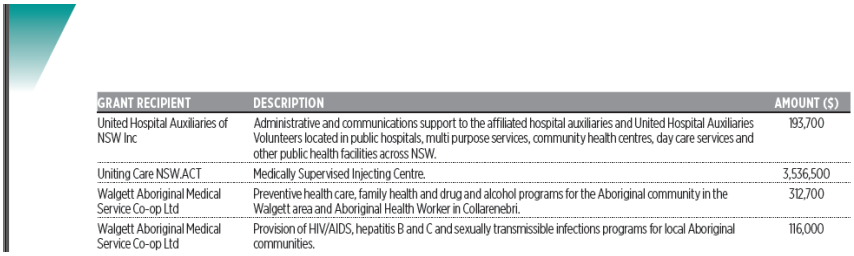
> "MSIC service utilisation after weekday operating hours were extended to 12 hours per day showed the MSIC could accommodate up to 330 visits per day (Kimber & Mattick, 2003). p 38

However their website currently indicates that there are only 180 injections daily. (Go to https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/what-the-uniting-sydney-msic-does)



The math – Sydney injecting room spends $3 million annually

From p 108 of the NSW Health Department's Annual Review for 2016, (http://www.justicehealth.nsw.gov.au/publications/201516NSWHealthAnnualReport.pdf) funding of around $3.5 million is extended for operation of the Kings Cross injecting room. While the injecting room has not reported for many years on the precise funding it receives from NSW Health, comparison with earlier NSW Health Annual Reports and previous injecting room expenditure figures indicates that operating costs are around $3 million per annum with the other funding presumably contributing to side-programming.



GRANT RECIPIENT	DESCRIPTION	AMOUNT ($)
United Hospital Auxiliaries of NSW Inc	Administrative and communications support to the affiliated hospital auxiliaries and United Hospital Auxiliaries Volunteers located in public hospitals, multi purpose services, community health centres, day care services and other public health facilities across NSW.	193,700
Uniting Care NSW.ACT	Medically Supervised Injecting Centre.	3,536,500
Walgett Aboriginal Medical Service Co-op Ltd	Preventive health care, family health and drug and alcohol programs for the Aboriginal community in the Walgett area and Aboriginal Health Worker in Collarenebri.	312,700
Walgett Aboriginal Medical Service Co-op Ltd	Provision of HIV/AIDS, hepatitis B and C and sexually transmissible infections programs for local Aboriginal communities.	116,000

The math – $30,000 per client for supervised safety

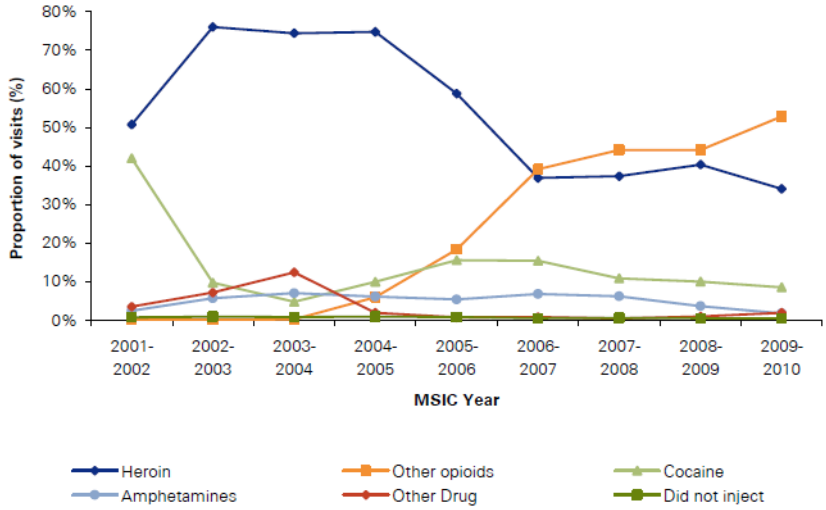
Given that any heroin injection can be fatal, and that there is no time of day that provides immunity from a fatal overdose, it would be necessary for clients to inject at all times in the injecting room for there to be a fully protective effect. This of course will never happen, because clients do not want to be leashed to a facility every day of

their lives, thus they will mostly inject at home, at their dealer's home, in a park, a toilet, a car . . . or anywhere other than the injecting room. This is what makes an injecting room so ineffective, and so cost-inefficient.

However, to perform 3 injections per day with the safety of supervision will cost $30,000 per user, given that the safety provided by the facility costs 3 million yearly for a maximum of 100 users daily. Unfortunately, because the Sydney injecting room hosts only 160 opiate injections per day it takes almost two years costing more than $5.6 million before it has hosted the equivalent of 300 opiate injections per day for a year.

The graph below indicates that a percentage of the average 180 injections per day in the injecting room are non-opiates. (Go to http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf p 112)

Figure 8-1: Type of drug injected[115]



CENTRAL ISSUES FOR VICTORIAN LEGISLATORS – 2

Protect 100, or 950?

Only one in the above 100 mentioned in Section 1 above would have fatally overdosed without an injecting room, Australian statistics show. Consequently the ratio of deaths to injections is one in every 110,000 injections (ie 100 opiate users injecting 3 times daily for 365 days a year = 109,500 injections).

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Of those 950 protected for a year, 9-10 (1%) would have otherwise died from a fatal overdose. For the one life saved in the injecting room, Naltrexone implant maintenance will save 9-10. This is a far better option for the Victorian government because the person whose life was saved in the injecting room today can die tomorrow injecting elsewhere. But this will not happen with a Naltrexone implant.

Upon the principle of distributive justice, the Victorian government should choose the programming that guarantees more lives saved for the same funding. 100 vs 950 protected. One life or 9-10? . . . this isn't a choice.

The science – one in every 100 opiate users die from overdose annually

There is strong agreement across multiple studies that one in every 100 opiate users die from overdose each year.

So strong is this agreement that the official estimate for how many heroin users there were in Australia in the year 1997 calculated the number, in part, from this mortality percentage. They multiplied the number of overdose deaths for 1997 by 100. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDARC%20monograph%2044.pdf

> "5.1.3 MULTIPLIER ESTIMATES
>
> Simple multiplier estimates of the number of dependent heroin users were produced using the number of opioid overdoses recorded in NSW and Australia during 1998. The multiplier used were 120 (based on the annual opioid overdose rate of 0.8%, discussed above) and the commonly used multiplier of 100 (Frischer, 1999; Larson, 1992)." p 16

The correlation between heroin user numbers in Australia can be seen in the IDRS Drug Bulletin of July 2006 which summarized the calculations of the above Monograph. Compare this to the opiate deaths for the same year, 1997, in the table copied beneath.

Table 1. Estimates of the number of dependent heroin users in NSW and Australia (rounded to nearest 1000)

Method of estimation	Estimate for Australia
Back projection	
National overdose deaths	67,000
NSW methadone entrants	71,000
Capture-recapture	
Methadone episodes	82,000
Arrests for heroin offences	86,000
Multiplier estimates	
OD fatalities:	
(x 100)	74,000
(x 125)	92,000
Methadone entrants (x 3)	68,000
Median estimate	**74,000**

Table 2: Number of accidental deaths due to opioids among those aged 15-54 years by jurisdiction, 1988-2012

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
1998	204	99	16	12	18	0	0	2	**351**
1989	158	99	19	8	18	1	2	2	**307**
1990	196	79	8	19	14	5	0	0	**321**
1991	146	64	9	13	13	3	0	2	**250**
1992	182	79	18	30	22	0	1	4	**336**
1993	188	86	23	41	24	5	2	5	**374**
1994	209	97	37	32	38	4	5	3	**425**
1995	273	140	42	38	70	6	0	13	**582**
1996	260	145	32	32	64	5	2	17	**557**
1997	333	203	36	52	76	2	2	9	**713**
1998	452	243	64	53	78	10	13	14	**927**
1999	481	376	79	64	92	5	8	11	**1116**
2000	349	323	124	50	72	8	2	10	**938**
2001	177	73	58	18	35	8	5	12	**386**
2002	158	93	40	21	28	9	6	8	**364#**
2003	143	129	32	14	16	4	2	17	**357**
2004	144	126	34	25	19	6	1	2	**357**
2005	133	104	42	37	36	14	np*	np*	**374**
2006	138	118	42	20	38	15	np*	np*	**381**
2007	115	103	52	34	27	15	np*	np*	**360**
2008	137	170	62	43	64	11	np*	np*	**500**
2009	174	143	103	47	71	10	np*	np*	**563**
2010	150	169	142	41	87	9	np*	np*	**613**
2011	176	175	134	24	88	7	np*	np*	**617**
2012	**157**	**126**	**128**	**42**	**90**	**13**	**np***	**np***	**564**

For another study indicating that 1% of opiate users die from overdose annually, see a study more particular to Melbourne's drug users, https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-015-0089-3 which found a mortality rate as follows,

> "We linked identifiers from the Melbourne injecting drug use cohort study (MIX; $n = 655$) to the National Death Index from 2008 to 2012 to estimate standardised mortality ratios (SMRs). Cox regression was used to examine the bivariate relationship between exposures determined at baseline and subsequent mortality. There were 24 (3.6 %) deaths over the study period. The mortality rate in the cohort was 1.0 per 100 PY (95 % CI 0.71–1.57)" – Abstract – Findings

The science – mostly long-term dependent users dying from overdose (reprised)

In 2001 the Prime Minister's special advisory, the Australian National Council on Drugs (ANCD) in 2001 requisitioned an authoritative document on heroin overdose in Australia. (Go to https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Mono.46.PDF) It was produced as ANCD Research Paper No. 1 by the National Drug and Alcohol Research Centre (NDARC), a body which has always campaigned in favour of the Kings Cross injecting room. Their scientific review disclosed that,

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> "Tolerance to the respiratory depressive effects of opiates increases at a slower rate than tolerance to the euphoric and analgesic effects. This fact partially explains why long-term users are potentially at greater risk of overdose than novices and why most users report not experiencing their first overdose until a number of years after commencing regular heroin use." p xiii

The science – dependent users average three injections daily (reprised)

The initial government-funded evaluation of the Kings Cross injecting room was completed 18 months after the facility commenced operation. (Go to https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf) It calculated estimates of the number of lives saved in that first 18 months by the facility. Involved with the calculations was their assertion that heroin users average 3 injections per day in Australia,

> " . . . it is plausible that 2000 IDU are regularly injecting heroin in the Kings Cross area. Allowing for an average of at least three injections per day per regular heroin users, there would be 6,000 injections of heroin in the Kings Cross area per day." p 58

The Canadian Government's review of the Vancouver injection facility in 2008 (Go to http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php#back) calculated that Canadian heroin users averaged four injections per day,

> "It has been estimated that injection drug users inject an average six injections a day of cocaine and four injections a day of heroin. The street costs of this use are estimated at around $100 a day or $35,000 a year." Background section – 4th paragraph

Dependent heroin users self-report injecting 2-12 times daily. See https://drugs-forum.com/threads/how-many-times-a-day-do-other-daily-addicts-use.90306/.

The math – one opiate injection in every 109,500 is fatal

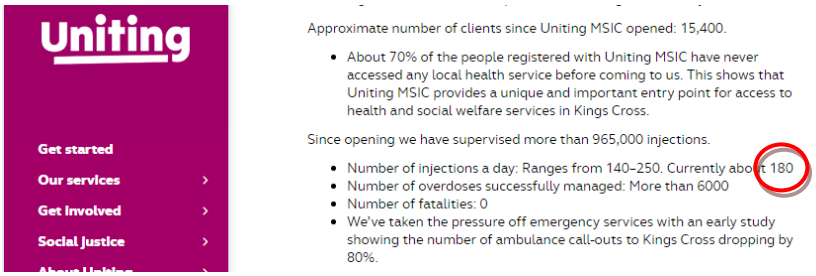
Given that most opiate deaths are for dependent heroin users who inject 'at least' 3 times daily, and given that one in one hundred opiate users will die each year from overdose, a ratio of one fatal injection in every 109,500 results.

Injections per day	3 x
Days in year	365 x
Users per single fatality annually	100
Injections per single fatality	**109,500**

Where the ratio of opiate fatalities is one in every 110,000 injections, the proposed Melbourne facility must host 110,000 injections in a year before it can claim its supervision has saved the life of the user whose single injection amongst the total 110,000 injections of the 100 users would have been fatal.

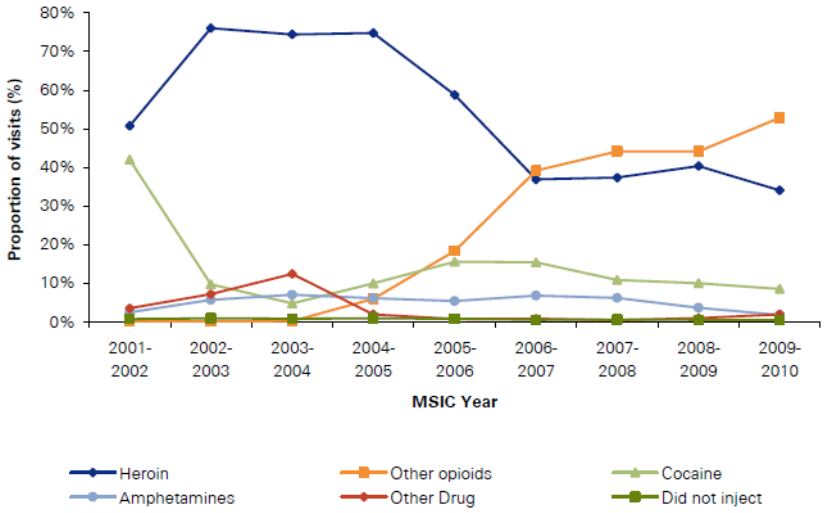
The science – Sydney injecting room hosts only 160 opiate injections a day

The website for the Sydney injecting room currently indicates that there are an average of only 180 injections daily. (Go to https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/what-the-uniting-sydney-msic-does)



Of these 180 injections, more than 10% will be other drugs, as indicated in the 2010 KPMG government-funded evaluation of the injecting room. (Go to http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf p 112) This gives a maximum of 160 opiate injections per day or 58,000 per year.

Figure 8-1: Type of drug injected[115]



The math – 58,000 injections a year is roughly half required to save <u>one</u> life

Of these 180 injections, more than 10% will be other drugs, as indicated in the 2010 KPMG government-funded evaluation graph above. This leaves at most 160 injections per day, or at most 58,000 injections per year.

To save a single life from fatal overdose a Melbourne injecting room needs to host 110,000 injections. If it, like the Sydney injecting room, hosts only 58,000 injections per year, it will take it almost two years to legitimately claim it has saved a single life. At $3 million per year, the Sydney facility expends more than $5.6 million to save a single life.

The math – 100 lives protected versus 950

The Western Australian Government has funded the provision of Naltrexone implants for opiate users for 19 years now, costing them the same cost as an injection room at $3 million annually. The Naltrexone implants are funded as part of a Perth and Northam rehabilitation program. As per the study below, (Go to http://www.journalofsubstanceabusetreatment.com/article/S0740-5472(07)00249-8/abstract) there were no overdose deaths recorded while the implant was active (about 6 months) in the Naltrexone cohort studied.

Drug Free Australia's submission is that the Victorian Government provide Naltrexone MAINTENANCE with the $3 million otherwise spent on an injecting room, protecting 500 users per year instead of the equivalent of 53 in an injecting room. For the Sydney injecting room's more than $5.6 million spent to supervise the injections of 100 opiate users, rather than the equivalent of 53 users it currently annually supervises, 950 Naltrexone implants would be funded, providing a superior protective effect for 950 opiate users.

Abstract
Concerns that treatment for heroin dependence using naltrexone may increase suicide rates during treatment and fatal overdoses post-treatment have been expressed. There is also disquiet about mortality during induction onto methadone. We assessed mortality during specific periods following treatment with naltrexone implants or methadone. Data were assembled using the Western Australian Data Linkage System. The methadone cohort comprised all those who started methadone in Western Australia during 2001–2002: The naltrexone cohort comprised all Western Australian heroin-dependent persons who received their first implant in 2001–2002. There were 15 (2.7%) deaths in the methadone cohort (n = 553) and 6 (1.8%) deaths in the naltrexone cohort (n = 341). Mortality rates for the "initial 14-day period," "stable treatment," and "overall" were 94.47, 0.0, and 5.83 deaths/1,000 person-years for the methadone group. In the naltrexone group, the rates "during first treatment (0–6 months)," "post first treatment," and overall were 0.0, 4.21, and 3.76 deaths/1,000 person-years. The age-standardized mortality rate ratio for naltrexone compared to methadone was 0.645 (95% confidence interval = 0.123–1.17). Increased mortality during induction onto methadone was confirmed. Evidence relating naltrexone to either increased suicide or overdose was not found. Overall mortality rates for naltrexone implant were similar to those for methadone, but increased mortality during methadone induction was avoided.

Drug Free Australia further recommends that maintenance only cease once an opiate user's life has been stabilised and drug-free habits and associations are well established. This would enable lower rates of mortality post-treatment, which we note are still superior to the currently dominant maintenance modality, methadone.

Alternately, contact with the Salvation Army in NSW confirmed that rehabs are funded $30,000 per rehab bed, with an expectation that users will be in rehab for 3 months each. Even if rehabilitation has a success rate of only 25-30% drug free 12

months after completing rehab, roughly 200 users will have been rehabilitated of which 2 (1%) would have otherwise died.

The science – Heroin drought hits October 2000

How many of these Kings Cross deaths since May 2001 were injecting room clients?

Injecting room statistics suggest a majority most likely were

6 months before the injecting room opens heroin drought hits in Dec 2000 and opiate deaths plummet Australia-wide by >60%

Injecting room opens May 6 2001. 6 months after the heroin drought, which continues to this day, commences

Opiate-related deaths

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	Total
Kings Cross	63 (13%)	42 (12%)	33 (11%)	10 (7%)	15 (10%)	26 (16%)	14 (10%)	7 (12%)	10 (12%)	13 (13%)	6 (9%)	239 (12%)
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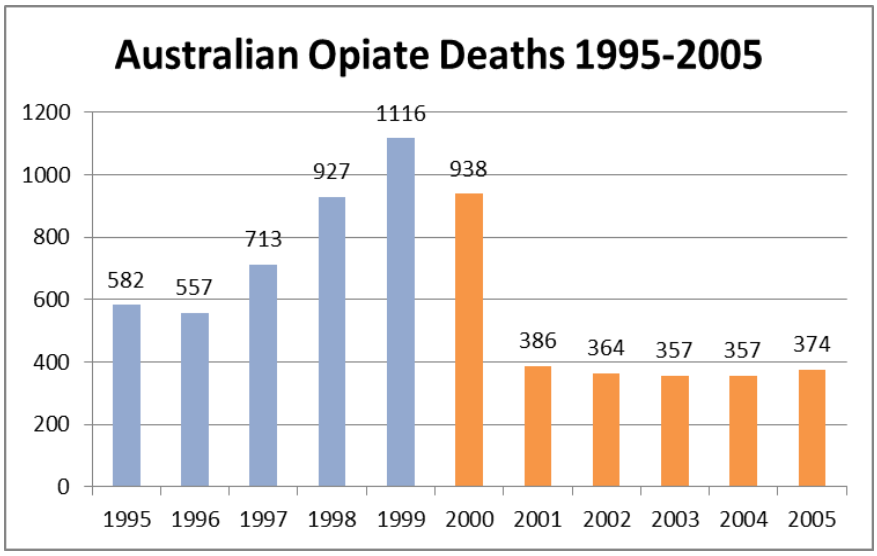
Total	500	345	287	146	148	160	139	59	84	103	67	2,038

What good is an injecting room saving a user's life today when tomorrow they die injecting elsewhere?

The heroin shortage commenced in December 2000 (see http://www.bocsar.nsw.gov.au/Documents/BB/bb26.pdf) and affected the drug market Australia-wide. The result was a sharp drop in opiate overdose deaths throughout the country as per the graph below. No other country in the world had a drought of this severity, although Canada experienced reduced supply but not to anything like the same degree as Australia. The shortage was explained by Federal Police as being the result of alliances between Australian and Asian Police, stopping supply near the countries of origin in the Golden Triangle. (See http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2005.01000.x/full)



Drug Free Australia has noted that while the various evaluations of the injecting room acknowledged the heroin drought, credit was too often backhandedly given to the injecting room for the results of the shortage. For instance, Evaluation 4 in 2007 (Go

to https://kirby.unsw.edu.au/sites/default/files/hiv/attachment/EvalRep4SMSIC.pdf) thoroughly misleads in its claim below concerning Kings Cross ambulance callouts,

> "These results (Table 9) indicate that while a significant decline was observed in both areas, the magnitude of the decrease in ambulance attendances at suspected opioid overdoses was greatest in the area covered by postcode 2011 (includes Elizabeth Bay, Kings Cross, Potts Points, Rushcutters Bay, Woolloomooloo) as compared to 2010 (which includes Darlinghurst, East Sydney, Surry Hills)." p27

The reality was that the entire state of NSW suffered a **61%** decrease in ambulance callouts due to the heroin drought, with Kings Cross enjoying a decrease of **19%** greater than the rest of NSW, and Darlinghurst only having a 45% decrease rather than the expected 61% elsewhere. (This disappointing result for Darlinghurst, which was **16%** less than the rest of NSW was due to sniffer dogs implemented in Kings Cross in June 2002 moving drug dealers from Kings Cross to Darlinghurst).

This happened to move many of the street users and their overdoses away from the Kings Cross postcode – thus the lower ambulance callouts for Kings Cross as is detailed in Appendix C). Of course the message the media gave was that the injecting room decreased ambulance callouts by 80% instead of 19%, with not a word about sniffer dogs or Darlinghurst increasing by roughly the same percentage as decreases in Kings Cross). This has continued to mislead the public and politicians such as this, (See https://www.megaphone.org.au/petitions/tell-daniel-andrews-victoria-needs-a-supervised-injecting-room-trial).

The math – a majority of deaths likely to be injecting room clients

There were more than 101 deaths from July 2001 to June 2009 recorded in the Kings Cross/Darlinghurst postcodes (we do not know exactly how many deaths occurred between May 6 and June 30 of 2001).

That a majority of these deaths would have been injecting room clients is suggested by the following.

- Taking the period from 2001 to 2006, when the mortality figures for Kings Cross/Darlinghurst were more likely from heroin rather than prescription opiates (which are a lesser known and researched quantity) opiate deaths in Australia were around 360 each year. Given the known opiate mortality ratio of one death for every 100 users, Australia's opiate using population was likely around **36,500**
- **40%** of Australia's opiate users live in NSW which gives a NSW population of **14,600** opiate users - see NSW deaths as percentage of national deaths at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDARC%20BULLETIN%20Opioid%20Deaths%202012.pdf p5
- **12%** of NSW opiate deaths occur in Kings Cross suggesting a user population in Kings Cross daily of **1,750** opiate users https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf p 58
- By June 2006 the injecting room had **8,900** registered clients https://kirby.unsw.edu.au/sites/default/files/hiv/attachment/EvalRep4SMSIC.pdf p13

With the opiate deaths in Kings Cross/Darlinghurst deriving from a mostly transient population of around 1,750 opiate users daily in the area, and with almost 8,000 clients registered by 2004/5, more than half of NSW's opiate user population (see https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf p 17 confirming that almost all registrants were from NSW and that 80%

lived in Sydney) there can be no question that a growing percentage of the deaths between 2001 and 2006 were injecting room clients, becoming a majority of local deaths by 2004/5. If this is the case for 2001-2006, there is no real reason to question that similar ratios continued where prescription opiates were increasingly used from 2006/7 on.

The question – why are there no cohort studies on injecting rooms?

The Sydney injecting room has cited the assigned anonymity of their client base as the reason that no cohort studies have ever been done in Sydney – i.e. all clients are assigned a number and no names and specific addresses are recorded at registration. Injecting room staff claim that anything other than anonymity would have prevented drug users, a highly vulnerable group, from using the facility.

Cohort studies would allow a group of perhaps 500 registered clients to be monitored particularly in terms of opiate mortality. There are many cohort studies of drug using populations, particularly for methadone programs. It is inconceivable that a cohort of 500 injecting room clients could not be drawn from clients whose trust had been gained by injecting room staff. However, such studies are never done on injecting room clients world-wide.

The reason? It is quite obvious that there will be multiple opiate deaths recorded amongst such a cohort simply because so few of their yearly number of injections are within the facility. And the deaths recorded would quickly overwhelm the media rhetoric that there have never been any deaths recorded in injecting rooms. Because such a high percentage of injections are outside the facility, opiate death ratios will be little changed by injecting rooms.

The science – False claims of many lives saved

In light of the likelihood of many lives lost by injecting room clients, some mention of the false 'lives saved' calculations in the facility's official evaluations is necessary.

The Sydney injecting room has had two government-funded evaluations of the facility that have claimed it saves many lives per year.

2003 NDARC evaluation	claimed 6-13 lives saved in first 18 months
2008 SAHA evaluation	claimed 25 lives saved per month

Both of these studies calculated their inordinately high estimates of saved lives from the massively inflated number of overdoses in the injecting room while failing to do the most basic Statistics 101 task of first checking how much higher injecting room rates of overdose were as compared to community rates of overdose (in fact 29 times higher – Go to page 9 of https://www.drugfree.org.au/images/13Books-FP/pdf/DFA_Analysis_Injecting_Room_2010.pdf).

Appendix A demonstrates how inept or otherwise partisan are both studies and their indefensible methodologies.

CENTRAL ISSUES FOR VICTORIAN LEGISLATORS – 3

Injecting facilities heavily used for experimentation

At best, the Sydney injecting room hosts just 5% of Kings Cross/Darlinghurst injections but accounts for 77% of all the recorded overdoses in the Kings Cross/Darlinghurst area.

400 overdoses are recorded on average in that facility each year. But the injecting room's own clients inject more often in the streets and houses outside the facility than in it, where the overdose rates outside should roughly match those inside the injecting room.

This massive number of overdoses indicates only one thing – experimentation with higher doses and different cocktails of drugs in the safety of the room.

Why would the Victorian government fund a facility, the safety of which encourages experimentation and greater drug use, adding significant harm to the Victorian community?

The science – facility overdoses 32 times higher than client histories

From the 2010 KPMG evaluation of the injecting room, the data indicates a ratio of one overdose for every 134 injections in the facility between 2001 and 2009. (Go to http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf p 9) However, clients when registering to use the injecting room for the first time record that of the 44% who have previously overdosed, their average number of overdoses is 3 in an average 12 year opiate using-career. (Compare https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf Table 2.4 p16 with Table 2.1 p 15) These client histories indicate a rate of overdose, at the height of Australia's epidemic during the late 1990s, which was 1 in every 4,380 injections.

Rates of overdose in the injecting room are a staggering 32 times higher than the overdose history of clients entering the centre.

The math – 400 overdoses per year in the injecting room

The Kings Cross injecting room claims to have intervened in 6,000+ overdoses in its first 15 full years of operation. (Go to https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/what-the-uniting-sydney-msic-does) This averages more than 400 overdoses per year.

Kings Cross injecting room staff appear to cite the 6,000 overdoses to date as a badge of honour, knowing that the public is oblivious to the total disproportion these overdoses represent when compared to overdose rates anywhere else in Australia. As stated before these rates of overdose are 32 times higher than the clients' own reported rates of overdose before registering to enter the facility. There can only be one explanation – that the injecting room is used by clients to experiment with higher doses of opiates as well as cocktails of other illicit drugs.

The science – high overdose rates mean experimentation

In the 2003 evaluation of the Sydney injecting room, the evaluators casually noted the high overdose rate and ventured an explanation.

> "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 first explanation offered by the evaluators, that clients were a higher-risk group, is ruled out by comparison of their overdose histories with other known Australian cohorts (See p10 of the Appendix B document – The Case for Closure). This comparison indicates injecting room clients are at a LOWER risk of overdose than other known cohorts in Australia and the UK. This leaves experimentation as the only other explanation.

The high overdose rate first needs to be put in perspective. The 2004 European Monitoring Centre (EMCDDA) review of injecting rooms by Hedrich found that overdose rates across the world's injecting facilities (comparing only those in which heroin is injected rather than smoked) ranged from 0.5 in every 1,000 injections to a high of 4 per 1,000, with just one German facility recording 6.8/1,000. (Go to http://www.salledeconsommation.fr/_media/dagmar-hedrich-european-report-on-drug-consumption-rooms-oedt-2004-2.pdf p45) The Sydney injecting room has the highest known rates worldwide recording a staggering 14.6 overdoses per 1,000 in 2009/10 (go to http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf p 159) which is an even more staggering 64 times higher than the overdose histories of clients in the first 18 months, who again had predominantly been using at the peak of Australia's heroin availability and mortality in the late 1990s.

Table 10-2 : Overdoses by 1,000 injections

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Overdose per 1000 heroin injections	11.5	6.7	7.6	6.7	7.8	10.6	10.1	12.9	14.6	9.1

With experimentation as the only explanation for the massive rates of overdose, testimony of an MSIC ex-client in the NSW Legislative Council's Hansard on 26 July 2007 is enlightening:

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

It is clear that the high overdose rates are likely due to more heroin and poly-drug cocktails being used in the MSIC, with the safety of the facility as a guarantee against the risks of such behaviour. This inevitably implies that the MSIC is an accessory to the enhanced profits of local drug dealers who must sell more drugs to support the higher amounts injected. The inescapable implication is that the NSW Government has become an accessory to an increased drug trade in Kings Cross.

Why would the Victorian government fund a facility, the safety of which encourages experimentation and greater drug use, adding significant harm to the Victorian community?

Outside of client overdose histories, there is abundant evidence that the Sydney injecting room's rates of overdose are inordinately high. Comparisons of the number of overdoses in the injecting room with the ambulance callouts for overdose outside the facility makes this overwhelmingly clear, as follows.

The science – 5% of all Kings Cross opiate injections in the facility

The Sydney injecting room averages 160 opiate injections per day (see p 6 of this document), with opiates causing 94% of overdoses in the facility. (See http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf p 158). While the researchers in the 2003 government-funded evaluation estimated that there were 2,000 users and thus 6,000 injections daily in the Kings Cross area, the average 160 injections in the MSIC made up just 3% of those estimated injections in Kings Cross.

The injecting room's Bernadette O'Keefe later questioned the evaluation estimates, asserting that only about 600 opiate users injected in the area daily. Drug Free Australia has pointed to the 2003 evaluation's listed 870 MSIC clients LIVING in the Kings Cross/Darlinghurst area in the first 18 months of operation, quite apart from all the other injectors travelling in by train to buy drugs daily (Go to page 17 of https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf and for estimate of 2,000 opiate users per day see page 58 of the same).

If O'Keefe's estimates were correct, the injecting room would still host just 9% of injections in the area. As stated above, though, the injecting room registered 870 clients from Kings Cross and Darlinghurst, and despite the transient living conditions of many drug users, it is likely that the real number of injections in the area is halfway between the two estimates. The injecting room, at best, hosts only 5% of injections in its local area.

The science – overdoses in facility 77% of those in Kings Cross

Out on the streets of Kings Cross 95% of opiate injections were producing around 130 ambulance callouts for overdose in each of the years for which month by month data is available (2001-2005). Below is the tabulated data for the post MSIC overdose callouts for the years 2002/3 to 2004/5 taken from the 4th MSIC evaluation. (Go to https://kirby.unsw.edu.au/sites/default/files/hiv/attachment/EvalRep4SMSIC.pdf p27)

Looking at the table below, compare the number of overdoses on the streets (blue bar) with the number of overdoses in the injecting room (red bar at base). (See http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf p158). Clients in the facility represent just 5% of injections in the Kings Cross area but subject themselves to overdose rates 3-4 times higher than out on the streets.

Ambulance Callouts for Kings Cross/Darlinghurst					
Year	**2001/2**	**2002/3**	**2003/4**	**2004/5**	
Jan	2	9	8	4	
Feb	2	13	8	10	
Mar	5	6	16	11	
Apr	2	13	20	5	
May	8	15	9	4	95% of
Jun	0	5	13	10	total
Jul	6	11	15	14	injections
Aug	4	7	12	11	
Sep	11	13	11	9	
Oct	11	11	10	10	
Nov	12	12	10	10	
Dec	13	6	16	5	
TOTAL	**76**	**121**	**148**	**103**	
MSIC ODs	**320**	**485**	**359**	**341**	5% of total

Quite clearly, the same clients posting massive rates of overdose inside the facility only have normal rates of overdose when injecting outside the facility.

That the vast majority of their injections are on the street cannot be questioned. The Table below from the KPMG evaluation of 2010 shows the number of injections each year from 2001 to 2009, (Go to http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf p 111) ranging from 32,000 to 82,000 per year.

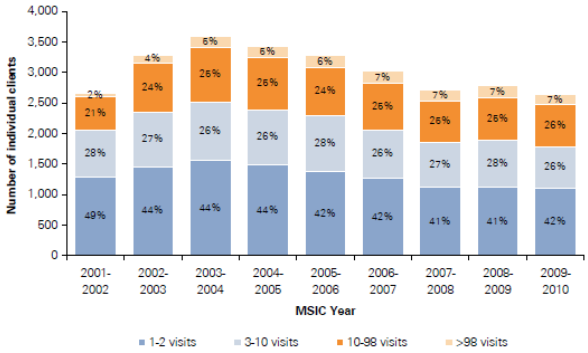
Table 8-1: Number of visits to the MSIC

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Total visits	31,827	56,876	80,331	68,880	72,520	82,085	72,504	74,852	69,302	609,177

Source: Medically Supervised Injecting Centre (MSIC)

Compare the number of clients per year, ranging from 2,600 to 3,600 per year.

Figure 8-3: Frequency of client attendance at the MSIC



Using data from the above table and graph, clients overall are typically averaging 24 or less visits per year, which is at best twice a month. Even if we very conservatively assume that MSIC clients as an overall average inject just once daily or 30 times per month, each individual would still be injecting 28 out of every 30 times outside the facility.

Looking at the graph above, 93-95% of clients, depending on the year, are injecting 98 times a year or less, which at maximum is a little over 3 injections per month in the facility. There can be no question that the vast majority of client injections are outside the facility, signifying that the enormous number of overdoses inside the facility should be replicated by those same clients on the street. But they are not.

APPENDIX A

Demonstrably False 'Lives Saved' Estimates

'Lives saved' estimates either partisan or inept

Starting with the SAHA evaluation of 2008, which claimed that the injecting room saved 25 lives per year, the estimate is immediately falsified by the actual fatalities in the Kings Cross area as displayed on page 19 of the 2010 KPMG government-funded evaluation (Go to http://www.health.nsw.gov.au/mentalhealth/programs/da/Documents/msic-kpmg.pdf - p 112),

Table 3-1: Opioid-related deaths

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	Total
Kings Cross	63 (13%)	42 (12%)	33 (11%)	10 (7%)	15 (10%)	26 (16%)	14 (10%)	7 (12%)	10 (12%)	13 (13%)	6 (9%)	239 (12%)
Rest of NSW	437 (87%)	303 (88%)	254 (89%)	136 (93%)	133 (90%)	134 (84%)	125 (90%)	52 (88%)	74 (88%)	90 (87%)	61 (91%)	1,799 (88%)
Total	**500**	**345**	**287**	**146**	**148**	**160**	**139**	**59**	**84**	**103**	**67**	**2,038**

Source: NSW Division of Analytical Laboratories (DAL)

We will generously take the MSIC's Bernadette O'Keefe's overly conservative estimate that there were only 600 opiate injectors injecting 3 times per day in Kings Cross, rather than the 2,000 estimated by the injecting room's own 2003 evaluators (we note that the 2003 evaluation listed 870 MSIC clients LIVING in the Kings Cross/Darlinghurst area in the first 18 months of operation, quite apart from all the other injectors travelling in by train to buy drugs daily – Go to page 17 of https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf and for estimate of 2,000 per day see page 58).

This yields the following table which shows the enormous disparity between the tiny proportion of Kings Cross area opiate injections **inside** the facility (9%) versus those **outside** (91%). Alongside these two columns are the inordinately high number of purported deaths supposedly averted in the facility (25 per year in the 3rd column) compared to the much lower number of actual deaths outside the facility in the last column.

Year	Inside the Injecting Room		Streets of Kings Cross/Darlinghurst	
	Percentage of Kings Cross injections	Claimed number of deaths averted - SAHA	Percentage of Kings Cross injections	Actual number of deaths
2002/3	9%	25	91%	15
2003/4	9%	25	91%	26
2004/5	9%	25	91%	14
2005/6	9%	25	91%	7
2006/7	9%	25	91%	10
2007/8	9%	25	91%	13
2008/9	9%	25	91%	6

This disparity renders the SAHA claims preposterous when it is again recognised that clients perform the vast majority of their injections OUTSIDE the injecting room. Out there, there are far fewer deaths actually occurring from 91% of Kings Cross injections than what SAHA projects for the facility from 9%.

Calculating from unassessed injecting room overdoses is not science

The 2003 injecting room evaluators, most of whom were colleagues of the then Medical Director at NSW University, (see https://www.dalgarnoinstitute.org.au/images/resources/pdf/injecting-rooms/DFA_Injecting_Room_Detailed_Research.pdf pp 35-6) calculated that between 6 and 13 lives had been saved in the first 18 months of the injecting room's operation.

These evaluators, for both estimates, calculated from the inflated overdose numbers in the injecting room, (go to https://uniting.org/__data/assets/pdf_file/0007/136438/MSIC-final-evaluation-report-2003.pdf p59) without performing the most basic first step required in any statistical calculation – comparing the overdose rates inside the facility with outside the facility to gauge whether the safety of the room was artificially inflating the number of overdoses. This is a requirement of Statistics 101, but the evaluators failed to do it. The 2003 evaluators, as with the SAHA evaluators, could well have used a number of methods by which the rates of overdose inside the injecting room could be compared to known data outside the facility.

> Clients previous overdose rates – 32 times less than in the injecting room
> Ambulance callouts in the area – 36 times less than in the injecting room
> Cohort studies of heroin users within Australia and their recorded overdoses

Calculating from artificially inflated overdose numbers in the injecting room is simply not science and is either inept or calculated to deceive.

Canadian study of lives saved discredited

Injecting room supporters will point to the 2011 Canadian study of Vancouver's Safe Injection Facility called Insite, with an associated Lancet study's claim that a significant number of deaths were demonstrably averted inside it.

The claims of this study were summarised in its abstract, (http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)62353-7.pdf)

> ***Methods*** We examined population-based overdose mortality rates for the period before (Jan 1, 2001, to Sept 20, 2003) and after (Sept 21, 2003, to Dec 31, 2005) the opening of the Vancouver SIF. The location of death was determined from provincial coroner records. We compared overdose fatality rates within an a priori specified 500 m radius of the SIF and for the rest of the city.
> ***Findings*** Of 290 decedents, 229 (79.0%) were male, and the median age at death was 40 years (IQR 32-48 years). A third (89, 30.7%) of deaths occurred in city blocks within 500 m of the SIF. The fatal overdose rate in this area decreased by 35.0% after the opening of the SIF, from 253.8 to 165.1 deaths per 100 000 person-years (p=0.048). By contrast, during the same period, the fatal overdose rate in the rest of the city decreased by only 9.3%, from 7.6 to 6.9 deaths per 100 000 person-years (p=0.490). There was a significant interaction of rate differences across strata (p=0.049).

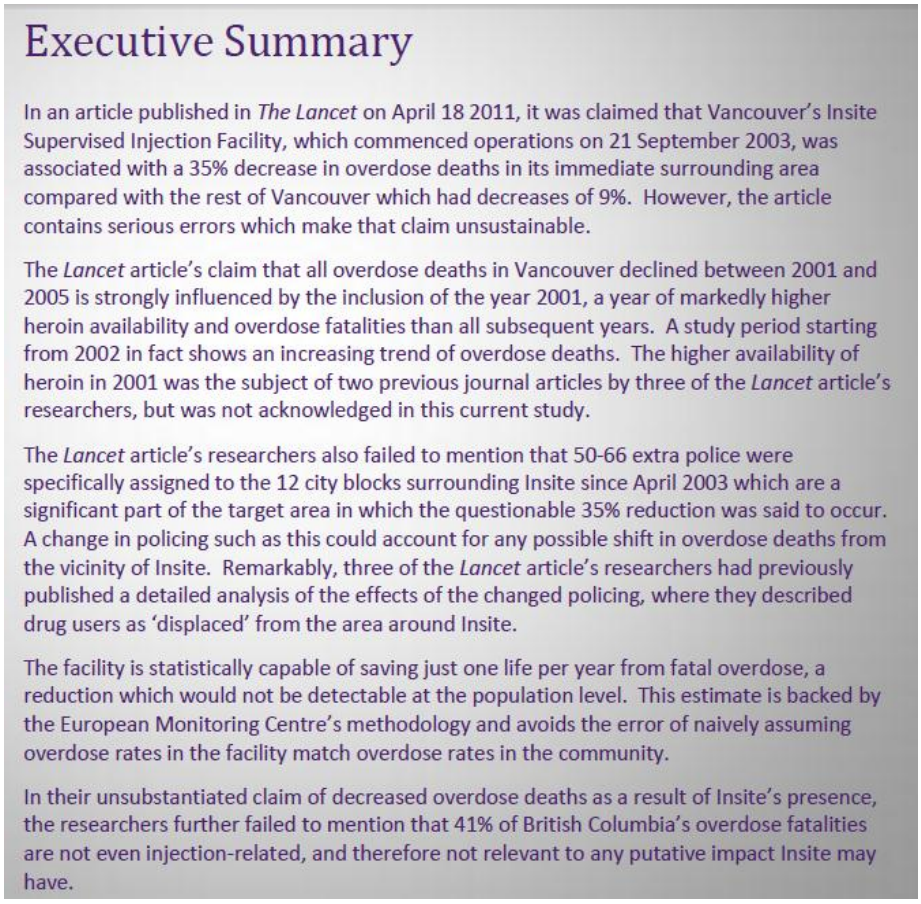
However the study used sleight of hand by including 2001 in their pre-Insite comparison period, artificially producing an appearance of decreased deaths in Vancouver when they were in fact rising since 2002, the year before Insite opened. Copied below are the official Coroner's data reproduced from their website below. (Go to https://web.archive.org/web/20101105115715/http://www.pssg.gov.bc.ca/coroners/publications/docs/stats-illicitdrugdeaths-1997-2007.pdf)

BC Coroners Service
Illicit Drug Deaths 1997 to 2007

Ministry of Public Safety and Solicitor General

Town / City	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997
Ucluelet	0	0	0	0	0	0	0	0	0	0	1
Vancouver	56	54	55	67	51	49	90	87	108	191	140
Vanderhoof	0	0	0	0	1	0	0	0	0	0	0

This was the least of the study's issues though. It also failed to declare significant changes in policing at the mid-point of their study, changes which demonstrably produced the positive results they were claiming for the injection facility. Drug Free Australia was involved in exposing the errors in the study, as per our analysis summarised below, (Go to http://www.drugfree.org.au/fileadmin/library/Policies_Legislation_and_law/DFA_Analysis_Injecting_Room_2010.pdf)



Executive Summary

In an article published in *The Lancet* on April 18 2011, it was claimed that Vancouver's Insite Supervised Injection Facility, which commenced operations on 21 September 2003, was associated with a 35% decrease in overdose deaths in its immediate surrounding area compared with the rest of Vancouver which had decreases of 9%. However, the article contains serious errors which make that claim unsustainable.

The *Lancet* article's claim that all overdose deaths in Vancouver declined between 2001 and 2005 is strongly influenced by the inclusion of the year 2001, a year of markedly higher heroin availability and overdose fatalities than all subsequent years. A study period starting from 2002 in fact shows an increasing trend of overdose deaths. The higher availability of heroin in 2001 was the subject of two previous journal articles by three of the *Lancet* article's researchers, but was not acknowledged in this current study.

The *Lancet* article's researchers also failed to mention that 50-66 extra police were specifically assigned to the 12 city blocks surrounding Insite since April 2003 which are a significant part of the target area in which the questionable 35% reduction was said to occur. A change in policing such as this could account for any possible shift in overdose deaths from the vicinity of Insite. Remarkably, three of the *Lancet* article's researchers had previously published a detailed analysis of the effects of the changed policing, where they described drug users as 'displaced' from the area around Insite.

The facility is statistically capable of saving just one life per year from fatal overdose, a reduction which would not be detectable at the population level. This estimate is backed by the European Monitoring Centre's methodology and avoids the error of naively assuming overdose rates in the facility match overdose rates in the community.

In their unsubstantiated claim of decreased overdose deaths as a result of Insite's presence, the researchers further failed to mention that 41% of British Columbia's overdose fatalities are not even injection-related, and therefore not relevant to any putative impact Insite may have.

A Drug Free Australia letter was published in Lancet (go to http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673612600543.pdf) to which a response was published by the reseachers on the following page (go to http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60055-5.pdf).

Most notably, the researchers defended their error regarding policing changes by appealing to a document that in fact did NOT support their faulty assertion (go to http://curtgriffiths.com/wp-content/uploads/pdfs/CET-evaluation.pdf p 49). Further, Drug Free Australia forwarded a letter from the then Police Commander confirming that the changed policing was operative during the entire second comparison period, thus destroying their conclusions.

STATEMENT TO LANCET

Beat Enforcement Team (BET) - Vancouver Police Department 2003 - 2006

John Mc-Kay - then Officer in Charge (BET)

Downtown East Side Vancouver - Policing Rationale

The inception of what eventually became known as the Beat Enforcement Team (BET) occurred in early 2003. At that time the Vancouver Police Department recognized that the Vancouver Agreement between 3 levels of government with the so called " 4 Pillars approach" was going to have a major effect on the VPD's ability to successfully police the Down Town East Side (DTES) of Vancouver. This was largely due to the harm reduction pillar which emphasized the value of the Supervised Injection Site which was going to be located in the heart of the DTES in the 100 block of East Hastings.

While the VPD could not at the time argue against the 4 Pillars approach – harm reductionists using

Summary – the science on 'lives saved'

To summarise, the two Kings Cross injecting room evaluations calculated their improbable estimates of lives saved from the number of overdoses in the facility without assessing whether the number of overdoses were comparable to street rates of overdose or rather highly inflated by the safety provided by its supervision.

The Canadian study failed to disclose a tripling of police numbers in the 12 city blocks surrounding the Vancouver injection facility and did not disclose their newly implemented zero tolerance approach to drugs in the months before Insite opened. Nor, against the evidence from multiple sources, including a statement by the then police commander in charge of the operations, did they ever admit that they were wrong in claiming that the policing lasted for only 6 months. Their study has been clearly discredited.

The European Monitoring Centre (EMCDDA) report on the European injecting rooms claimed 10 lives cumulatively saved per year by the 25 injecting rooms in Germany. (Go to http://www.salledeconsommation.fr/_media/dagmar-hedrich-european-report-on-drug-consumption-rooms-oedt-2004-2.pdf p54) However Hedrich's calculations based on 2% of opiate users overdosing each year is excessively high when it is considered that the EMCDDA's own cohort studies of opiate user mortality (see http://www.emcdda.europa.eu/system/files/publications/119/EMCDDA-cohort-study-mortality-drug-users-2000.pdf) which ranged from a low of 0.2% in Austria and Italy, to no more than 1.4% in Spain. At a more realistic 1% mortality for users, the 25 injecting rooms cumulatively save 5 lives per year.

Ultimately, there are no credible studies demonstrating more than one life saved per year by any single injecting room, and this at a cost of $3 million per life saved.

APPENDIX B

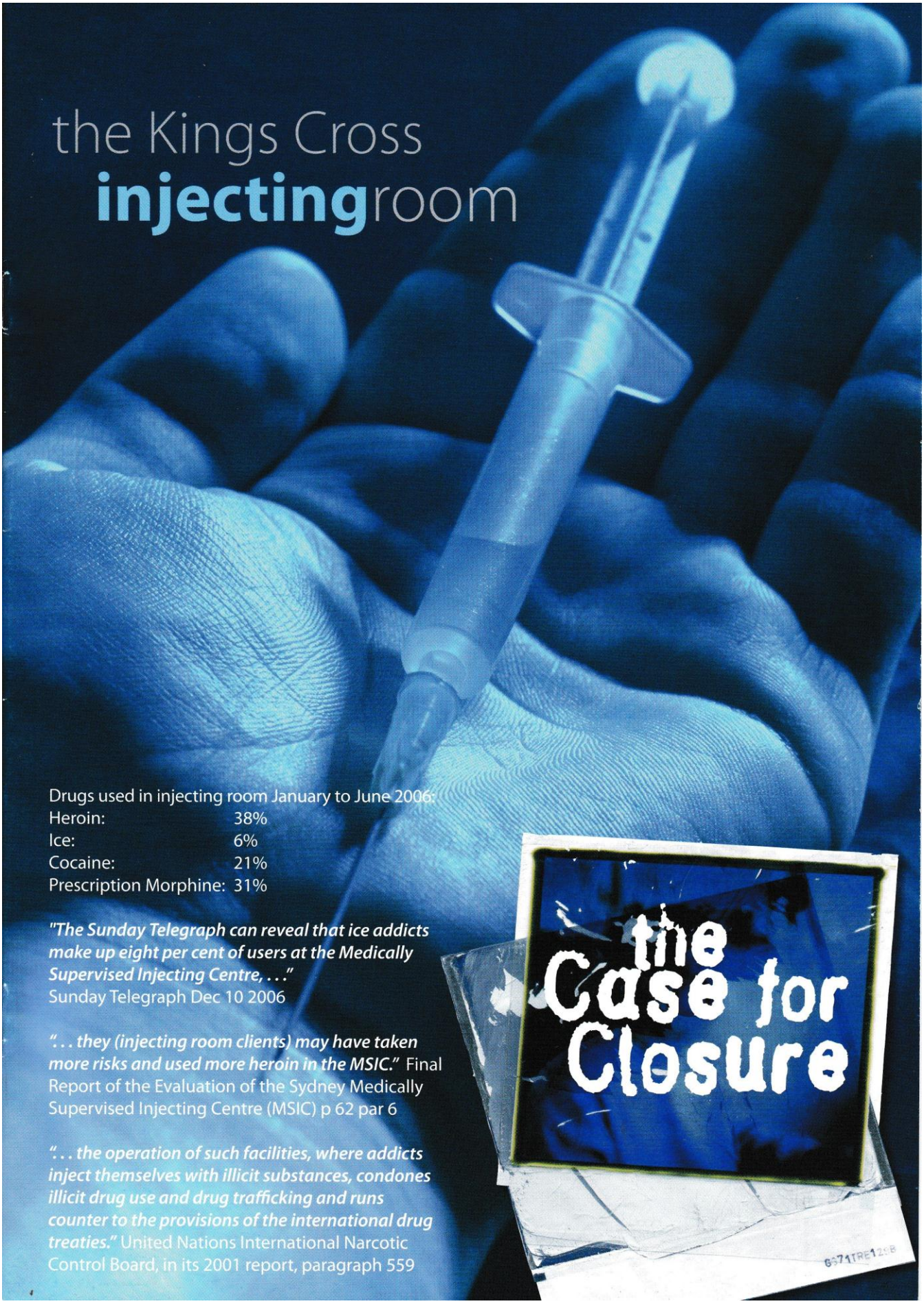
Drug Free Australia Analysis of the 2003 Injecting Room Evaluation

Analysis by:

Dr Joe Santamaria	Epidemiologist, previous Head of Community Medicine, St Vincent's Hospital Melbourne
Dr Stuart Reece	Addiction Medicine Specialist - Brisbane
Dr Greg Pike	Director of Southern Cross Bio-ethics Centre, Adelaide
Dr Lucy Sullivan	Social Researcher – Centre for Independent Studies
Mr Gary Christian	Senior Manager, Welfare – Mission Australia and ADRA Australia

Other issues for the injecting room dealt with in the 2003 analysis are:

1. Facility flouting International Narcotic Control Board stipulations p 1, 3
2. Propaganda campaign in the media repeated false statisitics p 2
3. Other drugs used in the facility p 5
4. Very low referral rates to treatment or rehab p 3, 10
5. No improvement in public amenity p 3,5
6. The non-independence of government-funded evaluation p 3
7. The confirmed honey-pot effect p 5
8. No change in blood-borne diseases such as HIV, Hep B and C p 7
9. Drug dealing at the front and back doors p 7
10. No perceptible improvement in new needle and syringe use p 7
11. False issue of "unremembered overdoses" p 10
12. Recommendations p 12


the Kings Cross
injectingroom
Drugs used in injecting room January to June 2006:
Heroin: 38%
Ice: 6%
Cocaine: 21%
Prescription Morphine: 31%
"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
". . . they (injecting room clients) may have taken more risks and used more heroin in the MSIC." Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre (MSIC) p 62 par 6
". . . 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
the Case for Closure

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:

"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

"In the first month of operation, **four lives were saved** . . ."
John Della Bosca, NSW Special Minister of State, NSW Legislative Council Hansard 4 July 2001 based on Dr van Beek's claims

"Since its controversial opening three months ago, the Sydney Kings Cross centre . . . says its staff has **saved more than a dozen lives** from overdoses."
Reporter Joe O'Brien The World Today Archive - Wednesday, 15 August , 2001

"The visit concluded with a public forum . . . . 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.**"
http://www.hepatitisc.org.au/resources/documents/36_01.pdf

"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.**"
The Hon Bryce Gaudry MP, NSW Legislative Assembly Hansard 29 May 2002 based on claims by Dr van Beek

"A final report on the controversial Kings Cross injecting centre is expected to declare it a resounding success that has **saved hundreds of lives.**"
Steve Dow & Frank Walker – Sun-Herald June 15 2003

Why was this error continually not corrected?

Drug Free Australia is the peak organisation for organisations and family associations around Australia that seek the prevention of illicit drug use.

Drug Free Australia's vision is:
Communities are well-informed about the harms of illicit drugs and empowered with anti-drug strategies

Drug Free Australia Ltd, ACN 102 169 139
National Office: PO Box 497, Elizabeth SA 5112
Phone: 08 8287 6815
Fax: 08 8255 2768
E-mail: admin@drugfree.org.au

DFA DRUG free AUSTRALIA

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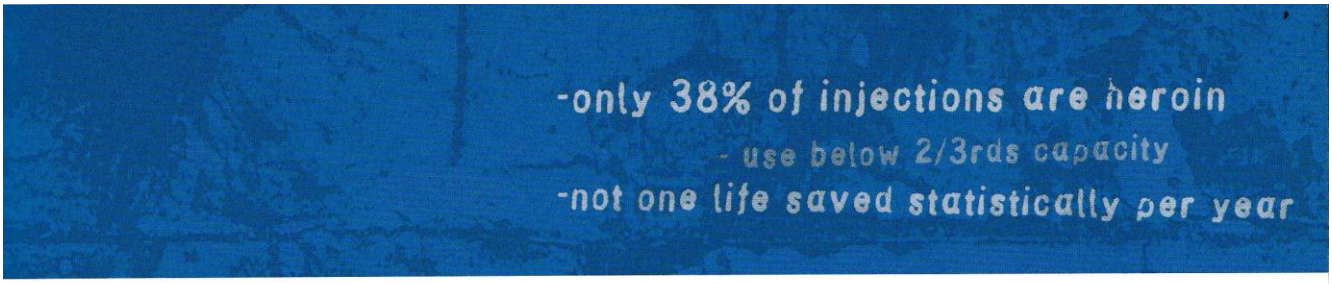


10 crucial things you need to know

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.

For the exhaustive 60 page DFA analysis backing this booklet, please go www.drugfreeaustralia.org.au

3

Statistically impossible to save even one life per year (cost: $2.5 million per annum)

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

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

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.

High Cost for Little Benefit

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

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.

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. [1]

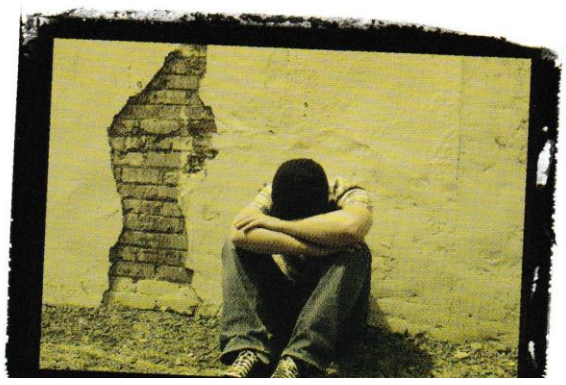
In each case respondents were asked whether they would use an injecting room if made available. 3.6% replied they would. Yet only 1.6% in the 2001 National Drug Strategy Household Survey indicated prior use of heroin. Alarmingly, 26 of the 28 who replied affirmatively in the 2002 survey had never tried heroin before. If more injecting rooms were opened this could lead to much higher heroin use.

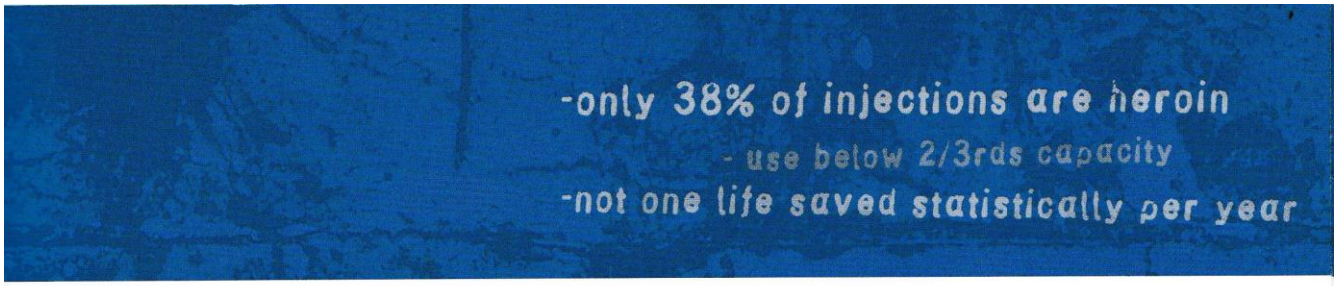
1. MSIC Evaluation; p 158

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.





Inject anything you want in an under-used facility

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%[1]

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.

Running at 2/3rds capacity

Despite almost 900 injecting room clients living within walking distance of the facility[2], the injecting room has averaged just 200 injections per day[3], despite a capacity for 330 injections per day[4].

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 - experimentation with high doses of heroin.

1 Report from Dr A. Byrne, Update, 21/7/2006
2 MSIC Evaluation, p 17
3 Report from Dr A. Byrne, Update, 21/7/2006
4 MSIC Evaluation p 38

An evident honey-pot effect?

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

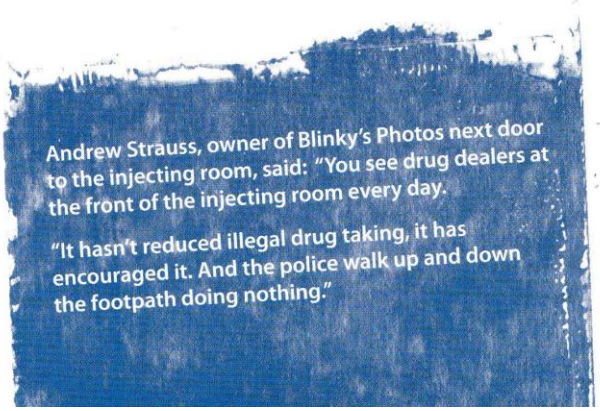
The following was stated in the injecting room's own government-funded evaluation of 2003.

"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, 12 months interview – p 146)"

"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.**"
(MSIC Evaluation p 146)

"The increase in loitering was considered to be a displacement of existing **users and dealers** from other locations."
(MSIC Evaluation p 146)

"**The train station never featured as a meeting place before.** It used to be Springfield Mall and Roslyn Street."
(Police 12 month interview – p 147)



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5

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.

KINGS CROSS	July '00	July '02	Change
Local Residents			
Observed discarded syringes	38%	35%	-8%
Observed public injecting	10%	8%	-20%
Local Business			
Observed discarded syringes	35%	31%	-11%
Observed public injecting	9%	9%	-0%
Needle/Syringe Counts			
KRC Needle Exchange clean-up team	60%	55%	-8%
Injecting room staff research team	7	3	-57%
South Sydney Council clean-up	284	240	-15%

19% decrease in needle distribution due to heroin drought

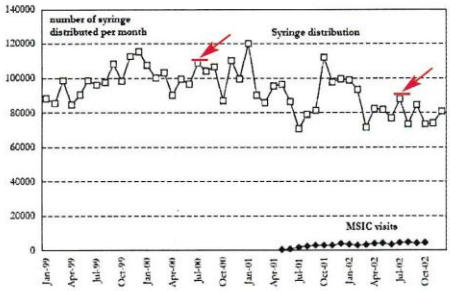
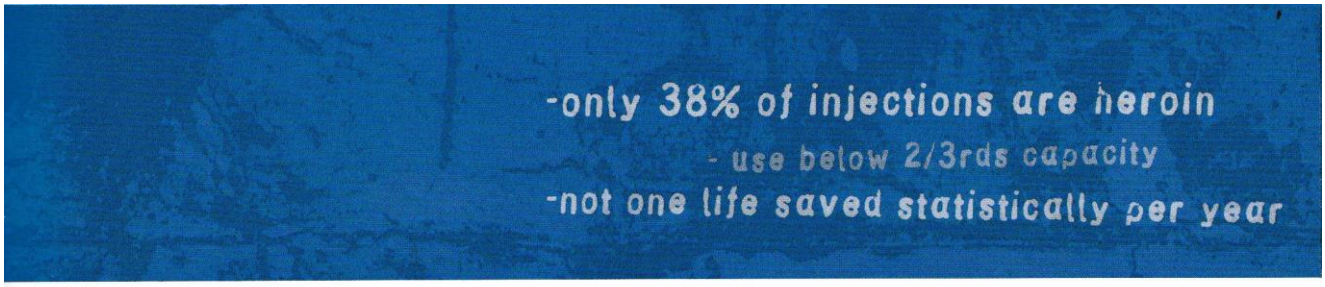


Figure 6.6: Syringe distribution from major NSP and pharmacy services in the Kings Cross/Darlinghurst area and MSIC visits, January 1999 – December 2002



Injecting room Scorecard –

No demonstrated success

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.

Number of overdose deaths in the area	no evidence of any impact p 62
Ambulance overdose attendances in the area	no evidence of any impact p 61
Ambulance overdose attendance during hours the injecting room was open	no evidence of any impact p 60
Overdose presentations at hospital emergency wards	no evidence of any impact p 60
HIV infections amongst injecting drug users	worsened p 71
Hep B infections	no improvement p 71
Notifications of newly-diagnosed Hep C	worsened p 71
Frequency of public injection	injection on the street - 57% (2001) to 46% (2002) in a public toilet - 40% (2001) to 33% (2002)use of commercial shooting galleries - 16% (2001) to 14% (2002) p 94
New needle and syringe use	no advantage by injecting room over the nearby needle-exchange p 92
Re-use of someone else's syringe	no improvement p 93
Re-use of injecting equipment other than syringes	no improvement p 93
Tests taken for HIV and Hep C	no improvement p 96
Tests taken for Hep B	improved in 2001, worsened in 2002 p 98
Referrals to drug rehab and treatment	extremely poor - 8% of clients referred to methadone or buprenorphine maintenance. Only 4.7% referred to abstinence-based detox or residential rehab pp 98-99
Publicly discarded syringes	declined and increased in line with the number of distributed needles during heroin drought pp 116-122
Perception of public nuisance caused by drug use	decreased only in line with heroin drought impact p 113
Public injections sighted	mixed – residents reported less in line with heroin drought impact, businesses reported no improvement p 116
Acquisitive crime (break & enter etc)	no improvement p 147
Drug dealing at rear door of MSIC	continual p 148
Drug dealing at Kings Cross station	worsened p 149
Injecting related health/vein care	improved, but can be viewed as teaching people how to be better junkies

*** These results recorded in the government-funded evaluation of the injecting room*

For the exhaustive 60 page DFA analysis backing this booklet, please go www.drugfreeaustralia.org.au

7

Massive rates of overdose... Why?

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 other known overdose rates that can be compared:

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

1 36 Times Higher than Streets of Kings Cross

The government-funded evaluation recorded 329 heroin overdoses in the first eighteen months of injecting room operation. There were roughly 35,000 heroin injections in the room during that period, resulting in an overdose for every **106** heroin injections in the room.

The same evaluation estimated that there were 6,000 heroin injections happening every day in Kings Cross (or 3.2 million injections during the evaluation period of eighteen months). Using Kings Cross ambulance call-out rates for heroin overdose during that same period, there were an estimated 845 overdoses outside the injecting room for all those millions of injections. The rate of overdose for Kings Cross was one overdose for every **3,820** injections.

The injecting room had 36 times more overdoses than on the streets outside in Kings Cross – a staggering rate of overdose.

2 At Least 40 Times Higher than MSIC Client's Previous History

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.

Yet inside the injecting room these very same heroin addicts averaged an overdose rate of 10 per year per client. This is more than 40 times higher than their recorded previous rate of overdose before entering the injecting room.

3 49 Times Higher than Estimated National Overdose Averages

The last official estimate of 74,000 dependant heroin users within Australia was for 1997.

In that same year there was an estimated 15,600 overdoses, of which exactly 600 were fatal.

At a conservative 3 injections per day, 74,000 heroin users would inject 81,030,000 times per year with an overdose for every **5,200** injections. Yet the injecting room had an overdose for every **106** injections in its facility – 49 times higher.

Why so many overdoses?

The injecting room's own evaluation on page 62 stated that:

"In this study of the Sydney MSIC there were 9.2 (sic) 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 explanation of higher-risk clients does not accord with the facts (see page 9) but the alternate explanation of clients using higher doses of heroin means that the injecting room is significantly adding to the profits of the local drug dealers. This should be a major concern for NSW residents.

-only 38% of injections are heroin
- use below 2/3rds capacity
-not one life saved statistically per year

Exposing the myths about overdose & the injecting room

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, . . ."[1]

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."[2]

Myth 3 - Heroin overdoses are caused by street heroin being 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. [3]

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.

1 MSIC Evaluation p 59
2 ANCD Research Paper No 1 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions p xi
3 ANCD Research Paper No 1 'Heroin Overdose p xiii

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."
"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' pp xi,xii

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Frequently asked Questions

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 Last 12mths
Injecting Room 2002	44%	12%
Aust. IDRS study 1999	51%	29%
Sydney study 1996	68%	20%
British study 1999	58%	30%

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.

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[2] 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.**

Another study[3] 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.

1 ANCD Research Paper No 1 'Heroin Overdose p 10
2 Darke, Shane and Zador, Deborah, "Fatal Heroin 'Overdose': A Review." Addiction. 1996; 91(12): pp. 1765-1772.
3 see Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre p 59

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

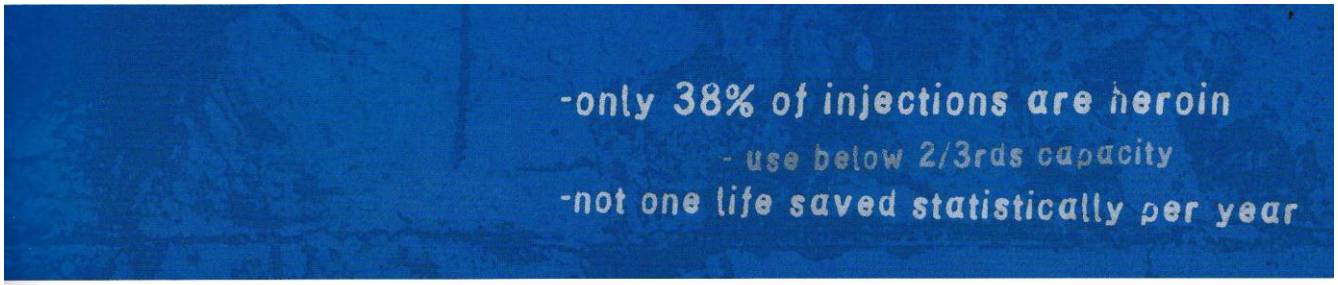
Nationally, acceptance of the injecting room is not that high. However it may be that those in favour have believed it is saving hundreds of lives, as promoted, when this is clearly not the case. See page 2 of this document.

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.

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.



Prevention/early intervention or harm-minimisation what's best?

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.

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 minimisation still predominating. It is certain that these decreases have not been produced by harm minimisation but by prevention strategies.

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.

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.

Rehabilitation Successful

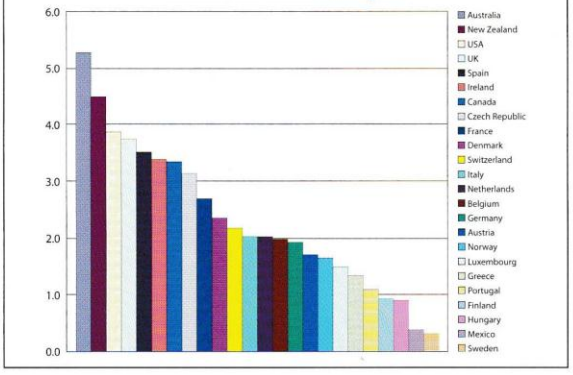
A key to the success of the Swedish model is mandatory drug rehabilitation for those found addicted to drugs. Swedish school education does not assume, as does Australian school education material produced by the Australian Drug Foundation, that illicit drug use is normal or should be socially accepted.

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.

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.

OECD Countries – Cumulative Average of all Illicit Drugs Used United Nations 2004 Report



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-only 38% of injections are heroin
- use below 2/3rds capacity
-not one life saved statistically per year

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).

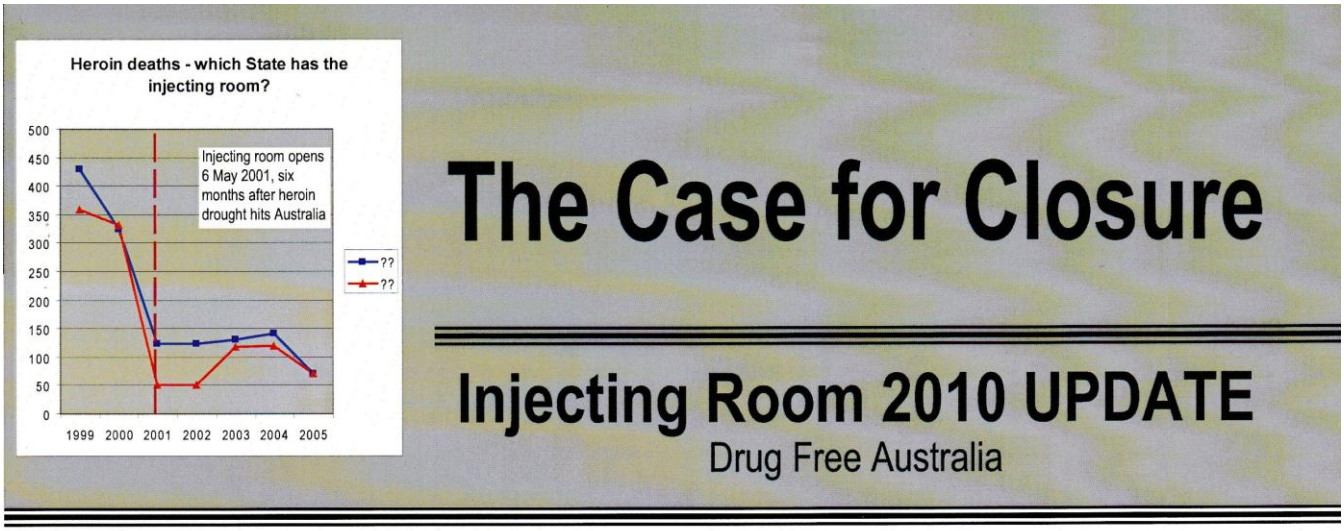
- only 38% of injections are heroin
- use below 2/3rds capacity
- not even one life saved per year statistically
- 36 times more overdoses than on the street
- more heroin sold by dealers
- $2.5 million per year to operate
- no improvement to public amenity
- clear honey-pot effect established
- in contravention of UN Conventions

KDR DESIGN (02) 4365 4010

This booklet draws much of its evidence from the Drug Free Australia's 2003 critique of the injecting room's own evaluation done by 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).

APPENDIX C

Drug Free Australia Analysis of the 2007 Claims About Ambulance Callout Reductions



INJECTING ROOM REDUCES AMBULANCE CALLOUTS?

EVALUATORS DEMONSTRABLY WRONG . . . AGAIN

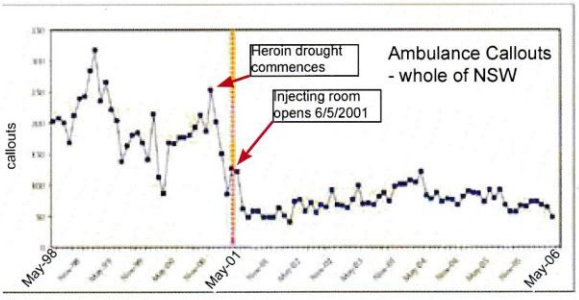
A 2007 injecting room evaluation concluded the facility had, along with the heroin drought, reduced ambulance overdose callouts in Kings Cross by 80%, with nearby Darlinghurst down only 45%.

NSW Parliamentarians favourable to the injecting room consequently trumpeted this reduction as evidence of the effectiveness of the injecting room (NSW LA Hansard, June 20, 2007).

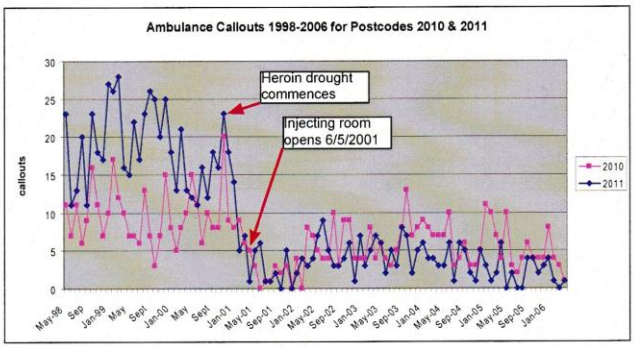
Drug Free Australia calculations demonstrate the injecting room can, at best, reduce ambulance overdose callouts by 13 per year (against a pre-heroin drought yearly average of 208 for Kings Cross). But the evaluators' claims are demonstrably wrong.

Heroin drought responsible for most reductions

Below is a graph of ambulance callouts for the whole of NSW from 1998 to 2006, showing the 61% reduction in callouts due to the heroin drought which intervened roughly 6 months before the May 2001 opening of the injecting room in Kings Cross.



The injecting room's Kings Cross 2011 postcode (the blue line in the following graph) did have much larger decreases in overdose callouts than the rest of NSW above, in fact 19% more with its 80% reduction.

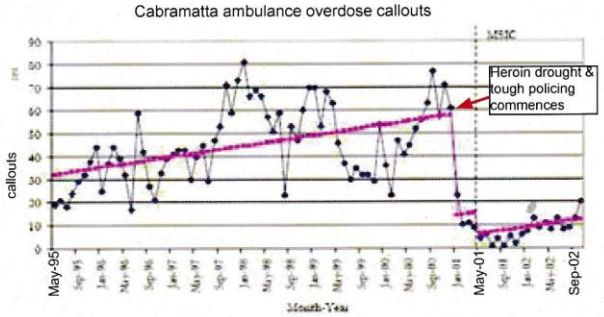


But very curiously, nearby Darlinghurst (postcode 2010 in pink) had only a 45% decrease in callouts (16% LESS THAN decreases for the rest of NSW)! Note the fewer overdoses for 2010 *before the drought*, and higher overdoses for 2010 *during the drought*. Quite clearly something was responsible for moving drug users, with their overdoses, from Kings Cross to Darlinghurst via a very evident displacement effect.

Why no mention of the police sniffer dogs?

Tougher policing with sniffer dogs predominantly in the Kings Cross area began in May 2002 (ABC news item, May 18 2002), 12 months after the injecting room opened. But there is not one word about sniffer dogs or increased law enforcement anywhere in the evaluation, despite plenty of media about the changes.

Why didn't the evaluators and NSW Parliamentarians ever mention tougher policing with sniffer dogs as the likely factor reducing ambulance callouts in Kings Cross? When introduced to Cabramatta, sniffer dogs, along with associated policing measures, reduced ambulance callouts by 83% as can be seen below.



Final Scorecard

The 1999 Drug Summit aims for the Kings Cross injecting room were to 1. reduce mortality and morbidity of injecting drug use 2. provide a gateway to treatment and 3. improve public amenity, reducing public injecting and discarded needles

	Evaluation Indicator	2003 Evaluation Outcome	2004-2007 Evaluation Outcomes
saved lives	Overdose deaths in the area	no evidence of any impact p 62	2007 evaluation found no measurable impact
	Ambulance overdose attendances in the area	no evidence of any impact p 61	not the object of later studies
	Ambulance overdose attendance during hours the injecting room was open	no evidence of any impact p 60	2007 evaluation found 80% reduction in Kings Cross but made no mention whatsoever of changed policing of hot-spots in 2002 with sniffer dogs - a likely cause
	Overdose presentations at hospital emergency wards	no evidence of any impact p 60	2007 evaluation could not obtain sufficient data for comparison
blood-borne virus	HIV infections amongst injecting drug users	worsened p 71	no later studies on blood-borne virus transmission but see Drug Free Australia's publication, "The Reality on Government Needle Programs" showing no weight of scientific studies supporting success worldwide
	Hep B infections	no improvement p 71	
	Notifications of newly-diagnosed Hep C	worsened p 71	
	New needle and syringe use	no advantage displayed by injecting room over the nearby needle-exchange p 92	MSIC attenders reported higher levels of sharing than non-attenders in 2003, 2004 and 2005
	Re-use of someone else's syringe	no improvement p 93	
	Re-use of injecting equipment other than syringes	no improvement p 93	
	Tests taken for HIV and Hep C	no improvement p 96	not the object of later studies
	Tests taken for Hep B	improved in 2001, worsened in 2002 p 98	not the object of later studies
refer	Referrals to drug rehab and treatment	extremely poor - 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	the 2007 evaluation found 11% of clients had been referred to treatment/rehab/detox, the same % as in the 2003 evaluation. However referral uptake by clients moved from 20% in 2002 to 84% in 2007
public amenity	Publicly discarded syringes	while needle handouts reduced by 19% due to the heroin drought, discarded needles markedly increased on 2 streets closest to the injecting room, or further from the room, failed to keep pace with reductions in distribution pp. 117-123	the June 2007 evaluation found a 48% decrease in publicly discarded needles after the injecting room opened but made no mention that this was the result of the heroin drought & tougher policing
	Client self-report of frequency of public injection	injection on the street - 57% (2001) to 46% (2002) in a public toilet - 40% (2001) to 33% (2002), in a squat - 13% in both years, use of commercial shooting galleries - 16% (2001) and 14% (2002) p 94 yet discarded needles relatively increased	self-report of clients re public injection in the prior month yielded lower levels than 2001 for 2002, 2003 and 2004, but 2005 had similar levels to 2001, the year the injecting room opened
	Perception of public nuisance caused by drug use	decreased only in in line with reduced demand due to heroin drought impact p 113	the 2005 study found some slight decreases in perceptions of public nuisance but failed to mention tougher policing from 2002 on
	Public injections sighted	mixed - residents reported less in direct comparison to heroin drought impact, businesses reported no improvement p 116	in the 2005 study there was a marked decrease in sightings of public injection - the evaluation made no mention of tougher policing with sniffer dogs as a likely cause
	Acquisitive crime (break & enter etc)	no improvement p 147	decreases in crime in 2006 and 2008 only in line with increased enforcement levels and heroin shortage
	Drug dealing at rear door of MSIC	continual p 148	a 2008 study found that while drug offences within 50m of the MSIC were a small proportion of the whole of Kings Cross, there were increases in the number of incidents in the proximity of the MSIC, such as at the station opposite
	Drug dealing at Kings Cross station	worsened along with drug user loitering at the station entrance 25 metres opposite the front door of the MSIC, evident particualrly during injecting room opening hours p 149	

The injecting room scorecard indicates substantial failure on each Drug Summit objective. Other data indicates increased drug use and drug dealing due to the MSIC and a clear honey-pot effect outside its doors - see the Case for Closure 12 pager www.drugfree.org.au

APPENDIX D

Executive Summary of Drug Free Australia's Analysis of the KPMG 2010 Injecting Room Evaluation

Contributors to this Drug Free Australia analysis were:

Dr Robert DuPont	First President of the United States' National Institute of Drug Abuse (NIDA)
Dr Kerstin Käll	Clinic for Dependency Disorders, University of Linkoping, Sweden
Frans Koopmans	Director of Communications, De Hoop Foundation, the Netherlands
Dr Neil McKeganey	Centre for Drug Misuse Research, University of Glasgow, Scotland
Dr Greg Pike	Director, Southern Cross Bioethics Institute, South Australia
Dr Stuart Reece	Addiction Medicine practitioner, Queensland
Dr Joe Santamaria	Epidemiologist, retired Dept Head of Community Medicine, St Vincents Hospital, Victoria
Dr Charles Slack	Retired Asst Professor of Psychology, Harvard University, teacher, researcher, Western Australia

Executive Summary

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

Client Characteristics

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

Regarding the following MSIC objectives:

1 Decreasing overdose deaths

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

2 Providing a gateway to drug treatment

- The KPMG evaluation reports 3,871 referrals to drug treatment or counseling without indicating the very low percentage of clients receiving those referrals. In 2003 and 2007

the percentage was just 11% of clients, which in light of known motivations of drug users to quit, has been abnormally and unjustifiably low.

3 Reducing discarded needles and drug use in public places

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

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

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

Conclusion

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