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HARM REDUCTION DIGEST 10

Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia

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Introduction

Rooms set aside for the consumption of illicit drugs have been referred to as drug consumption facilities, or rooms, health rooms or injecting rooms in Europe. Terms used in the Australian context include medically supervised injecting centres (in NSW), supervised injecting place (in the ACT) and off-street injecting facilities (in Victoria), among others. In this article the term 'supervised injecting centre' or 'Centre' will be used to denote the facility as a whole and 'injecting or smoking room' will be used to refer to the actual space in which drug consumption occurs.

Supervised injecting centres in general may be defined as '. . . legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injection drug use'. Further, these centres '. . .enable the consumption

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Note from the Editor

The possibility of conducting trials of supervised injecting centres has been one of the hot topics debated in the media in Australia in late 1999 and early 2000. To date, examples of drug consumption facilities operate in a handful of European countries and there is little published work in English describing these or what evidence exists regarding their effectiveness. The authors of this Harm Reduction Digest contribute to the debate in Australia and elsewhere by providing descriptions of the European facilities, summarizing the available evidence, and outlining the trials of supervised injecting centres planned in three Australian jurisdictions.

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of pre-obtained drugs in an anxiety and stress-free atmosphere, under hygienic and low risk conditions' [1].

These supervised injecting centres differ from illegal shooting galleries, which operated in New York in the 1980s and in Sydney in the 1990s. These galleries operate for a profit and with little regard for the health and safety of patrons. In contrast, supervised injecting centres are sanctioned and professionally staffed health and welfare services. The four main expected benefits of supervised injecting centres are: reduction in public nuisance (including inappropriately discarded injecting equipment, public injecting and intoxication and visible drug dealing); reduction in opioid-related overdoses (both fatal and non-fatal); reduction in blood-borne virus transmission and improved access to health and other welfare services. Common objections to these centres include: sending the 'wrong message', condoning drug use, the 'honey pot effect'—the congregation of drug users and drug dealers, and delayed entry to drug treatment.

The purpose of this paper is to draw together available information on supervised injecting centres. We describe centres in the Netherlands, Switzerland and Germany and then review available literature. Recent events within three Australian jurisdictions that plan to trial these facilities—NSW, Victoria and the Australian Capital Territory—are outlined.

Supervised injecting centres currently operate in a number of cities in The Netherlands, Switzerland and Germany. These centres were established as a pragmatic harm reduction strategy for highly concentrated open drug scenes, characterized by deteriorating health conditions for the drug users who frequented them, and increasing public nuisances associated with highly visible street-based drug purchase and use.

Descriptions of supervised injecting centres in Europe

The following accounts of supervised injecting centres in the Netherlands, Switzerland and Germany are based on author contact with colleagues in Europe and visits to Centres in the Netherlands, Germany and Switzerland.

The Netherlands

There are 16 official drug consumption facilities throughout the Netherlands in Amsterdam (3), Apeldoorn (1), Arnhem (2), Den Bosch (1), Eindhoven (2), Heerlen (1), Maastricht (1), Rotterdam (4) and Venlo (1). Groningen, Roermond and Utrecht have plans to establish centres in the near future. In some cities 'unofficial' centres are tolerated by government and law enforcement officials. The Netherlands' first supervised injecting centres were established during the 1970s when views on youth culture including drug use changed. 'Deviant behaviour', including drug use, was no longer seen as maladjustment but as part of testing the limits while defining a personal way of life. So-called 'alternative youth services' developed new approaches to meet the needs of young people with psychosocial problems [2]. One of the new issues identified was the use of illegal drugs, which was now met with tolerance instead of an abstinence-orientated approach.

Over the years this approach attracted a growing number of young people who did not want to, or could not, stop drug use as traditional drug services had little to offer them. Problematic drug users, mainly heroin injectors, needed a more specific approach than general youth services. Two services in the early 1970s combined an informal meeting place, drop-in centre and basic health service [3,4]. The primary aim of both services was to improve the psychosocial functioning and health of the clients. Basic medical care, counselling, food, laundry, shower and drug consumption facilities were provided. One service introduced a syringe exchange machine (about 10 years before syringe exchange) and a house dealer to regulate dealing on the premises.

Reverend Visser, of St Paul's church, started a supervised injecting centre, 'Perron Nul' (Platform Zero), close to Rotterdam Central Station to provide drug users with an alternative to street-based drug use. There was some support from law enforcement and local government officials. A centre also opened in St Paul's church and later expanded after 'Perron Nul' closed. It served 700 drug users in 1996 and provided one room for injectors and one for smokers.

In 1996, the city of Rotterdam formally supported a centre. This reflected a general shift of opinion towards illicit drug use in Dutch drug policy. Although in the mid–1990s public nuisance is still a prominent issue in the drugs debate, there is a growing awareness that law enforcement 'constraint and pressure' alone—cornerstones of Dutch drug policy since the late 1980s [5]—is insufficient as a response. Consequently, supervised injecting centres and other low-threshold facilities were again promoted, this time

as measures to reduce public nuisance and harms associated with increasing street-based injecting. A newspaper report in 1995 on a centre in Arnhem had a catalysing effect on other regions and on regional and national policy. Besides backing from the city council, the police and the Public Prosecutor, the national government supported this development. The guidelines published by the Public Prosecutor's Office of the Ministry of Justice in 1996 stated that the possession of drugs in centres would be tolerated, provided that those facilities were approved by the local 'triangle committee', which consisted of the mayor, police and Public Prosecutor [6,7].

Most Dutch centres are run by regional drug services, offering a wide range of services from low-threshold harm reduction measures to drug-free treatment. Often they are incorporated in existing low-threshold services with medical care, counselling, food, laundry and shower. Most centres in the Netherlands have both smoking and injecting rooms. At some centres, users have to apply and be approved to use the rooms. Some centres limit access to the centre to residents of the area.

Switzerland

The first Swiss supervised injecting centre opened in 1986. There are now 17 injecting centres in Basel, Bern, Olten, Schaffhausen, Wattil, Wil, Solothum, St Gallen, Winterthur, Basel, Chur and Zurich. Health workers had noticed that increasing numbers of injecting drug users (IDUs) were congregating in public spaces as a result of being shunned from cafes and restaurants. Health workers established special cafes for IDUs who did not utilize health services and IDUs began injecting on-site. The workers took the opportunity to monitor and modify IDUs risk behaviour to reduce harms associated with injecting.

In general, Swiss Centres contain a cafe, a counselling room and a clinic for primary medical care. The injecting rooms are discrete rooms within the centres, and are often small with a 'sterile ambience'. Injecting rooms often contain several tables where clients sit to prepare and inject their drugs. Injecting paraphernalia such as needles and syringes, a candle, sterile water and spoons are provided, along with paper towels, cotton pads; Band-Aids and rubbish bins are nearby. Tabletops are made of stainless steel, to facilitate easy cleaning.

Staff must verify that clients are at least 16 years old and have a history of injecting before they are allowed to use the injecting room. Most centres have a maximum capacity limit. Clients are encouraged to wash their hands on entering the injecting room, and clean their own place at the table after injecting. However, experience has shown that such practices are difficult to both monitor and standardize. Clients are not allowed to smoke anything in the injecting rooms, and most centres apply a maximum time limit (30 or 60 minutes) in the injecting room. Clients are only allowed to prepare their own drugs in the injecting room. Staff are not permitted to help clients inject; however, clients may assist one another.

Centres open for about 7 hours a day, 5 or 6 days a week, and cities with a number of centres often stagger operating times to increase the number of hours per day that IDUs can inject safely. Doctors work a few hours a week at the centres, and some centres have direct phone lines to the police and ambulance service. All Swiss centres have at least one staff member present in the injecting rooms at all times, and all staff are trained to resuscitate clients if they overdose—although one staff member has prime responsibility for this duty. When a client collapses, a team of staff assist. A small bottle of oxygen is taken to the client and administered via a face-mask and simple resuscitation bag until the client regains consciousness. If the client is unable to resume breathing within 10 minutes, an ambulance is called. Naloxone, an antagonist, is not used to revive clients. Counselling, referral to drug treatment, free soup, tea and coffee and cheap fruit and vegetables are provided in the centres.

Approximately 100 clients per day visit the centres in Zurich and Basel. In three centres in Zurich, there were an estimated 68 000 injections, 3000 abscesses treated, 22 clients resuscitated and 10 calls for an ambulance to attend in a 1-year period. The centres are well tolerated in Swiss communities, and police work closely with the staff of injecting centres. The Swiss experience has shown that injecting centres are only required within localities in which frequent public injection occurs.

Germany

The first official German supervised injecting centre opened in 1994, and there are 13 consumption rooms currently in operation in Hamburg (7), Frankfurt (4), Hannover (1) and Saarbrücken (1). Similar to Switzerland, the establishment of these facilities has been a pragmatic attempt to minimize the impact of large open drug scenes in which public injecting,

homelessness and a high prevalence of blood-borne viral infections were evident. They also represent to many a logical extension of acceptance-orientated drug services and humane drug policy [8]. The planning, development and operation of these centres in Germany has typically been facilitated by extensive round-table consultation with the police, residents, businesses and local government.

Injecting centres are typically located within low-threshold, professionally staffed centres that aim to provide an accessible, stress-free, hygienic and humane environment for drug users. Service delivery is based on harm reduction, acceptance and anonymity. There is typically no detailed assessment or registration process to track individuals or outcomes. Routinely collected data tend to be 'count' data used to generate operational statistics.

The legal status of consumption rooms in Germany has until recently been a 'grey area' where their operation was tolerated on a local and state government level. In February 2000, amendments to Federal narcotics law, the *Bet¨aubungsmittelgesetz*, were passed allowing for the legal operation of injecting centres according to specified conditions and standards [9]. The integration of centres within a wider referral network is a common feature in Germany. Clients may be referred (often within the network of the same non-government agency) to accommodation, legal aid, detoxification, opioid substitution therapy, psychotherapy, therapeutic communities, employment services and other social services and health services.

Staffing consists primarily of social workers, nurses and medical officers. Some services employ ex-IDUs. Staff activity is typically on a rotating schedule and at least one staff member supervises clients in the consumption room at all times. There were no security staff employed in six of the centres visited.

Injecting centre clients are expected to be over 18 years, have a history of drug use and not currently in substitution therapy. Rules include: no violence; no drug dealing; no sharing of drugs; no injecting of others; no staff assisted injecting; and a 30-minute time limit in the injecting room. Centre staff advise clients against risky injecting practices and promote safer injecting. As some individuals, in particular women, inject into their groin, curtained areas are provided to allow for private injection. Some centres also provide rooms for heroin and cocaine smoking.

There have been no fatal overdoses in any German centres to date and in most services several hundred clients inject each week with only one or two non-fatal overdose episodes. Opioid-related overdose is managed quickly and efficiently as centres have oxygen tanks and masks or resuscitation bags in the injecting rooms. Most centres have a direct telephone line to an ambulance service.

The impact of supervised injecting centres in Europe

There have been few thorough impact evaluation studies on supervised injecting centres conducted in Europe, and the majority of the published literature does not currently appear in English. Available studies, however, provide some evidence in relation to the four main expected benefits of such facilities: reduced public nuisance; improved access and uptake of health and other welfare services; reduced opioid related overdose risk; and reduced risk of blood-borne virus transmission.

Public nuisance

Two studies have pointed to the acceptability and substantial uptake of these services by the target group [10,11]. Virtually all clients of an injecting centre in Hannover reported having not encountered a negative experience with residents in the area (98%) and had not encountered a negative experience with police in the area (94%) [11].

Studies have reported a shift from public drug use to using in injecting centres in Switzerland and Germany [10,11] and also a general reduction in the visibility and public nuisance of the drug scene [12]. The main reasons that IDUs visit these centres include: the opportunity to consume in peace; the needle and syringe programme; availability of advice and counselling; and as a meeting place [11–13]. Conversely, the main reasons given for continued public drug use in spite of injecting rooms include: limited opening hours; waiting time; and the distance to the centre from the point of drug purchase [12].

Improved service access

Contact with health and other on-site and referral services at these centres have contributed to a stabilization or improvement in general health and social functioning of clients [10,14]. The attainment of stable living arrangements has also been shown to be a significant predictor for individuals ceasing to visit an injecting centre [15].

Opioid-related overdose

While opioid-related overdose deaths have declined in Switzerland and some German jurisdictions (e.g. Frankfurt) during the period in which supervised injecting centres have operated [7,16], it is difficult to know how much is attributable to the operation of injecting centres, given concurrent significant changes in drug policy [12], the increased availability of substitution treatments [17] and targeted policing operations [18].

Immediate intervention in the case of overdose is a significant function of injecting centres [10,11]. Consequently, there have been no overdose deaths at any supervised injecting centre to date, and the number of non-fatal overdose episodes relative to the number of injections supervised is very low. Reported rates of on-site overdose episodes or complications per number of injections include: two in 1000 [12]; one in 520 [19]; one in 648 [20] and one in 498 [11]. Moreover, the likelihood of staying in hospital for one night is 10 times greater for a person who overdoses on the street, compared to one who overdoses in an injecting centre [21].

Blood-borne viral transmission

While there is no direct epidemiological evidence to show reduced incidence of blood-borne virus (BBV) transmission among clients, observed reductions in needle sharing and increased condom use reported by clients indicate a reduction in BBV risk behaviours [10,11,14,22].

Relevant Australian research

Recent studies in Sydney [23,24], Melbourne [25–29] and Canberra [30] have shown:

- that heroin market places have become increasingly street-based, overt and public in nature;
- the price of heroin has decreased and heroin purity has increased;
- there is some indication that the number of heroin users is increasing, and that a greater number of younger people in particular are starting to use heroin; and
- current law enforcement efforts to restrict the operation of these street-based heroin markets appear to have been unsuccessful.

Other studies have reported on a number of health and other harms that are commonly associated with street-based heroin use, such as:

- increasing rates of non-fatal and fatal heroin overdose, particularly following prison release [31–33];
- continuing high rates of hepatitis C virus (HCV) transmission among injecting drug users [34];
- persistent unsafe injecting practices that increase the risk of HCV, HBV and HIV transmission [35,36]; and
- public nuisance such as visible injecting equipment litter, risk of violence, crime, impact on traders and residents, and displacement from public spaces [23,25–29].

The increasing public visibility of street-based heroin markets, and the related health and other harms for both market participants and the broader community, have to a large extent facilitated recent Australian interest in supervised injecting centres as a potentially beneficial harm reduction strategy with which to respond to street-based heroin use and related harms.

Two random telephone surveys of 300 local residents in Kings Cross, Sydney, found support for the provision of injecting rooms increased from 68% in 1997 to 76% in 1998 [37]. Surveys of injecting drug users in Melbourne suggest that there is a demand and willingness to use injecting centres if established there [38–40].

In general, there have been four main arguments proposed as to why such facilities should be trialled within Australia [41–46]. Supporters of supervised injecting centres have claimed that such facilities would: (1) lessen the public impact of street-based injecting; (2) improve clients' access to primary medical care, drug treatment and health and other welfare services; (3) reduce the incidence of fatal heroin-related overdose and (4) assist in reducing blood-borne viral transmission.

The proposed Australian trials

Governments in three Australian jurisdictions have stated they are committed to trialling supervised injecting centres. NSW and the ACT will trial one facility and both have the necessary legislation in place. Victoria proposes to trial up to five facilities in Melbourne if legislation is passed.

New South Wales

Discussion about trialling supervised injecting centres commenced in earnest following a recommendation

from the NSW Wood Royal Commission into the NSW Police Service that such facilities be trialled in this country [47]. Since then a diverse range of community organizations, the clergy, alcohol and other drug agencies, local government, researchers, professional bodies, advocacy groups, state and federal government have participated in this debate.

Illegal shooting galleries have operated in sex shops in Kings Cross since the early 1990s. Customers pay $A6 to use a room for 10 minutes. Some customers used the rooms for sex work, while others used the rooms to inject in private—some engaged in both activities. These rooms came to light during a Royal Commission in the NSW Police Service, 1997, when Commissioner Wood recommended that the NSW Government trial a supervised injecting room. He said:

> At present, publicly funded programmes operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances, to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short-sighted [47].

As a result of the Commission, a NSW Parliamentary Joint Select Committee was established in July 1997 to consider the feasibility of trialling of centres in NSW. The Committee recommended that supervised injecting centres not be trialled; however, it did outline a set of minimum mandatory requirements which it thought necessary to impose should such centres ever be trialled in Australia [45]. In 1998, frustrated health and welfare professionals decided to open an unsanctioned but supervised injecting room, the Tolerance Room, at the Wayside Chapel, Uniting Church, Kings Cross. The room operated for several weeks with much media attention. The police closed the room and arrested the Reverend. The charges were later dropped.

In May 1999, a Drug Summit was held by NSW Parliament. One recommendation was:

> The Government should not veto proposals from non-government organisations for a tightly controlled trial of medically supervised injecting rooms in defined areas where there is a high prevalence of street dealing in illicit drugs where those proposals incorporate options for primary health care, counselling and referral for treatment, providing there is support for this at the community and local government level [45, p.46].

The Sisters of Charity (who operate a public hospital near Kings Cross) offered to operate the injecting centre. However, the Vatican ordered the offer to be withdrawn (October 1999). Meanwhile, the necessary legislation was passed in NSW Parliament to enable an 18-month trial of a medically supervised injecting centre to proceed. The University of NSW offered to operate the injecting centre in (November 1999) but also withdrew its offer as it was involved in the evaluation of the injecting room. The Federal Minister for Education warned the University not to spend federal funds on this service.

The medically supervised injecting centre will be trialled for 18 months in Kings Cross, a Sydney suburb. This area has a high level of drug dealing and sex work and has recently experienced an increase in cocaine injectors [48].

During this trial no other injecting centre is allowed to operate in NSW. The Uniting Church has secured funding to operate the injecting centre, although the licence is still to be granted. Premises have been secured. There has been opposition by the local Chamber of Commerce to the actual site chosen and they have threatened legal action. The Government-selected evaluators are to monitor the impact of the injecting centre on crime, public health and public amenity and community attitudes.

Victoria

Prior to the Victorian election in September 1999, the Victorian Labor Party, then in opposition, announced its proposed drug strategy which included a controlled multiple-site trial of supervised injecting centres throughout Melbourne, with an expected funding of $4.5 million over 3 years. Five possible sites were nominated, including the central business district, Springvale, St Kilda, Footscray, and Fitzroy/Collingwood [49]. The Victorian Labor Party agreed that centres will not be established within any municipality without first obtaining council and community agreement [50,51]. In November of that year the newly elected Labor Government appointed a Drug Policy Expert Committee to be chaired by Professor David Penington [52]. Labor had previously supported the recommendations of the 1996 Premiers Drug Advisory Council [53], also chaired by Professor Penington, but recently had been critical of the previous Liberal Government for slow action on drug issues [54].

The brief given to the newly appointed Drug Policy Expert Committee (DPEC) was to develop

recommendations regarding the implementation of Labor's new drug policy, and to report to Government in two stages. Stage one of the DPEC brief related to the issues of local drug strategy development within existing areas of high drug usage, and the establishment of a five-site trial of supervised injecting centres in Melbourne. Stage two of the Committee's brief covered broader drug policy issues such as service delivery reform and expansion, as well as legislative and regulatory changes for Government consideration [42]. Consistent with the Victorian Labor Party's commitment to community consultation on the trial issue, DPEC developed a number of consultation mechanisms. Despite various consultative efforts, the process attracted criticism from some sectors of the community who thought that insufficient time had been allocated [55,56] and that some groups were not afforded sufficient opportunity to participate [57,58].

The Australian Capital Territory

The ACT's 1999 Drug Strategy, entitled *From Harm to Hope* [59] included the possibility of establishing a 'scientific trial of a safe injecting facility'. Legislation enabling the trial to be conducted was enacted on 9 December 1999. The provisions of this legislation are based on legal advice that a scientific trial is indeed permissible under the international drug control conventions. The ACT policy (which has bipartisan support in the ACT Legislative Assembly) is the culmination of a lengthy period of discussion and public consultation in which demands were made for a more comprehensive drug strategy, including the trial of a supervised injecting centre. Some key events in this process have included: the establishment in 1998 of a Supervised Injecting Place Steering Committee; the review of the proposal by the ACT Sexual Health and Blood-Borne Diseases Advisory Committee and large public forums on drug injecting issues.

It needs to be stressed that the ACT facility is being established as a trial. The ACT *Supervised Injecting Place Trial Act* 1999 states (in section 4) that the object of the Act is: 'to allow the temporary operation of a supervised injecting place, for the purpose of an independently evaluated scientific trial of (a) the public health benefits and risks of such places; and (b) other matters relating to the operation of a supervised injecting place'. It does not, as the INCB claims, permit the establishment of a 'shooting gallery', places characterized by high-risk patterns of drug use. The supervised injecting place is defined, in the Act (at section 3), as 'a place that provides (a) a supervised and hygienic environment for the self-administration of substances by drug dependent persons; and (b) access to clean equipment for such self-administration, and safe facilities for disposing of the equipment; and (c) an opportunity for users of the facility to be referred to counselling, medical treatment, detoxification and similar services' [60].

The trial will be conducted on the basis of three publicly available protocols, covering operational issues, policing issues and trial evaluation. It is being overseen by an Advisory Committee, the members of which represent the diverse interests held in the community at large. It will be a 'low threshold' facility, structured to maximize the uptake of its services by potential clients, and will not be overly medical in orientation. The legal framework facilitating the trial includes maintaining the existing offences of possession and use of certain drugs, along with a provision whereby the Attorney-General will issue directives to the Director of Public Prosecutions (DPP) to not prosecute people for possessing or using prohibited drugs at the facility. The DPP will also be directed to operate in such a manner as to not jeopardize IDU attendance at the trial centre. The trial will run for a period of 2 years, and will be evaluated by an independent, external research team.

As this Digest was going to press, significant developments occurred in the Australian Capital Territory. In June 2000, the ACT Government's annual budget, which included funds to establish and operate the SIP trial, was defeated in the Legislative Assembly for the ACT. The budget was subsequently passed, with the support of key Independent members who are opposed to the trial, on the condition that no funds be appropriated for the trial. This means that the trial will not be conducted until after the next ACT election (scheduled for October 2001) at the earliest.

Conclusions

In Europe, there are over 45 drug consumption rooms. While these facilities differ in their models of service delivery, there are some basic common elements. These include: being officially sanctioned; regulated entry; supervised injecting; provision of sterile injection equipment; immediate resuscitation after overdose; primary health care and referral to drug treatment. On-site drug dealing is prohibited

and ancillary services such as meals, showers and laundry facilities are available.

The European facilities in general operate successfully in consultation with the local community, police and local government. Outcome research into these facilities is limited and very little has been published in English. Findings, however, have been encouraging. In some areas public nuisance has been minimized, the number of overdose deaths and complications from non-fatal overdoses have decreased, BBV risk behaviour has decreased and health and social functioning of clients have improved.

After considerable debate and public consultation, three Australian jurisdictions are preparing to trial supervised injecting centres in 2000. The legislative stipulations and models of service delivery vary between jurisdictions but all centres will be evaluated independently. The indicators under evaluation will include aspects of public nuisance and amenity; referral and utilization of drug treatment, transmission of blood-borne viral infections and overdose events.

While evaluation of these centres is important from an evidence-based approach to health services, as has been highlighted by Bammer [61], it may be difficult to determine the impact of these services. For example, changes in low prevalence events such as fatal overdose may be to small to allow for meaningful measurement and may be confounded by other factors, such as changes in drug treatment services. It is important, therefore, for the Australian community to be realistic about what these trials can achieve. In spite of well-planned and conducted evaluation research, the success or failure of these services may be ambiguous and the interpretation contingent upon the prevailing political climate.

The trial of supervised injecting centres in Australia represents just one new intervention within a much broader existing harm reduction framework. Additional and complementary interventions may include the distribution of naloxone to drug users, low threshold methadone, needle and syringe exchange in prison, pre-release methadone programmes for prisoners, the facilitation of IDUs to move to non-injecting routes of drug use and the expansion of opioid pharmacotherapies.

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