

OCCASIONAL PAPER No. 2

***“Safe Injecting Facilities
Their justification and viability in the Victorian setting”***



Drugs and Crime Prevention Committee
PARLIAMENT OF VICTORIA

The views expressed in this paper do not reflect current or proposed Victorian Government policy, and they do not necessarily reflect the final position of the Victorian Parliamentary Drugs and Crime Prevention Committee.

Drugs and Crime Prevention Committee

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Terms of Reference

The Parliamentary Crime Prevention Committee shall inquire into, consider and report to the Parliament on the implementation of the Government's Drug Reform Strategy, and in particular to: -

1. Monitor the implementation, and evaluate the effectiveness, of the comprehensive drug reform strategy announced in response to the report of the Premier's Drug Advisory Council in the document *Turning the Tide*
2. Investigate and evaluate national and international experience in the drug area. This will include undertaking an evaluation of differing approaches to the drug problem in other states, particularly South Australia and the A.C.T., and international jurisdictions.
3. Monitor and evaluate two research projects which will be commissioned by the Government. The first will further investigate any linkage between marijuana use and the onset of schizophrenia and other mental illness. The second will investigate the effects of marijuana use on driving and support expanded work on the development and commissioning of a roadside testing mechanism for marijuana.

A preliminary report focusing on the extent to which implementation of initiatives has been achieved will be required to be tabled in the Parliament no later than December 1997.

A second report providing a clear indication of the extent to which the use and abuse of drugs and the physical, emotional and social harm that results has been reduced will be required to be tabled in the Parliament no later than June 1999. This report will take into account the results of the research projects considered by the committee and the evaluation of national and international experience.

The two reports will form the basis for ongoing action, including legislative reform.

Dated 25 June 1996

Responsible Minister:
J. G. Kennett
Premier

Preface

For many years in Victoria, heroin use and the harms associated with that use – particularly fatal overdoses - have continued to rise. This is despite the fact that Victoria has had a consistently developing system of harm-minimisation programs and interventions that span the range of government activity and social domains. This, by no means, is to suggest that these programs and interventions have had no impact at all. The drug problem in Victoria would clearly be much worse than it is without them.

What this trend of increasing harms does suggest is that something more needs to be done. It is not clear, though, that more of the same sorts of interventions and activities will be quite enough. There is a need to consider different, and perhaps sometimes courageous, options as well. One such option is the provision of a controlled context or place for street-level heroin users to inject safely. Safe injecting facilities are intended to target a specific range of drug-related harms, and experience from overseas suggests that they ought to be given serious consideration.

It is the responsibility of the Victorian Parliamentary Drugs and Crime Prevention Committee to evaluate the Victorian drug reform strategy “Turning the Tide”, and also to examine the range of options and interventions that might be brought to bear on reducing drug-related harms in Victoria. This discussion paper on safe injecting facilities in the Victorian setting is intended to be part of this process of examination. It is hoped that the arguments and findings presented in this paper will contribute to public discussion and greater understanding so that more informed and justified policy decisions can be made on the issue.

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A number of people have made helpful comments on earlier drafts of this document, and their contribution is greatly appreciated. Any further feedback can be directed to the following email address:

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KEY FINDINGS

Safe Injecting Facilities are designed as a *specific response to a specific problem* - public street-injecting and the specific harms associated with it [eg., public nuisance, high risks associated with hurried and unsafe injecting, etc.].

Finding One: There are few interventions other than Safe Injecting Facilities that are specifically suited to comprehensively deal with the range of harms arising from public street injecting.

Safe Injecting Facilities have been operating in Europe for more than 10 years, and appear to be effective in achieving the goals they are designed for.

Finding Two: Safe Injecting Facilities may be effective in dealing with the harms of street injecting, (particularly public nuisance), but only if they are properly targeted, and sensitively managed in the context of community consultation and education.

Not all purportedly harm-reducing interventions are completely free of the potential to create harms themselves. Safe Injecting Facilities appear to have a potential to produce significant harms, including the possibility of a further entrenched local drug market and related crime, perceptions of condoned drug use, and entrenching drug injecting as the major route of administration.

Finding Three: There are potential dangers and possible disadvantages in implementing Safe Injecting Facilities. The extent to which these disadvantages would actually arise, and what the true balance of costs and benefits would be in Safe Injecting Facilities (as an ongoing established form of intervention) will best be determined through a controlled trial.

Finding Four: There are legal factors involved in the implementation and operation of Safe Injecting Facilities, but they are not unique or insurmountable. The possibility of implementing Safe Injecting Facilities will depend on a full consideration and resolution of these legal issues.

Finding Five: *There are good reasons for adopting a model of implementation that incorporates safe injecting as a part or aspect of a primary health-care centre which addresses the general health needs of drug users, rather than having a facility that is devised for and largely dedicated to safe injecting.*

1. *What are Safe Injecting Facilities?*

As the name suggests, safe injecting facilities are establishments whose specific and officially sanctioned purpose is to provide injecting drug users with a safe environment in which to inject their drugs. Safe injecting facilities (or SIFs) are to be distinguished from “shooting galleries”, which are not officially sanctioned places for injecting, and are often unsafe. Although SIFs ultimately need to be sanctioned by governments, they can be established, operated and funded by non-government organisations, or in conjunction with government agencies.

Clients of safe injecting facilities inject drugs that they have acquired themselves. No drugs are administered or distributed by the facility staff or management. Staff do not help clients to inject, either. The safety of SIFs revolves primarily around their capacity to reduce the risk of fatal overdose, as well as the risk of blood-borne viral infections associated with unsafe injecting practices. This safety is sought through:

- the presence of trained health-care staff who are available to supervise users, provide advice and use available equipment to resuscitate overdosing users or call for an ambulance promptly;
- the free availability of sterile injecting equipment, such as needles, syringes, ascorbic acid (in some regions), water, alcohol and dry swabs, and tourniquets (all of which are collected after use).

SIFs should also play a secondary health and welfare role for users through

- the provision of education and advice to users on safe drug use;
- the provision of primary health-care and medical treatment (given that users’ general health tends to be

poor, and their access to appropriate primary health-care is very poor);

- the increased access to and availability of drug treatment and rehabilitation;
- the increased access to advice and help with life-skill problems (eg., help with completing social security forms, seeking housing, etc..)

Although there is no one set model for the operation of SIFs, a facility may have the following characteristics:¹

- located within a larger Centre which can include a clinic for primary medical care, counselling room, and cafeteria;
- the injecting rooms are likely to be sterile looking, containing chairs and tables for clients to prepare and inject their drugs, as well as sterile injecting equipment (needles, syringes, a candle, sterile water and spoons), as well as paper towels, bandaids and rubbish bins;
- Staff will control who enters the facility, and the number of clients present at any one time. Clients might have to formally apply to use the facility;
- There might be a maximum of 6 to 10 clients in the injecting room at any one time, where clients stay in the room to inject for up to 30 minutes;
- A staff member will be on duty in the injecting room at all times (on a rotating basis);

¹ Based on the operation of well-established facilities in Switzerland as described in NSW Joint Select Committee into Safe Injecting Rooms (JSCSIR), 1998.

- The facility must have clear rules to be followed by all clients, such as no dealing, no violence and no smoking, and also possibly, rules concerning cleanliness while using the facility. Users may be banned for a period of time for breaching the rules.
- A doctor may regularly visit the Centre, and the Centre may have direct phone lines to the police and ambulance services;
- If a client overdoses, the staff member on duty (probably with assistance) will attempt to resuscitate the client with an airbag, and if the client's breathing does not resume

normally after a few minutes, an ambulance will be called;

- The opening hours of a facility may be staggered to maximise the number of clients it can cater for;
- The facility managers may maintain ongoing consultation with the local community to ensure smooth operation of the facility.

Across the world, there are five SIFs in Frankfurt, and others in Hamburg, Hannover, Bremen and Bonn in Germany; there are fourteen in Zurich, Berne and Basel in Switzerland; and a number operate in the Dutch cities of Rotterdam, Arnhem and Maastricht.

2. The Impetus for Safe Injecting Facilities

Consideration of SIFs as an option for Victoria has arisen largely as a result of the apparent increase in a range of harms associated with injecting drug use (and trafficking) in public places in metropolitan Melbourne (most notably in Fitzroy/Collingwood, St. Kilda, Footscray, Springvale, Box Hill, and parts of the CBD).

Street-level use tends to be a phenomenon involving mostly young users, older ones generally having more opportunity to purchase and use in private settings. Street-level use is typified by users making quick, small purchases of heroin or cocaine from known or newly encountered street-dealers, and then consuming the drug very soon after, and very close to the point of purchase – often in close-by streets, secluded laneways, or public toilet facilities.² The shorter the time

between buying the heroin and injecting it, the less the likelihood of being detected or intercepted by police in possession of the drug or injecting equipment.

The health risks to users commonly associated with injecting are increased substantially by street use. Quite clearly, people who inject all of their drug supply very quickly increase their risk of overdose. One major study of the circumstances of overdose showed that nearly all of the overdoses in Cabramatta in Sydney were of users from outside that area who had come in to purchase and use near the point of purchase (Darke, et. al., 1997). But the risks are high even with non-fatal overdose, particularly if overdose is taken to include anything that counts as more than an “effective” dose (Fitzgerald, et. al. 1998).

A recent survey of 40 street injecting drug users in the Melbourne CBD

² In Smith St. Collingwood, for instance, 68% of syringes collected from syringe

disposal bins are collected from bins in public toilets (Fitzgerald, et. al., 1998)

indicated that half had overdosed in the city (Don, 1998). Users who overdose in the sense of being either acutely drug affected, or else lapsing into and out of consciousness, are a danger to themselves and others, particularly in an open street context. Losing consciousness or “dropping off” directly outside shops has also been identified by shop-traders as a significant nuisance. If “deals” are shared, as they often are between users, injecting equipment is also likely to be shared in the urgency of the moment. Along with this come the risks of transmitting blood-borne viruses and infectious diseases. The survey of Melbourne CBD street injectors revealed that nearly half (47%) shared needles and syringes either because they were sharing with a partner, or because of cost and lack of availability of needles/syringes, or because of the possibility of police detection (Don, 1998). That same survey also indicated that over three-quarters of the CBD users interviewed shared injecting equipment other needles and syringes (ie, spoons, water), and only 15% administered their own injected does themselves (Don, 1998).

Apart from the risks and harms to users themselves from street use, there are also harms for third-parties. Clearly, there is a fear on the part of the general public of needle-stick injury from discarded syringes.³ There is also the general nuisance to consumers and business operators of a visibly present illegal drug-market, as well as bodily fluids (blood, vomit) and anti-social behaviour. One major concern for members of the public is the appropriation of public toilet facilities by injecting users.

As well as this there is also the occurrence of, and fear of, opportunistic property and street crime in the locality. In business districts this impacts on

³ The probability of becoming infected with a blood-borne virus following a needle-stick injury is very low for members of the general public, and there are no known recorded cases of this to date (NDARC, 1999).

business operations and viability. As well as all this, there is another set of potential harms which is too often overlooked - the hazards to police, ambulance workers and paramedics of emergency attendance at overdoses (with the risks associated with speeding in emergency vehicles, needle-stick injuries,⁴ etc..)

Although public street-level trafficking and use is a recent phenomenon, there are reasons to think that it will become more and more common. It has been suggested by senior police that one of the reasons for this increasing movement of using into the public area from the home or residential environment is the more sophisticated police surveillance methods being used in relation to trafficking and use in residential areas and static addresses (Fitzgerald, et. al., 1998).

Another suggested reason is the fact that, while there are undeniable risks, there are nonetheless certain advantages for users in purchasing and using publicly in consumer zones and shopping malls (Fitzgerald, et. al., 1998). These areas are generally accessible at most hours for users (who often do not live in the immediate locality). There is also the element of anonymity for users where they are able to limit their personal contact with dealers. And also there is the convenience of being able to choose between dealers and deals packaged in a variety of ways (e.g., balloons and foils which are usually small, easily concealed, and transportable).

The convenience and anonymity of public use has been encapsulated by Fitzgerald, et. al. as reflecting what could be thought of as a “take away” ethic among street users. So, in view of the fact that there are these attractions for a

⁴ The risk though of contracting HIV from any one occupational needle-stick injury has been estimated to be 1 in 316. The estimated risks are higher for hepatitis C (1 in 11) and hepatitis B (1 in 4) per exposure (Ippolito, et. al. 1994).

certain group or type of user, it is not unreasonable to think that the phenomenon of street use will continue

to grow, along with the harms and risks that are connected with it.

3. *The Role of Safe Injecting Facilities in Addressing Harms*

Street injectors, as described above, not only experience greater than usual risk of serious harm, they are typically the most marginalised group of users, and are less likely to access treatment and other health-care services. The majority of people who have overdosed are those who have never been in treatment (NSW JCSIR, 1998). There are limited ways of addressing the increasing occurrence of public street injecting use.

The common initial response to this injecting use is sometimes to engage in saturation policing to “clean up the streets”. Experience shows, though, that this measure has limited long-term impact. As Fitzgerald, et. al., have observed, “if drugs cannot be kept out of prisons, they cannot be kept out of a city full of alleyways, nooks and crannies”.⁵ Even if users leave initially and move somewhere else, they still come back. There is also the possibility of a rebound effect, where users move back in more heavily (Fitzgerald, 1998).

One could speculate that the reasons for this rebound effect revolve around the perception among users that that particular area has already been “done” by police, and that there will not be a similar degree of intensive policing in the same area for a while. And even if users don’t come back, they are simply moving their activity somewhere else, and there is no guarantee that their injecting or associated behaviour will be any less harm-producing than it was in the first place. In fact, the more aggressive the policing, the more harm is likely to be done. As Lisa Maher has observed:

... the effects of aggressive street-policing on socially marginalised

groups and particular ethnic communities can produce big problems, including alienation or a distrust of the police or they can confound those problems where they already exist, and with it goes the potential for serious public disorder.⁶

This is not to say that police activity of some sort has no role to play at all in addressing the various harms arising from street-level dealing and use. It is not unreasonable to expect that low-level, but nonetheless visible police foot-patrols might act to decrease the openness of trafficking and use to some degree, and thereby allay public concerns about the possibility of opportunistic crime, and some of the general nuisance associated with injecting behaviour. Police should not tolerate open markets.

This police presence, though, is only one measure which deals with only one dimension of the problem. It could be argued that the presence of SIFs might provide a more reliable response to the visibility and nuisance of public injecting, and the offensive and criminal behaviours often associated with it. Clearly, if persistent street users are provided with a safe and sanctioned place to go to inject away from the street, then the harms arising from street use can be expected to decline. For example, public drug use in Frankfurt shrunk from 800 individuals in 1991-2 to 150 in 1993, and neighbourhood complaints about drug use decreased significantly (Kemmesies, 1995). Drug overdose deaths in Frankfurt also dropped sharply.

⁵ Fitzgerald, et. al., (1998), p. 118.

⁶ Lisa Maher, 1998, commenting on problems of policing in Cabramatta.

It is also often overlooked with street use that users themselves, and not just non-using third-parties, are at risk of offensive, unsafe and sometimes criminal behaviours from other users and non-users. Users, unlike the general public and business operators, are understandably reluctant to seek police aid when subjected to this behaviour. So, while police presence may be of some benefit to third-parties, it will have a limited place for users at risk. One of the main reasons that clients cited for using injecting rooms in Switzerland was the fact that they provided a secure place to inject (Dolan & Wodak, 1996). This general pro-attitude to SIFs among users is echoed in Melbourne as well, with a 1998 survey of 400 injecting drug users in Melbourne finding that 77% of those users would use a SIF with appropriate equipment rather than injecting in public. The remaining 23% indicated they had a fear of authorities and preferred to inject in privacy (Fry, 1998)

This is where safe injecting facilities can also be seen to have a very pertinent role to play in addressing a range of other serious harms of street use. Existing options like needle and syringe programs have the capacity to deal with some of the risks of injecting drug use in a street context. But again, it is only some of the harms that are targeted, namely HIV and hepatitis C transmission, (serious as these harms are). And when it comes to Hepatitis C, it has been hypothesised that the virus can be transmitted through drug using paraphernalia other than needles and syringes. Safer injecting facilities can provide each client with a whole complement of sterile injecting paraphernalia. This is particularly important with the possibility over time in Victoria of increasing cocaine use, where users tend to inject at a higher rate than heroin users. Further to this, used needles and syringes will not be carried by clients to SIFs, unlike needle exchanges.

Also, in contrast to needle exchange outlets where clients generally visit briefly, safe injecting facilities allow for a more prolonged interaction between

health-care staff and clients. This interaction provides the opportunity for users to access advice from staff, and for staff to assess the general health and wellbeing of clients. As noted earlier, this contact facilitates safer using habits⁷ (for instance, use of smaller-gauge 1ml needles instead of 2ml to minimise vein damage⁸) provides opportunities to undertake treatment, increases detection of conditions requiring primary health-care or medical treatment (for instance, abscesses, general infections and poor health), and provides opportunities for the development of increased life-skills and coping strategies for users. In SIFs in Zurich, Basel and Berne, some clients have been documented to enter treatment as a result of attending SIFs (Dolan & Wodak).

With the increased accessibility of education, counselling and treatment, there is an increased potential for users to diminish their use and perhaps to eventually cease it. Evidence gathered from overseas SIF programs in Frankfurt and Rotterdam indicates that when clients are provided with the opportunity to engage in skills programs and community activities, they decreased their drug use (JSCSIR, 1998).⁹

It has been proposed also that the “life-stabilising” influence of these programs and activities in SIFs could contribute to the reduction of criminal activity of clients. Needless to say, resort to crime will probably always be a consequence of the illicit drug black market. But, as the NSW *Report on the Establishment or Trial of Safe Injecting Rooms* conjectures “. . . when an injecting drug user gains more control over his or her life, it is more likely that will cease or reduce their involvement in petty or opportunistic

⁷ Clients in Swiss SIFs report themselves to inject more safely (Haemmig, 1996).

⁸ Staff at the Berne SIF successfully encouraged users to switch to the smaller bore syringes. (Dolan & Wodak, 1996)

⁹ It should be kept in mind that there have been very few impact evaluation studies conducted of overseas SIFs.

crime".¹⁰ One recent survey study of clients of the Berne SIF in Switzerland indicated a self-reported reduction (over 5 years) in their reliance on drug dealing as a source of income (Buerki, et. al., 1996).

One of the significant and primary benefits of safe injecting facilities is their capacity to respond immediately and effectively to resuscitate clients who overdose, and to reduce the incidence of overdose in the facilities themselves, as well as in the community. Participants in the Melbourne CBD street injector survey stated that they were hesitant to assist in peer overdose incidents on the street because of the possibility of disease transmission, fear of being detected themselves carrying drugs, and because of the presence of the general public (Don, 1998). These factors would not be a significant issue in SIFs, where staff would immediately assist overdose, and where users could be educated about appropriate modes of assistance for street overdose, as well as safer injecting habits.¹¹

There have been no fatal overdoses in any overseas SIF. Overdoses in the Frankfurt community have declined from 147 in 1991 to 26 in 1997, and this has been attributed to a range of harm reduction programs of which SIFs are a key part (Frankfurt, 1998). A decrease in the incidence of overdose has obvious benefits for users. The 1998 NSW Joint Select Committee Investigation into Safe Injecting Rooms cited some estimates of the number of overdose deaths that could be prevented by SIFs. One estimate suggested that an injecting facility with 600 injections per day would, in every 100 days, prevent the

¹⁰ P. 100, NSW Joint Select Committee Investigation into Safe Injecting Rooms (1998).

¹¹ One effective habit which can be encouraged in users through SIFs is to take their drugs in two injections, rather than all at once. In this way, some initial idea can be gained of the strength and purity of the drug being injected.

one death that would otherwise be likely to occur without a SIF. Another estimate is that a SIF with 120 injections per day would prevent a death as often as once in every 7 weeks. Estimates based on overseas experience suggest the prevention of one death in every five days.¹²

As well as these obvious personal benefits, there are considerable benefits to be had to the broader community. It could be expected that the occupational harms to police and emergency workers who would otherwise attend overdoses would be averted to some degree. And then there are well-known savings to the community resources that would be expended in dealing with fatal and non-fatal overdoses.

The most obvious are savings to ambulance and hospital emergency department resources. It has recently been estimated that ambulances attended 205 overdoses in the Fitzroy /Collingwood area between July and October, 1998. At an estimated cost of \$600 per attendance, the presence of a SIF could have produced a potential saving of over \$120, 000 in attendance costs for this period in that small area.¹³ This amounts to \$360, 000 per annum saved. Considerable savings could also be made to hospital casualty and emergency units. As well as this, there would be significant costs to be saved in connection with the rehabilitation of users who become disabled as a result of non-fatal overdose.

Apart from these economic savings in relation to overdose, there have been other projected resource benefits in

¹² P. 79, NSW Joint Select Committee Investigation into Safe Injecting Rooms (1998). These estimates were presented to the NSW Committee by Professor John Kaldor, Deputy Director of the National Centre in HIV Epidemiology and Clinical Research.

¹³ The estimate is based on discussions with epidemiologists at Turning Point Epicentre.

connection with SIFs. Some of these are as follows:

- A reduction in the health-care costs of serious blood-borne viruses. It has been estimated that one HIV infection costs the community approximately \$100, 000. The direct health-care costs per person of Hepatitis C infection have been estimated to be \$14,000 per infection, or \$150 million per annum in Australia (Brown & Crofts, 1998). However, it is suggested that a burden of \$71 million per year is added to health-care costs as a result of new infections in NSW;¹⁴
- A reduction in the costs of SIF clients' general primary health-care, through earlier detection and treatment of general health needs;
- A reduction in costs associated with needle/syringe clean-ups, and general maintenance of using areas. In Swiss cities with SIFs, there are fewer discarded syringes (Haemmig, 1996)

The advantages of officially sanctioned SIFs also need to be judged in the context of increasing calls from certain sectors of the public for the establishment of such facilities, including some non-government drug service agencies which have the resource capacity and apparent willingness to establish them. If there is sufficient willingness on the part of these otherwise respectable agencies to act in disobedience of the law and to establish a SIF, then this introduces the possibility of under-resourcing, poor practice, and even, perhaps, corruption and criminality.¹⁵ These possibilities can arise in unregulated, under-resourced and

unmonitored facilities. There is some sense, therefore, in having an officially regulated or sponsored SIF in circumstances where it is inevitable that one will be set up anyway, but illegally and officially unmonitored.

The brief overview above gives an indication of some of the ways in which the provision of safe injecting facilities could act to decrease some of the harms, risks and nuisances associated with public drug use. However, not all drug interventions are completely harm-free, and there is always the possibility that safe injecting facilities will themselves act to produce certain harms. A representative discussion of SIFs will need to encompass not only their advantages, but also their drawbacks, and solid conclusions about their viability will only emerge in the light of how these advantages and disadvantages balance out against each other. The following section outlines what have been perceived by some to be the possible disadvantages of safe injecting facilities. Where appropriate, some responses are proposed to some of these concerns and perceptions.

¹⁴ These cost estimations were presented respectively to the NSW Joint Select Committee Investigation into Safe Injecting Rooms by Professor John Kaldor, and Mr. Stuart Loveday, Executive Officer, Hepatitis C Council.

¹⁵ These issues have also been broached in Wood 1997.

4. Concerns that have been expressed about Safe Injecting Facilities

Many of the major concerns that have been expressed about safe injecting rooms revolve around the possibility that they may not sufficiently remove the problems of public nuisance they are designed to, and might make them, and other harms, worse in certain ways. For example, it could be argued that even if SIFs play a role in removing the occurrence of injecting from business, consumer and residential areas, clients leaving SIFs may still constitute a public nuisance through being intoxicated.

Although this argument might seem plausible, the available evidence suggests that this problem may not eventuate all that readily. In Frankfurt, neighbourhood complaints about drug use dropped as a result of that city's comprehensive harm-reduction strategy, of which safe injecting rooms are a central part (Kemmesies, 1995). There are also some other significant concerns about safe injecting facilities. The major and most forceful of these are listed below.

The 'Honey-pot' hypothesis. It has been argued that an established, government sanctioned safe injecting facility in some area might act as a strong attraction for users and traffickers from outside the area. If this were the case, and these people did frequently enter the area in sufficient numbers, the problems that the SIF was designed to address would not have been averted at all. There would be significant public nuisance created, along with many of the other harms associated with a visible drug market. So, the hypothesis is that the public nuisance and associated harms that would be caused by SIFs attracting outside users and traffickers, would negate the public nuisance and associated harms prevented by those SIFs, and may even make those problems worse than would have been without SIFs.

Various factors, though, suggest that this honey-pot effect may not be as strong or

as inevitable or as likely as it might initially seem. A number of measures can be taken to minimise the possibility of a honey-pot effect. One measure adopted in overseas SIFs is to regulate who is eligible to enter the facility through a system of registering clients (who must be established local users and must apply for registration). If this regime of restricted access becomes common knowledge among users, then there is less incentive for outsiders to come into the vicinity seeking access to the SIF.

It could be replied here, though, that this might not stop more traffickers coming into the vicinity, knowing there will be a sure market, and other non-client users coming in seeking a sure deal from those traffickers. There might be something in this suggestion. But, it really needs to be viewed in light of the fact that the specific localities in which SIFs are intended to operate will already be well established hotspots of public use and trafficking, which are also already well-known to users as places of open trafficking and use. This suggests that any users who would be inclined to visit the area in order to purchase and/or use are *already* likely to be doing just that. It is not clear that the existence of a SIF in the area would provide any independent incentive for *more* users to come in than would have come anyway.

There are also other measures, some of which have been successfully adopted overseas, to actively decrease the incidence of use and trafficking in the vicinity of SIFs, including:

- Maintaining a consistent police presence around SIF localities to provide disincentive to traffickers
- Ban or suspend clients who deal or buy in the vicinity of their SIFs.
- Locate SIFs as discretely as possible so as not to advertise too widely their presence.

It has been suggested also that it is wise to establish SIFs around a number of hotspots of street use in order to preclude any possibility that one locality will be stigmatised in the eyes of the public as an “illicit drug centre” (Micallef, 1998) or targeted by users and traffickers as the place to go. If the incidence of dealing can be reduced in the vicinity of SIFs, then it is likely that there will be less occasion for drug-related property crime in the local area as well.

It is also worth noting here, in connection with the issue of community disturbance, some anecdotal observations recently made by a recent visitor to a central Berne SIF:

Arriving at Berne railway station we enquired of the Tourist Information Centre about the location of the safe injecting facility. In a very matter of fact manner the assistant pointed us in the right direction. On locating the street we then asked a passing elderly nun which was the building. Without batting an eyelid she directed us to a nearby door. The premises were a cross between a no frills coffee bar and a medical clinic.¹⁶

From this description, the SIF in question had become such a normalised feature of the Berne city-scape that it elicited little in the way of any notable response, and certainly not an antagonistic one.

Official support for SIFs might convey the attitude that injecting drug use is acceptable, and might consequently contribute to an increase in intravenous drug use. This perception is a common one, but it is not clear what evidence there is to suppose that a message of acceptability is being sent, and if there is, that this will contribute to increased use. If SIFs are established discretely, then adverse messages will be minimised. Also, if the image of SIFs is

¹⁶ Tony Trimmingham of the Trimmingham Foundation, ADCA Update Email List, April 8, 1999.

managed well, a constructive message could be produced - perhaps something to the effect that SIFs exist because of the potential dangers and harms of injecting drug use in certain contexts. The message here is a dual one: that injecting use in these contexts is a harmful activity, and that the state is responsible and compassionate in the face of these harms.

It has been suggested by the NSW Joint Select Committee into Safe Injecting Rooms that community education would be essential to the establishment of SIFs, as well as ongoing community involvement in their planning and operation. This would help dispel any confusion, for instance, that might arise in connection between standard laws against drug use in the broader community, on the one hand, and exemptions in the context of SIFs, on the other.

Even if there is no strong reason to think that SIFs will condone or increase injecting drug use in the wider community, it has been suggested that SIFs might act to maintain injecting drug use among people who are established users, and perhaps to further encourage or entrench that use in younger clients who are not so established, through making it easier for them. With respect to clients with established usage, one of the express roles of SIFs is to provide them with opportunities to access treatment and rehabilitation, in order to empower them to moderate their use. If the “in-house culture” of SIFs explicitly reflects this push toward treatment and rehabilitation, then this will help negate any use-prolonging effect that SIFs may have.¹⁷ With respect to younger, non-established users, the system adopted in Zurich SIFs is to register only existing and persistent problematic street users who are local residents (Dolan & Wodak). The idea there is that young new users would not become clients of

¹⁷ In the Netherlands, there is a room provided in which to smoke heroin, so as not to entrench injecting as the route of administration.

SIFs. A similar scheme of registering only established users as clients could be adopted in Victoria. The disadvantage with this option, however, is that it excludes just those users who are most at risk, ie., young new users.

SIFs will not be able to effectively minister to their intended target group. This last suggestion about the intended clientele for SIFs brings to light some further concerns about just how well SIFs can target their clientele, given the circumstances in which they are intended to operate. One of the suggestions made above to reduce a honey-pot effect is to register only established local users as SIF clients, the local user requirement being intended as a disincentive to outsiders coming into the vicinity. The fact is, though, many of the persistent frequenters of the street injecting hotspots in Melbourne are itinerant and not necessarily from the local area, and are indeed often homeless (Don, 1998). If these are the target group – the group who are at risk through street injecting, and whose presence creates harm in the locality – then they will be missed if

entry to SIFs is restricted to local residents.

Other than residence status, it is hard to know what other solid and consistent evidence of being a “local user” there might be. Similarly, if the target is users who have an established history of use, then it is not clear how this can be reliably determined among street users who are again itinerant, and who are also the most marginalised of users who access treatment, primary health-care and other health-care recording services little. On top of this, most of the street-level users are youth (Fitzgerald, et. al., 1998), and any age restriction for registration to avoid any possibility that SIFs might further encourage injecting use among young users will therefore miss the target group.

The planning, design and implementation of SIFs in Victoria will need to address the issues of exactly what clientele group it intends to target, and just what means are available to effectively capture that target clientele.

5. Legal issues relating to Safe Injecting Facilities

Some of the most difficult issues to be tackled with safe injecting facilities are legal and legislative ones revolving around:

1. Criminal Liability: Conflicts with, and exemptions from, existing State laws prohibiting illicit drug use and aiding and abetting that use.
2. Observance of international treaties. Australia is signatory to (and so bound by) various international treaties that require possession and use of scheduled drugs to be prohibited by signatory states.
3. Civil Liability: The possibility of the managers and sponsors of SIFs being

legally liable for injuries sustained to SIF clients, staff and third-parties.

1. Criminal Liability. The operation of SIFs would conflict with current laws largely on two counts: (i) where individual clients, by injecting drugs, would be acting in contravention of laws which prohibit the possession and use of scheduled drugs; and (ii) where the managers or sponsors of SIFs, in providing facilities specifically designed to facilitate the injecting of prohibited drugs, would be acting to aid and abet a crime or acting to incite a crime.

The NSW Committee Investigation into Safe Injecting Rooms identified three ways (both legislative and non-legislative) in which SIFs could be formally and

officially mandated by the state. The strongest option is to explicitly amend the existing legislative acts which prohibit the use and abetting of use of illicit drugs to provide for the existence of SIFs. This could be done either by creating a new part to the Act, or by creating a new separate Act specifically devoted to injecting facilities.

The second, slightly weaker, option is to simply amend and qualify current Acts by providing regulations exempting SIFs (their clients and managers/sponsors) from the operation of those Acts. This option avoids having to go through the entire process of creating new legislation or significantly adding to existing legislation.

The third option is a non-legislative one which relies on the establishment of administrative protocol agreements between police and the Director of Public Prosecutions. The idea with this is that even though the activities within SIFs remain illegal on the books, the police force uses its discretionary power (through various means including Chief Commissioners instructions and operational protocols) to refrain from pursuing and charging clients and management of SIFs. The Office of the Director of Public Prosecutions would also use its discretionary powers to refrain from prosecuting in this matter.¹⁸

The stronger options of creating, adding to, or amending legislation will provide the most consistency and certainty, and will have all the force that comes with legislation. However, from a pragmatic point of view, the prospect of bringing about this sort of legislative reform might be low, given that it would presumably require a very high degree of state-wide community consensus. Legislative measures can also be less than flexible when it comes to responding to changing and unforeseen circumstances, given the lengthy

¹⁸ A non-legislative administrative protocol operates in the case of the current Cannabis Cautioning and Drug Diversion schemes currently operating in Victoria.

processes involved in modifying legislation. Also, even though it is entirely questionable as to whether the official sanctioning of SIFs will send a confused or wrong message about drug use to the community, it might be argued that if there is any danger at all of that, it might arise most acutely where SIFs are publicly enshrined in state legislation as acceptable. An administrative protocol, on the other hand, does have more flexibility when it comes to responding to any changes in arrangements and allowances that may be needed. And if the sending of unintended messages is a concern, these protocols might be seen to hold less chance of that, seeing they do not publicly institutionalise SIFs.

The major disadvantage of sanctioning SIFs through administrative protocols is the fact that they are purely at the discretion of the Police and the Office of Public Prosecutions. Although, in practice, any such protocol would need state government approval for its adoption or withdrawal, there is still less than the certainty and consistency that is provided by legislation. [Please refer to footnote 22 below for further comments on approaches to sanctioning SIFs].

2. Observance of International Treaties.

Australia is signatory to a number of international treaty conventions,¹⁹ the main thrust of which commit Australia to treating the possession, use and supply of scheduled drugs as punishable offences. If the injecting drug use that takes place in SIFs were to be sanctioned by the state, by whichever of the modes discussed above, this might appear to conflict with those conventions.

However, this is not necessarily the case. There are provisions within the 1961 Single Convention on Narcotic Drugs²⁰ that allow the possession and use of scheduled drugs for medical and scientific research purposes, including

¹⁹ Namely, the 1961 Single Convention on Narcotic Drugs, and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

²⁰ Article 2(5)(b)

controlled clinical trials. This means that the possession and use that takes place within SIFs could be legitimately sanctioned by Victoria in the eyes of international treaties if SIFs are designed to operate as medical or scientific clinical trials. There is no doubt that if SIFs are to be implemented, then they should be implemented in the first instance as clinical trials, where rigorous and systematic monitoring and evaluation takes place. So, there are quite good independent reasons for introducing SIFs in the form of clinical trials.

However, a good clinical trial will always have a determinate time frame, at the end of which it will be completed. What then, though? A good clinical trial will also be conducted with the express and central purpose of determining whether SIFs are scientifically viable as an ongoing public health-care arrangement. But if an ongoing arrangement is no longer a trial, it can no longer be justified under the relevant provision of the Single Convention. Moreover, if no ongoing SIF arrangement is allowable, this arguably brings into question the whole point of having SIFs as a genuine clinical trial in the first place.²¹

What is really needed here is some further provision under international treaties which allows SIFs as an ongoing concern. As it happens, there is such a provision built into the qualifications expressed in Article 2(5)(b) which states that possession, use and supply should be prohibited only if the prevailing conditions in the country “render it the most appropriate means of protecting the public health and welfare”. This means that if SIFs can be shown to be beneficial to public health and welfare in Victoria, they would be allowable under this provision.

This suggests that, from the point of view of international treaties, the sanctioning of safe injecting facilities as

²¹ Though it could be argued that having such trials might provide further relevant information for assessing the appropriateness of the existing legislation.

an ongoing concern might best be done in two stages: firstly, as a clinical trial justified under the “medical and scientific purposes” clause of Article 2(5)(b); and then, if the trial is successful, and SIFs are shown to be viable to the extent that without them public health and welfare would not be appropriately protected, then SIFs could be justified as an ongoing concern by appeal to the second provision in Article 2(5)(b), just noted above.^{22, 23}

3. Civil Liability: Clearly, any facility that allows, and sets out to oversee, a potentially dangerous activity like heroin or cocaine injecting, will be at risk of being legally liable for damage and injuries incurred to people as a result of the conduct of that activity. It might be, for instance that a client overdoses and suffers a disability as a result of not being revived quickly enough, or that a staff member is assaulted or suffers injury in the conduct of their duties, or that an uninvolved third-party is, say, hit by a car driven by a user under the influence of a drug recently injected at a SIF. Unless issues can be resolved about the degree to which the management and sponsors of SIFs may be legally liable in such cases, and the degree to which they can insure against that risk or otherwise protect themselves, SIFs could not be considered as a practical option.

It is not clear that SIFs would introduce any particular or peculiar problems in this area that wouldn't apply already to other health-care or treatment facilities. With respect to clients, it can be argued

²² It may well be also, that a SIF *trial* would be best mandated through administrative protocol approach, and perhaps legislatively as an *ongoing operation* if it is shown to be substantially and enduringly beneficial to public health and welfare. From a pragmatic point of view also, the existence of a successful rigorous SIF trial might help to achieve the sort of community consensus that is important for legislative changes.

²³ The fact that SIFs have operated in Europe for some time suggests that international conventions can be interpreted in a way that is compatible with the state sanctioning of these facilities.

that the management of any such operation owes a common law duty of care to any client who enters the premises. This means that SIF managers are legally responsible for reparation in the case of death or injury to clients only when the managers have not acted with "reasonable care" to avoid or prevent the prospect of the death or injury.²⁴ It has also been argued²⁵ that clients enter the SIF voluntarily to enjoy the perceived benefits of the facilities and can be taken to have consented to the risks involved (assuming they have been properly informed by staff). In this case, clients would only have recourse to litigation if injured through careless acts of the staff and management of SIFs. In some states as well, immunity is provided to the state in respect of death or injury in relation to the care of (alcoholically) intoxicated people. This indemnity could be extended to those under the influence of injectable drugs. The bottom line, though, is that SIFs are specifically designed to minimise the prospect of death or injury resulting from injecting drug use, and so the occasions on which death or injury might occur are very minimal. It should be kept in mind also, that no deaths have occurred in SIFs in Europe.²⁶

With respect to the civil liability of management for injuries to the staff of SIFs, there again do not appear to be any unique problems. Staff would be eligible to be protected under whatever occupational health and safety acts and regulations operate for health-care workers, and it could be argued that litigation would be pursuable only upon neglect of those acts and regulations on the part of SIF management.

²⁴ Advice given to the ACT Minister of Health, Michael Moore, by the ACT Government Solicitor's Office, November 23, 1998.

²⁵ In advice given to the ACT Minister of Health, Michael Moore, by Hunt & Hunt Lawyers, Canberra ACT, December 7, 1998.

²⁶ In Frankfurt, clients had to sign to say they were over 18 and understood the risks of injecting.

Third party liability matters tend to be more complex because they involve issues of causation, and rely on a sufficiently plausible case that there was a causal connection between the injecting at the SIF and the subsequent harm to some third-party. In cases where a causal connection can be established between injecting at a SIF and a subsequent third-party injury, it may not be a sufficient defence that the SIF in question was just allowing the user to do something (ie. inject drugs) more safely than he or she was going to do anyway. It does seem reasonable though, that SIF management should not be liable for third-party harms that were not foreseeable or expectable. Difficult as it may be to establish such things, it is not clear that the civil liability matters that arise in the case of SIFs will be any more complex than those arising in the case of hotels, or venues where alcohol is sold and consumed, for instance.

6. *Models for Safe Injecting Facilities*

There are various views about what the best model of operation would be for a safe injecting facility. Two of the central objectives in providing a safe and supervised injecting environment are to minimise the health-related risks of injecting, and to increase the access of at-risk injectors to the primary health-care, counselling and rehabilitative opportunities that they wouldn't otherwise access. The health of clients is a key focus with safe injecting facilities, and it makes sense therefore that such facilities should operate in conjunction with primary health-care services of some sort. The question, though, is how they should be incorporated.

There are, broadly speaking, two possibilities. One possibility is to have a facility that is devoted to safe injecting, but which also includes some supplementary primary health care services. The other possibility is to make provision for safe injecting as just one aspect or part of a broader health-care centre or unit, the central purpose of which is to provide a range of primary health care services for injecting drug users.

Though both of these models of incorporation equally address the immediate harms of street-based injecting, there are a number of reasons for preferring the latter model. The main reason is its explicit general health-care

emphasis, and the fact that it places safe injecting in the context of the wider health needs of injectors. Safer injecting, important as it clearly is, is merely one of the many and diverse health and social needs of itinerant, problematic injectors. It seems appropriate, therefore, that provision for safe injecting should be made within a setting that addresses all these needs, and in so doing, ministers to injectors as persons.

This holistic approach could serve two purposes: firstly, it may go some way toward lessening the sense of hopelessness and alienation that many problematic injectors feel; and secondly, it may increase users' own adoption of safer injecting behaviours through increasing their sense of being socially supported, less marginalised and more empowered in their lives. A "primary health-care centre" model of safe injecting might also lend itself more readily to users themselves becoming involved in the running and operation of the centre, thereby enhancing a sense of ownership and empowerment on the part of the target group. A primary health-care centre is also likely to have more comprehensively trained, qualified and on-going health-care staff than a mere safe injecting facility. This means that there will be staff who can work on demand reduction and prevention, deal with overdose problems and also follow-up on people who overdose and recover.

7. *Conclusion*

The general upshot of all this is that there are potentially strong advantages in having properly organised and operated SIFs. There are possible disadvantages, as well, and there are dangers in viewing SIFs as a panacea for all the harms of street-based injecting. One of the dangers is that of ignoring or neglecting some of the other options that are currently available to address such harms. For example, there are many

ways in which needle and syringe programs could be improved. For example, extending the range of injecting equipment provided, extending the hours of operation, improved funding for disposal hotlines/services. Also, there are a range of steps that local and state governments could take to address the issues of the street-based environment of public injecting. For example, the design and maintenance of

public toilets, provision and maintenance of disposal bins, improved street lighting, general upkeep and maintenance of public areas and amenities, and improved community discussion of the issue.

Another danger in viewing SIFs as a panacea is to overlook the possibility that even if a SIF may be appropriate and workable in one area where street-based injecting takes place, such facilities may not be appropriate for all such areas. The nature of the harms of street-based injecting, and indeed, the degree to which the local community might be receptive or supportive of the possibility, may well vary from region to region. It is crucial to maintain a clear sense of the fact that SIFs need to be viewed as a part (albeit a significant part) of a package of approaches.

If SIFs are seriously considered as a harm-minimisation option, they need to be viewed in the light of the limitations they might have in their proposed context of operation. It is crucial also that their operation be governed by a minimum set of standardised operational guidelines for SIFs which need to be developed in consultation with all the key stakeholders.²⁷ Similarly, the decision-making process concerning their viability for Victoria and the nature of their implementation should be as inclusive as possible, and take into account the concerns, interests and perspectives of all the key stakeholders in the community. It is only in the context of this broader, informed community deliberation that appropriate decisions about safe injecting facilities can be made.

²⁷ Many of the points in this, and the previous paragraph were suggested by Craig Fry, Research Fellow at Turning Point Alcohol and Drug Centre.

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