

Drug Free Australia

**A CRITICAL RESPONSE TO THE
KINGS CROSS INJECTING ROOM 2003 REPORT**

Reporting on the Report

That takes injecting addicts on a road to nowhere in

The Kings Cross Injecting Room

*** Insert opening letter here**

INTRODUCTION

Drug Free Australia welcomed the findings of the Federal Parliamentary Substance Abuse Inquiry tabled earlier this week, calling for prevention to replace harm minimisation as the national drug policy focus.

In adopting such recommendations across all levels of government we are calling for the immediate closure of the Kings Cross MSIC.

The injecting room, although initially tolerated by the people of NSW continues to operate under a cloud for the following reasons:

- the variety of illicit drugs used were not limited to those for which the room was established**
- drugs would be used in a manner which placed the room and related activities in contravention of State laws and international conventions**
- public reservations about helping addicts inject illicit drugs purchased with the proceeds of crime and illegally injected**
- inflated figures (overdoses) and other reported data not audited or independently verified**
- even keen supporters now admitting that cost blow-outs have put the injecting room beyond what can be publicly justified.**

It is recognised that the Carr government needed to explore the options provided by its drug policy advisors, but in doing so has now exhausted the need to continue the injecting room experiment.

In calling for the injecting room intervention, the government's drug policy advisors have caused millions of dollars to be wasted along with tens of thousands of lost opportunities for improving the drug user's lot. Worse, they have presided over a program that continued criminal rackets instead of reducing them. They favoured drug suppliers and users over local residents and businesses which are affected by the honey-pot effect of the Centre for drug dealers.

The injecting room is in breach of international agreements, and some still argue that it should not continue to assist with the activities of illicit drug users in their use of illicit substances. Rather it should be more concerned with prevention, treatment and rehabilitation.

10 RECOMMENDATIONS

1. **IMMEDIATE CLOSURE** - In light of the magnitude and long established problem of illicit drug use imposed on the Kings Cross community, the number of people affected directly or indirectly by the injecting room and its continued facilitation of increased drug use and increased local crime statistics, we recommend the immediate closure of the Kings Cross Injecting Centre, with funds to be diverted into treatment/rehabilitation programs and otherwise targeted publicity aimed at users to advise them of their treatment and rehabilitation options.
2. **CONSISTENT MESSAGES** – It is important that there is a consistent message in drug policy that is clear and uncompromising. Acceptance, even tacit assistance, of illicit drug use sends a mixed and compromised message to young people. The immediate closure of the injecting room will give recognition to the valid concerns of community groups and parents about this message.
3. **BOLD AND BRAVE GOALS** – Around the world there are numerous examples of cities, suburbs or towns that turned their community, public image and economic viability around. While not a magic bullet, the goal to clean up the Cross, or even become a drug free State must begin somewhere. We recommend that the NSW Government make a bold and sweeping aim of cleaning up NSW from Kings Cross to Cabramatta and beyond in the next three years. While absolutes may be unrealistic, such a goal and focus could direct significant efforts into halving this problem in the term of this government. This message is one that is realistic and needs to be sent to the entire community, particularly the State’s young people to acknowledge that it is their lives and futures we are fighting for in holding back the illicit drug cartels.
4. **ANTI-ADDICTION, ANTI-INDUCTION TO ADDICTION**: One over-riding factor in all of this is the message that is sent to young people. In calling for all means possible to be focused on preventing induction to addiction, we recognise, and call on the NSW State government to recognise, the value in preventing induction to addiction.
5. **MORE TREATMENT** - In order to assist illicit drug dependent injecting users, whether registered or non-registered clients of the injecting centre, make the progressive step from injecting towards treatment and rehabilitation, there will need to be increased funding available for a wider range of programs whose aim is to help addicts ultimately achieve a drug free status. These programs will need to be targeted primarily at more recently recruited drug users and those who demonstrate a greater motivation to voluntarily be involved in treatment and ongoing rehabilitation.

6. MORE REHABILITATION – the comprehensive life-rebuilding work of post treatment rehabilitation must take a greater emphasis as a post recovery ‘prevention’ program integrated throughout government policies.
7. OPEN ARMS – We recognise compassionate and effective treatment, rehabilitation, community support programs, social work and outreach programs and place an increased emphasis on prevention of ongoing illicit drug use rather than blind tolerance of a crime and addiction cycle that is harmful for both the addict and the wider community. While we recognise strong community support to ‘get people off drugs’ it should also be acknowledged that the Australian people are very compassionate and take an open arms approach to helping people get back on their feet when they have demonstrated a willingness to do so. This should be a message strongly supported by government programs.
8. COMPASSION NOT COMMERCIAL - It is also of great concern to us that current proposals calling for Injecting Centres in Redfern and the A.C.T. are being supported by outspoken pro-drug groups on commercial grounds rather than on drug policy reasons aimed at helping people achieve a drug free outcome. We recommend strongly that commercialisation of substance abuse, addiction or human misery be rejected. Clearly while the operators of such facilities enjoy large contributions by sponsoring governments these funds are better used in treatment and rehabilitation services aimed at helping addicts achieve a drug free status.
9. COMPREHENSIVE - That all new programs of the NSW government focus on a comprehensive and consistent prevention of harm message, encouraging abstinence, moving addicts into treatment and rehabilitation and helping addicts become drug free, with a focus in all drug treatment programs on an ultimate though not always imminent drug free outcome. That any such programs be integrated with National Tough on Drugs Approach with a strong view towards prevention based education programs, support from law enforcement, preventive care, treatment and rehabilitation. Also in doing so it is necessary to ensure that recovering addicts are offered and provided with the comprehensive support they need from housing, education, health care, social support etc leaving no gaps or waiting periods where they may fall through the program for want of support.
10. We welcome the Federal Substance Abuse Inquiry’s report findings that look more towards prevention of harm than current harm minimisation practices tend to. Drug Free Australia urges the NSW State government to adopt all relevant recommendations immediately.

Including;

- a. To revise all school drug education content and materials to ensure that a clear and uncompromising prevention-based message is conveyed.

- b. That in regards to law enforcement, authorities are provided with the necessary powers and resources to strongly focus efforts on preventing induction to addiction and send a clear message to criminals and illicit drug users alike that this NSW government will not tolerate drug dealers profiting from the misery of our most vulnerable members.
- c. That law enforcement, legislative arrangements, policies and practices be carried out strictly to provide an opportunity for the appropriate courts to determine an appropriate response.
- d. That programs that have already proven their great benefit such as the NSW Drug Court programs continue to be expanded to provide opportunities to assist, and if necessary compel addicts to enter treatment and rehabilitation programs for substance dependency.
- e. That a Working Party be established between government, community and industry representatives to consider, develop and report to government on possible options regarding the feasibility, costs and other relevant matters relating to the development of a RBT type policy for both roadside and workplace, testing for substance abuse and illicit drug use.

Drug Free Australia

ANALYSIS OF KINGS CROSS INJECTING ROOM REPORT

Drug Free Australia is calling for the NSW Government to close the Kings Cross Medically Supervised Injecting Centre (MSIC) due to its failure to meet the expectations upon which it was first established. It should be closed on the additional grounds that it appears to be increasing drug abuse, it has not decreased criminal activity, nor has it demonstrated an ability to effectively move addicts through to rehabilitation.

This Drug Free Australia assessment of the recently released 2003 injecting room report demonstrates the overwhelming failure of the Centre, and also exposes the biases and flaws in the Injecting Room Evaluation Report.

It is our belief that these biases are in line with certain harm minimisation agendas that would lead Australia towards a future where heroin would be legalised via a prescription program, and where cannabis and other currently illicit drugs would be as available as alcohol or tobacco.

Drug Free Australia also appeals to the NSW Government to re-evaluate the quality and integrity of its drug policy advice. It also notes that:

- The injecting room was always in breach of the International Conventions against illicit drug use dating back to 1912, and was condemned by the International Narcotics Control Board of the United Nations on April 19, 2003.*
- Five other States and the Northern Territory have clearly said that they see no future for injecting rooms under their jurisdictions.*

Analysis

The Final Report of the Evaluation of the Sydney Supervised Injecting Centre found at <http://www.druginfo.nsw.gov.au/druginfo/reports/msic.pdf> is a reasonably thorough and informative report (with some extraordinary gaps in analysis) recording a large amount of data by which some aspects of the the injecting room can be carefully assessed.

Unfortunately the data within the report does not support the enthusiastic reception of many media reports. It is clear, for any person reading the 233 pages of the report, that these media reporters could not have possibly read the report.

The report loses credibility by ignoring the one blatantly obvious comparison which would have destroyed all justification for keeping the injecting room open. This is explained in Point 1 below, and expanded upon in Points 2 and 3.

1. OVERDOSES MORE THAN 36 TIMES THE REST OF KINGS CROSS

On the injecting room's own calculations there were 6,000¹ heroin injections in the Kings Cross area, of which only 65² heroin injections per day were in the injecting room. Over the 18 month evaluation period there were 329³ overdoses for less than a total of 35,000⁴ heroin injections in the injecting room. Yet out on the street, for the same period, there was a total of 845⁵ overdoses out of the report's estimated 3,229,030⁶ heroin injections.

Thus in the injecting room there was one overdose for every 106 heroin injections, while on the street outside there was one overdose for every 3,821 heroin injections. The injecting room consequently had 36 times more overdoses than the rest of Kings Cross. It would have been remarkable if the injecting room had had twice the number of overdoses, horrifying if it had had 3 times the number, but it's own data shows 36 times the number of overdoses as per Table 1 below.

The injecting room report irresponsibly downplayed the truth by glibly noting:

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.⁷

¹ p 58 par 4

² The report records 106 injections per day – p 58 par 5 – of which 61% - p 8 par 4 – are heroin injections

³ p xi par 7

⁴ Maximum 34,969 heroin injections (61% - page 8 par 4 - of 56,861 total injections - page 8 par. 3)

⁵ There were 431 ambulance overdose callouts for the Kings Cross area (p 52 Table 3.5) during the 18 month evaluation period, corrected on the report's own assumption that only 51% of non-fatal overdoses are attended by an ambulance -p 59 par 3 thus giving 845 total overdoses likely for the area)

⁶ 3,264,000 total heroin injections per day (6,000 per day – p 58 par 4 – multiplied by the 544 days of the 18 month evaluation period) in Kings Cross area minus 34,969 injections in the MSIC

⁷ p 62 par 6

What the report has carefully avoided is the comparison to overdoses in the Kings Cross area, which was 0.26 overdoses per 1000 heroin injections, 36 times less than in the injecting room. Below is a table of data from the report which makes the report's silence on this matter extraordinary.

Table 1

<i>Over 18 month evaluation:</i>	Injecting Room	Kings Cross/DSH
Injections per day	65	6000
Number of Heroin Injections	34,969	3,229,030
Number of Overdoses	329	845
Injections per overdose	106	3,821
Overdoses per 1000 injections	9.2 ⁸	0.26

⁸ This estimate appears to be an underestimate on our calculations. It is more likely to be more than 9.4/1000

2. INJECTING ROOM FIGURES INDICATE NOT EVEN ONE LIFE SAVED “STATISTICALLY”

The injecting room report estimates on page 59 that the service had saved up to 13 lives during the first 18 months of operation. The claim is sustained by calculating the number of lives saved from the extraordinary number of overdoses in the Centre. But measured against other relevant data from the Kings Cross area, the estimate is proven false, and notably so.

There were 17⁹ heroin overdose fatalities in the Kings Cross area during the 18 month evaluation period, out of a total of 3,229,030¹⁰ heroin injections outside the injecting room. This indicates that there was one heroin overdose fatality for every 190,000 injections on the street – see Table 2 below.

Yet the injecting room had less than 35,000 heroin injections during the 18 month trial period. Keeping in mind that there was one fatality for every 190,000 heroin injections for the rest of the Kings Cross area, the injecting room cannot claim to have even saved one life statistically speaking.

Table 2

<i>Over 18 month evaluation:</i>	Injecting Room	Kings Cross/DSH
Number of Heroin Injections	34,969	3,229,030
Number of Overdose Fatalities	0.18	17
Injections per Fatality	189,943	189,943

3. \$19.5 MILLION TO SAVE JUST ONE LIFE

Statistically, the injecting room saved 0.18 of a life in the 18 month evaluation period. This translates to 0.12 lives saved per annum at its evaluation rate of injection, or more than 8 years before it could save just one life.

The cost of running the injecting room for 8 years to save this one life, based on the report's own estimate of \$2.4 million¹¹ per year to run the Centre, is \$19.55 million.

This is enough money for the NSW Government to subsidise, at the usual \$23,500 per annum, a total of 832 rehabilitation beds for a full year at Salvation Army drug rehab centres.

⁹ p 59 last paragraph

¹⁰ see footnote 6

¹¹ p 195 par 2

4. FACILITATED HIGHER TURNOVER FOR LOCAL CRIMINALS

The clear implications of the massive number of overdoses is that clients are using the presence of nursing staff as insurance against the risks of experimenting with much higher heroin dosages. The injecting room thus unquestionably facilitated a higher turnover of heroin for drug dealers.

Note also that most of the 5% in a state-wide survey who said that they would use an injecting room for injecting heroin had not injected heroin previously.¹²

5. ONLY 2 IN EVERY 100 INJECTIONS WERE IN THE INJECTING ROOM

The Evaluation Report data shows a clear disregard by injecting room clients for its ongoing utility for safe injection. 98 out of every 100 client injections were unsupervised, at a friend's place or squat, at a dealer's home, on the street, in a car, in a public toilet or in an illegal shooting gallery despite obvious access to the injecting room. This is clearly contrary to what was the public expectation in helping addicts. Given it was more likely to be a rare event for addicts to visit the MSIC than to be a regular daily practice how else can we consider this but an appalling failure of its own objectives?

(Note that this calculation is made only for the 42%¹³ of clients who injected daily. Using the report's own estimate of 'at least' 3 injections per day¹⁴ for these 1600¹⁵ clients over the 538¹⁶ days the room was open, the average of 2 injections out of every 100 by each client is derived. As the frequency of injection is not known for the other 58% of clients, these have not been factored in. If so, the utilisation rate would be even poorer than 2%.

¹² p 157 par 2 and 158 Table 8.4

¹³ Table 2.1 p 15

¹⁴ p 58 par 4

¹⁵ ie 42% of the total 3810 (p 36 par 1) clients

¹⁶ p 19 par 2

6. NO IMPROVEMENT IN ALMOST EVERY SUCCESS/FAILURE INDICATOR

- a) No evidence that the injecting room reduced the number of overdose deaths in the area p. 60
- b) Ambulance overdose attendances in the area - no improvement p. 60
- c) Ambulance overdose attendance during hours the injecting room was open - no improvement p.60
- d) Overdose presentations at hospital emergency wards - no improvement p. 60
- e) HIV infections - no improvement was realistically possible in this area p. 71
- f) Hep B infections - no improvement p.72
- g) Notifications of newly-diagnosed Hep C:
 - Darlinghurst/Surry Hills - worse by 11% per year (in line with the Hep C epidemic trend Australia-wide) despite presence of the injecting room p. 80
 - Kings Cross - no improvement presented by presence of the injecting room (due to similar statistics for non-users of the injecting room at the nearby needle exchange) p. 80
- h) New needle and syringe use - no advantage displayed by injecting room over the nearby needle-exchange p. 92
- i) Re-use of someone else's syringe - no improvement p. 93
- j) Tests taken for HIV and Hep C - no statistical improvement p. 96
- k) Only 20% of written referrals to various forms of assistance followed through. p. 98
- l) Less than 8% of injecting room clients were given written referrals to drug treatment or rehabilitation. p. 98
- m) Perception of public nuisance caused by drug use - no uniform opinion but with a heroin drought there reasonably should have been uniform consensus of less public nuisance p. 113
- n) Public injections sighted - residents reported less, businesses reported no improvement (despite the heroin drought) p. 116
- o) Publicly discarded syringes - initial improvement (at peak of heroin drought) slipping back towards previous levels p. 123
- p) Drug-related loitering at Kings Cross station - worsened p. 147

7. MISLEADING CLAIMS IN MEDIA CONCERNING LIVES SAVED WERE MANIPULATIVELY INFLUENTIAL

The previous injecting room claims of saving hundreds of lives ignored the fact that only 4.1% of overdoses are fatal.¹⁷ One must question the injecting room publicity, which has shaped public attitudes towards it for the last 2 years, which has equated every overdose intervention as a life saved - as can be evidenced by media reports such as Kelly Burke's SMH article 22/6/2001 which stated that:

"The centre has recorded more than 500 injecting episodes in its first month of operation. In one four-hour period more than 60 clients used the premises. Four overdoses have been recorded on site. In each case the user had arrived at the centre alone, which is a known risk factor in drug overdose death," Dr van Beek said.

"Potentially we've saved four lives in the first month."

This false equation (and vast over-estimate) would unquestionably have created a far more favorable public perception than reality would have, we encourage greater scrutiny of this and other similar claims made around the same time based on their own data.

8. PRIOR PRO-REFORM ASSESSMENTS PREDICTED IT WOULD HAVE NEGLIGIBLE IMPACT

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

"It is recognised that it is unlikely that this trial will have a significant impact on heroin overdose rates. There are a number of reasons for this. Firstly, the number of injecting events likely to occur in the facility, even while operating at full capacity, will represent only a small proportion of all injecting events in the State. Secondly, it is known that the majority of overdoses occur in a private home or hotel and there is no reason to believe that heroin users will choose to inject in an injecting centre rather than in their own home. Finally, the injecting centre will have limited hours of operation and therefore cannot influence overdoses that occur outside these hours. Of particular relevance is the fact that most overdoses occur between the hours of 6pm and midnight, outside of the proposed operating hours of the centre. These factors suggest that it is unlikely that the trial of a safe injecting centre will have a detectable effect on heroin overdoses.

"However, the evaluation of this trial will provide an insight into the effectiveness of supervised injecting centres at reducing high-risk behaviours for overdose, such as injecting on the street or alone. It may also reduce other harms associated with injecting drug use, such as the transmission of blood-borne viruses, and may reduce public nuisance from heroin use. As such, the trial is deemed valuable and the evaluation of the centre will provide a sound

¹⁷ p 59 par 3

body of evidence on which to base policy decisions regarding the role of injecting centres in a multifactorial public health strategy for reducing the harms and public nuisance associated with injecting drug use.”¹⁸

9. EVALUATION REPORT BIASED AND FLAWED

9.1 Inconclusive experimental design

The paragraph on page 205 addressing trial design limitations¹⁹ frankly acknowledges that the real role of the MSIC is not verifiable outside of a randomized comparative trial design.

At this stage there appears to be no other way of estimating the number of lives saved outside of comparisons to national or local overdose and mortality averages, thus subjecting these estimates to the indeterminacy of the social sciences.

* No evidence has arisen from the MSIC report which can realistically be described as a significant contribution to the science relating to the medical assistance of addicted patients.

9.2 Research methodologies suspect

Telephone surveys^{20,21} were the subject of bitter criticism from NDARC and its associates in relation to the follow-up of addicted patients treated with Naltrexone, and yet are freely employed in this evaluation.

Furthermore the primary research tool in the report is the self-report survey which has been extensively criticised and derided by international experts. There is no obvious reason to ascribe increased reliability to addicts' accounts of their lives than there is for their accounts of anything else. These limitations are acknowledged to a limited extent within the report²². Such questionnaires nevertheless provide its major statistical content.

9.3 Purports to measure the immeasurable

Furthermore just as the prevention of death is frankly acknowledged to be one of the primary driving factors of the MSIC politically²³, it is also frankly acknowledged that this was never possible from only one centre²⁴.

9.4 Loyalty to culturally liberal pedigree

The report clearly acknowledges that it was set up after the NSW Drug Summit²⁵, a convocation which was nationally notorious for the liberal direction of its drug

¹⁸ Warner-Smith M.; Lynskey M.; Darke S.; Hall, W. ANCD Research Paper 'Heroin Overdose – Prevalence, Correlates, Consequences and Interventions ANCD Canberra (2001) p 47

¹⁹ p 205 last par

²⁰ p 109 par 5

²¹ p 154 par 1

²² p 38 par 4. Note references to social desirability and recall bias.

²³ p 45 par 1

²⁴ p 58 par 6; p 205 par 6

policies. The MSIC was pre-empted by a campaign of civil disobedience organised by, among others, the Chairman of the NSW Parliamentary Joint Select Committee which had previously advised against such a Centre. It is evident from a detailed reading of this report that its final evaluation bears more loyalty to its culturally liberal pedigree, than a rigorous and single minded adherence to the objective demonstrated truths.

9.5 Appearance of drug law reform advocacy

The stress observed in the staff in relation to the centre's operation. Specifically the report²⁶ mentions staff's helplessness with daily observing hundreds of patients inject, and many overdoses; and the difficulty in terms of preventing dealing which the centre appears to have encouraged. The scenario which is repeatedly painted is that several friends would come in to share a "deal", which had to be reluctantly discouraged by the centre staff as it legally constituted "dealing" or drug "supply."

Indeed so much reluctance was expressed by staff that the report appears to advocate for legislative change to acknowledge the reality of street drug use²⁷.

Despite the appearance of liberal drug advocacy by the MSIC management, one notes the obvious anger of staff over the "groin injectors" indecent behaviour, and the frustration and anger while some clients jab repeatedly in frenzied confusion clearly hundreds of times, trying to hit a vein in a cocaine induced frenzy. The report notes also that the local anaesthetic action of cocaine makes the clients oblivious to the damage that they are doing to themselves²⁸.

Further, the inclusion in the survey of questions relating to controlled heroin prescription, legalization of heroin and tolerance of small amounts of drugs by police²⁹ would also appear to be prima facie evidence of social engineering by this classically liberal academic concatenation.

A role in this report of liberal social advocacy is noted.³⁰ Detailed considerations contained within this document demonstrate that it continues that tradition.

9.6 Overly optimistic interpretation of results

Remarks such as "Staff reported some challenges in the work environment related to the nature of the service"³¹ barely scrape the surface of the serious soul searching and angst reflected in the detailed accounts of chapter 2³² and the serious methodological flaws to which the whole community might well pay careful heed, and the statement that "the absence of an observed effect should not be taken as evidence of the absence of an impact from the MSIC."³³

²⁵ p 3

²⁶ p 28; further pp 26-31

²⁷ p26 Pars 5 & 3; p 37 par 4

²⁸ p 30 par 6

²⁹ p 174 p 2 and Fig 8.13; p 176 par 1 and Fig 8.15

³⁰ p 202 par 3

³¹ p 202 par 4

³² pp 25-33

³³ p 206 par 1

The concept that a MSIC could have been set up simply to effect treatment referrals³⁴ seems frankly outlandish and disingenuous in the extreme. Better results might have been expected from a soup kitchen.

These, of course, are added to the optimistic claims of lives saved, already noted, and the blithe lack of concern about the massive number of overdoses in the Centre.

9.7 Centre's name more about marketing than reality

The study specifies that the medical director was present for only 0.5 FTE (Full time equivalents) weekly³⁵. Hence it was not medically supervised in point of clinical fact, but only in an administrative sense. In practice "treatment" administration and overdose management was often not "medically supervised."

9.8 Failure to corroborate data

One notes that in the all important area of overdoses no objective data such as video tapes, or transcutaneous oxygen saturations were provided to document the claims made. As the cubicles are understood to have been videoed routinely, this important omission from the factual dataset would appear to be noteworthy.

Indeed some form of evidence is given for only a single overdose (of uncertain severity) as having occurred within the clinic. The comment is made that one patient claimed to have overdosed there previously³⁶. If in fact there had been 409 as claimed, and given even mediocre continuity of patient care, one imagines that other clients would have made a similar observation. However this appears not to have occurred.

Regarding referral, the report claims that 43 patients were referred for residential rehab. Yet the Salvation Army, the managers of some of the largest programs in the area, deny that even one single such referral was received³⁷.

9.9 Selectively biased focus

The authors' treatment of the single reported overdose death which is said to have occurred in an MSIC overseas³⁸ is strikingly different from their analytic treatment of a single reported death from sedated rapid opiate detox using naltrexone. As such it is substantial evidence of bias.

9.10 Conclusions unsupported by evidence

The conclusion at the end of Chapter 5 in relation to the MSIC supposedly *improving* clients health is contradicted by the data presented. The chapter and earlier notes describes increased rates of skin infections, public using, needle and

³⁴ p 85 par 1

³⁵ p 27 par 5

³⁶ p 96 par 1

³⁷ Major Brian Watters, Personal Communication; Drug Free Australia Peak Community Group

³⁸ p 45 par 2

paraphernalia sharing; Hepatitis C infection rates, no effort to vaccinate the group against Hepatitis B, and an increased heroin overdose rate by virtue of the presence of the supervising nursing staff. Reduction of health status would have been a more equitable description.

9.11 No correction of false public perceptions

The public perception of MSIC's as reducing the risk of BBV transmission, reducing the overdose rate, reduce publicly discarded syringes, and reducing the death rate³⁹ have all been disproven by this report but there is no comment by the evaluators on this point. Rather the false public perceptions seem to be produced as evidence that the MSIC succeeded.

9.12 Media misinformation not questioned

Any unbiased evaluation of the MSIC would have questioned the truth of the media reports emanating from the MSIC regarding the equation of overdoses with lives saved. The report does indeed demonstrate that the number of overdoses in the Centre does not equate to the number of lives saved. And yet it glowingly notes that public perceptions improved over the evaluation period, despite this misinformation being spread far and wide by the MSIC management.

10. FAILURE OF THE REPORT TO DEMONSTRATE VARIOUS ASSERTIONS

The study did indeed demonstrate that such an enterprise was feasible. This would be its single accomplishment. However this was readily apparent without performing the study. All that was required was a law change.

However there was much that was not demonstrated:

10.1 Contact with target population

The study claimed to have made contact with its target population. But if the average injections in the Centre for daily users was a mere 2 in every 100 - this can hardly be considered a vote of confidence in the Centre by users. In addition, 66% had previously experienced treatment,⁴⁰ meaning that 34% of clients could be considered as resistant to treatment advice. But because this is a completely non-specific treatment effect it could equally have been achieved by any other treatment modality including a soup kitchen.

³⁹ Page 160 Para 1; Page 163 Para 2

⁴⁰ p 16 par 2

10.2 *No impact on overdose mortality demonstrated*

The study claimed that at least 6 lives were saved over the 18 month evaluation period. But there was no demonstrated impact on heroin overdose⁴¹ or death rates in the community. The estimates were clearly false as the report clearly recognises that there was an increased number of heroin overdoses in the MSIC⁴². This is attributed directly to the supervision itself⁴³. Furthermore the report spells out in the greatest clarity⁴⁴ that with less than 1.8% (106)⁴⁵ of the 6,000 daily injections in the area⁴⁶ being given in the MSIC, it should never have been expected to impact this rate. The administration of naloxone in this scenario is dubious for several reasons. Furthermore, the actions taken in the 60 cases of cocaine OD management is nowhere specified. Formal cardiological or pharmacological management as is required by complex cases⁴⁷ is nowhere suggested.

At several points in the report it mentions that the overdose rate in this group (9.6/1,000 injections) was unusually elevated⁴⁸. This means that there is evidence that the MSIC may have made the overdose situation worse. It also mentions that virtually all of the clients also used other MSIC venues. This also makes the evidence that the MSIC saved a number of lives (about four annually) tenuous, as this calculation is based on the number of observed overdoses. If this number was falsely elevated due to the presence of nursing attendants, then so too was the estimate of protection of life. It is reasonable to assume that it may have been elevated several times, making the supposed saving of life very dubious indeed. The report also states⁴⁹ that the rate of skin infections and thrombosis in these patients was worse than patients not accessing the MSIC-MSIC. With our recent understanding of the effects of opiates genuine concern must be voiced at the immunosuppressive actions of the “treatments” encouraged and supported in such a facility. MSIC patients also reported higher rates of injection in public places including toilets, than non-MSIC patients⁵⁰.

NOTE : Data for protection of life in MSIC - MSIC is dubious at best. Naloxone was only given 81 times, and in these cases it would usually seem to have been done by a nurse.

10.3 *Effective referral not demonstrated*

⁴¹ p 60 par 2

⁴² p 63 par 1

⁴³ p 63 par 1

⁴⁴ p 58 par 4

⁴⁵ p 58 par 5

⁴⁶ Page 58 Para 4; Page 61 Para 3

⁴⁷ Page 62 Para 4

⁴⁸ Page 45 Para 4

⁴⁹ Pxiii; P 94; Page 94 Para 4; Page 100 Para 1

⁵⁰ Pxiii

The referral rate (2.4% of visits; 15% of clients) is very low for such a service. These referrals were mostly (54%⁵¹) not in writing, and in less than 10% of all referred cases was confirmation received that they had actually made contact with the referral agency. This contrasts to our own referral rate which was recently demonstrated to be 91% of patients seen. Referral can of course be accomplished by any service including a soup kitchen. 66% of patients had already accessed treatment services, 26% in the past year⁵². This should then have been termed “re-referral.” Indeed the rate of other treatment uptake appears to have been adversely affected by the MSIC-MSIC itself, with referral rates declining significantly from 40% to 32% 2000-2002⁵³.

10.4 Sufficient medical attention not demonstrated

There appears to have been minimal medical attention given to patients in the clinic⁵⁴. The emphasis appears to have been on vein care (rotating injection sites) which could just as easily have been given by nurses or doctors working in more traditional clinical settings. In particular the report contains no mention that Hepatitis B vaccine was given to what it acknowledges is a particularly vulnerable group.

10.5 Impact on blood-borne diseases not demonstrated

It is untrue that there was no increase in the transmission of blood borne virus transmission. The documented rate of HCV positivity in this group was 60-90%⁵⁵ depending on the drug most used. Detailed analysis of the Hepatitis C sero-incidence data⁵⁶ shows that the new infection rate in KCDSH postcodes shows that the infections rose 20% from a mean of 284 annually to 342 after the MSIC commenced operation compared to only a 5% rise for the remainder of the city from 4751 to 4997⁵⁷. The annual rise in DSH was 41% in this period from 177 to 249. It is indeed possible that the indirect cultural effect of the MSIC (as opposed to its actual operation) had a significant influence on this. The MSIC-MSIC had no effect on needle sharing amongst heroin users and remained stably high at about 20%; but significantly deteriorated amongst amphetamine users (4% to 24% 2000-2002, P= 0.007)⁵⁸. These figures can hardly be described as a satisfactory demonstration of harm minimization. Similarly figures suggest a movement of injectors from public toilets to brothels, with continued high levels of the sharing of implements⁵⁹. Similarly MSIC-MSIC users reported elevated rates of use of illegal shooting galleries⁶⁰.

⁵¹ P 98

⁵² P16

⁵³ Page 98 Para 3

⁵⁴ Table 2.12 P22

⁵⁵ Table 4.8 Page 78, block 4, column 5, 2002

⁵⁶ Table 4.3 Page 73

⁵⁷ P xiii, 72-73

⁵⁸ Page 93 Para 1

⁵⁹ Page 93; Page 102, Para 2

⁶⁰ Page 94 Para 1

10.6 Higher public amenity clearly not demonstrated

The King's Cross-Darlinghurst-Surry Hills (KCDSH) area is an area which experiences one of the lowest public amenity ratings in Sydney. Events documented in the report in relation to loitering at the back of the MSIC and around the local train station contradict this assertion. King's Cross Railway station was mentioned by name at least 14 times⁶¹, several pages⁶² are devoted to a detailed discussion of the events at the rear of the MSIC. Police clearly indicted the MSIC-MSIC for increasing drug traffic into the area via the station⁶³. The suggestion that the community supported this facility is contradicted by the statement on page xv that only one third of local residents, and one quarter of local businesses did not object to the MSIC. This suggests that in fact 66% of residents and 75% of businesses had at least some problems with it. With the presence in the MSIC of 10% of country patients⁶⁴, and many patients from outside Sydney, the claim that the area generally is not a "honey pot" for addiction⁶⁵ must be doubted. The report notes that 75% of clients were from outside this area⁶⁶.

10.7 Claim of static crime rates not demonstrated

Crime is said not to have been increased locally. Such assumptions however openly acknowledge a dependence on a constant reporting rate.⁶⁷ This is unlikely to have been true however, as independent evidence suggests that there has been major political pressure brought to bear on police not to action crimes reported to them during this same period. For this reason widespread disenchantment with policing services and tactics appears to have set in which has mitigated against usual reporting patterns.

***** A DFA Report into the Comparison of crime rates in hot spots will be available at a later date.**

10.8 Faulty assumptions in economic analysis

The economic analysis of the MSIC is based, as the study itself states⁶⁸ on many highly questionable assumptions. While making claims many of these claims are based on assumptions that clients have made lifestyle changes when in fact that could not be demonstrated to notably impact in this area. Any such claims should be considered as highly optimistic and entirely speculative. Some obvious ones are:

- a) A doubling of the "throughput in the following year" after marked stability in numbers for most of its period of operation;

⁶¹ PP 144-147; page 128; Page 149

⁶² Pages 140, 141, 148

⁶³ Page 144, 147, 149

⁶⁴ Table 2.6 P17

⁶⁵ Page 39 Para 3; Page 129 Para 1

⁶⁶ Page 37 Para 2

⁶⁷ Page 129 Para 4

⁶⁸ Pxxv

- b) The number of four lives saved annually, which as mentioned above is highly dubious;
- c) The cost in terms of cultural change and attitudinal drift on favour of IVDU practices;
- d) The cost / benefit ratio calculated by this group suggest that this is one of the least cost effective public health interventions of all. That is with the biased input data points alluded to above. The real benefit is likely to be substantially less with more realistic figures used in the calculations⁶⁹.

This is a final and authorised copy of the report as issued 11-09-2003

⁶⁹ Page 198 Table 9.15