

Report

The Medically Supervised Injecting Centre – An Evidence Based Approach to Drug Policy?

By Matthew Tieu

Introduction

In this report I begin by discussing the information presented in the major reports published on the efficacy and achievements of the Medically Supervised Injecting Centre (MSIC) in Kings Cross over the last decade of its operations. I summarise the main results of those reports and demonstrate that they do not provide any substantive evidence that the MSIC has achieved its objectives. Therefore, one can only conclude that the New South Wales government's recent legislation to enable the permanent operation of the MSIC is more likely to reflect an uncritical acceptance of a particular kind of harm reduction strategy rather than a critical evidence-based approach to drug policy. In the broader social context, the government is therefore faced with the difficulty of having to reconcile this particular harm reduction strategy with the greater goal of minimising or eradicating the social and economic burden of drug related crime and disease.

The initial debate responsible for the establishment of the MSIC occurred during the NSW Drug Summit in 1999, in which it was proposed that there be a trial of an injecting room carried out in a supervised environment. Legislation was subsequently passed in 2000 to establish the MSIC on a trial basis for 18 months initially¹.

The objectives of the trial were:

1. Decrease drug overdose deaths
2. Provide a gateway to drug treatment and counselling
3. Reduce problems associated with public injecting and discarded needles and/or syringes
4. Reduce the spread of disease such as HIV, Hepatitis B and Hepatitis C

At the end of this initial trial period an independent evaluation of the MSIC's efficacy was published in a 2003 report². Due to the inconclusive results of this report the NSW government subsequently endorsed and legislated for two further trial extension periods. The first of these saw the trial period extended to 2007³ during which a number of "interim evaluation" reports on the efficacy of the MSIC were published^{4 5 6 7 8}. A second extension was subsequently granted until 2011⁹ however a year prior to the proposed trial deadline an evaluation report on the efficacy of the MSIC was published by KPMG¹⁰, and subsequently on October 27th of 2010 the Parliament of New South Wales passed a Bill entitled "Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Bill 2010". This new

2 *Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre (2003)*. MSIC Evaluation Committee. http://www.druginfo.nsw.gov.au/__data/page/1229/NDARC_final_evaluation_report4.pdf

3 *Drug Summit Legislative Response Amendment (Trial Period Extension) Bill 2003*

4 *Interim Evaluation Report No 1: Operation and Service Delivery (November 2002 to December 2004), May 2005*. [http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_Rep1/\\$file/INT_EVAL_REP_+1_SYD_+MSIC.pdf](http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_Rep1/$file/INT_EVAL_REP_+1_SYD_+MSIC.pdf)

5 *Interim Evaluation Report No 2: Evaluation of Community Attitudes towards the Sydney MSIC, March 2006*. [http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_Rep1/\\$file/INT_EVAL_REP_+1_SYD_+MSIC.pdf](http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_Rep1/$file/INT_EVAL_REP_+1_SYD_+MSIC.pdf)

6 *Interim Evaluation Report No 3: Evaluation of Client Referral and Health Issues, March 2007*. [http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/\\$file/IntEvalReport3SMSIC+.pdf](http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/$file/IntEvalReport3SMSIC+.pdf)

7 *Interim Evaluation Report No 4: Evaluation of service operation and overdose-related events, June 2007*. [http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/\\$file/EvalRep4SMSIC.pdf](http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/$file/EvalRep4SMSIC.pdf)

8 *Economic Evaluation of the Medically Supervised Injection Centre at Kings Cross (MSIC) August 2008 Final Report*. http://www.druginfo.nsw.gov.au/__data/page/1189/MSIC_Final_Report_26-9-08.pdf

9 *Drug Summit Legislative Response Amendment (Trial Period Extension) Bill 2007*

10 *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial Period (2007-2011)*. Final report – KPMG. http://www.health.nsw.gov.au/resources/mhdao/msic_kpmg_pdf.asp

1 *Drug Summit Legislative Response Act 1999*

legislation essentially allows the MSIC, which had previously operated as a trial that began on 1st May 2001, to operate on a permanent ongoing basis¹¹.

1. Decreasing Drug Overdose Deaths?

One of the claims made in the initial 2003 report was that opioid overdoses may have been fatal had they occurred elsewhere and not under the supervision of the MSIC. It was estimated that at least approximately 4 to 9 deaths per year were prevented due to the interventions of staff at the MSIC (pg. 59). However, in this report it was stated that with regard to opioid overdoses:

In the months preceding the opening of the MSIC, the number of opioid overdose ambulance attendances and deaths decreased dramatically in the Kings Cross vicinity and across NSW. These decreases were attributed to a substantial reduction in the supply of heroin in Australia that occurred at the same time (pg. 44).

And with regard to heroin overdose deaths:

There was no evidence that the operation of the MSIC affected the number of heroin overdose deaths in the Kings Cross vicinity (pg. 44)

Furthermore, with regard to ambulance and emergency attendances:

Subsequent to the opening of the MSIC, there were further reductions in the number of opioid overdose ambulance attendances in the Kings Cross vicinity and across NSW. These reductions were associated with ongoing decreased heroin availability. It was not possible to distinguish the role of the MSIC in reducing demand on ambulance services from the effect of the continued reduction in heroin availability (pg. 44).

In an interim report during the second phase of the trial¹², it was again acknowledged that the heroin shortage was a confounding factor however, this was supposedly addressed by including an experimental control (a comparison with the rest

of NSW) in the analyses of opioid-related deaths and ambulance attendances at suspected opioid overdoses. It was found that while there were no statistically significant differences in the rates of decrease in opioid related deaths between Kings Cross and the rest of NSW, there was a decrease in ambulance attendances at suspected opioid overdoses in the Kings Cross vicinity during the operating hours of the Sydney MSIC compared with the rest of NSW (Pg. 31). This claim is also supported by the most recent evaluation published in 2010 by KPMG¹³.

However, a confounding factor that has not been considered or mentioned in any of the reports is the increased policing with the aid of sniffer dogs in the Kings Cross area which began in May 2002¹⁴. The role of this kind of law enforcement may have had a significant impact on ambulance callouts. This was highlighted in an independent evaluation published by Drug Free Australia (DFA). They claim that when introduced in Cabramatta, "sniffer dogs, along with associated policing measures, reduced ambulance callouts by 83%"¹⁵.

Interestingly the 2010 KPMG report does not draw any conclusions about the impact that the MSIC has had on preventing opioid related deaths. It states:

The absolute numbers of opioid-related deaths in the Kings Cross area are too low to draw out trends around deaths. In addition the absence of opioid-related death data for the period prior to the commencement of the MSIC means it is not possible to comment on the impact the MSIC has had on opioid-related deaths. (Pg. 185).

Clearly the reports from all three trial phases provide very little evidence to suggest that the MSIC is responsible for reducing overdose related deaths in Kings Cross and surrounding postcodes.

11 *Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Bill 2010*

12 *Interim Evaluation Report No 4: Evaluation of service operation and overdose-related events, June 2007.* [http://www.nchechr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/\\$file/EvalRep4SMSIC.pdf](http://www.nchechr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/$file/EvalRep4SMSIC.pdf)

13 *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial Period (2007-2011). Final report – KPMG.* http://www.health.nsw.gov.au/resources/mhdao/msic_kpmg_pdf.asp. Pg. 178-182.

14 <http://www.abc.net.au/news/s559063.htm>

15 http://www.drugfree.org.au/fileadmin/Media/Global/2010_Update_Injecting_Room.pdf

2. Provide Gateway to Treatment?

The 2003 report concludes that MSIC clients were more likely to report that they had started treatment for their drug use than non-MSIC drug users (pg. 98-103). At the end of the first trial phase a total of 1,385 referrals (751 verbal and 634 written) for further assistance had been made for 577 MSIC clients (15%). During this phase a study of the rate of referral uptake revealed that of the 634 written referrals, 129 referral cards were returned. This data suggests that the rate of referral uptake as a proportion of total registered clients of the MSIC (3,810) was relatively low. It is stated in the 2003 report that "one in 20 MSIC clients received a written drug treatment referral... and 1% of MSIC clients were confirmed attenders at the referred drug treatment agency" (pg. 99). Again, this is very low proportion of referrals made and confirmations of referral uptake.

However, this is likely to be an underestimate of the actual number of referrals/referral uptake due to limitations with the referral card methodology (e.g. clients misplacing their referral card, agencies not requiring them or not returning the referral cards to the MSIC). Furthermore, it is worth bearing in mind that the study only accounts for approximately half of referrals since the other half were verbal referrals.

Another result discussed in the 2003 report was that referrals appeared to be targeted more towards those who were frequent attendees of the MSIC (42% who visited on more than 10 occasions received a referral). This explains why clients who visited the MSIC with greater frequency were more likely to have confirmed referral uptake. Similarly, the 2010 KPMG report also demonstrates that those with a greater frequency of attendance (constituting 2-7% of the MSIC clients) were more likely to accept a referral.

64% of frequent attenders (>98 total visits) accepted a referral to drug treatment, whereas only 1% of infrequent attenders (1-2 total visits) accepted a referral to drug treatment. Similarly, 60% of frequent attenders (>98 total visits) accepted a non-drug treatment referral, compared to 1% of infrequent attenders (1-2 total visits). (Pg. 136).

First one should bear in mind that not all referrals are specifically for drug addiction treatment which, as shown in the 2003 report, constituted only 43% (601 total) of the referrals, with 32%

(439 total) being health care referrals and 25% (345 total) social welfare referrals (pg. 98-99). Very similar percentages were observed for the period 2001-2004 as stated in the interim report, with the total number of referrals offered also similar at 16% (Pg. 25). The 2010 KPMG report presents cumulative data on these proportions from the commencement of the MSIC until 2010. Thus at 2010 there were a total of 8,508 referrals made, with 3,871 drug treatment referrals (45%), 2,278 health care referrals (27%), and 2,359 social welfare referrals (28%).

Second, only 15% of clients received any kind of referral at all (as stated in the 2003 report) which is a relatively low number of referrals made at all. Similar figures were also observed in the interim report which states that 16% of MSIC clients received a referral (pg. 25). Furthermore, the total rates of referral decreased and remained fairly low from 2006 onwards as stated in the 2010 KPMG report. There were 860 referrals for the year 2006-2007, 801 (2007-2008), 779 (2008-2009) and 648 (2009-2010) (pg. 124).

Therefore, on the basis of the relatively low and declining referral rates, the efficacy of the MSIC serving as a gateway to treatment is still relatively low. Perhaps this also demonstrates a lack of demand on the part of MSIC clients for referral services offered by the MSIC, particularly for drug addiction treatment. This is reinforced by the data in the 2010 KPMG report that only 1% of infrequent attendees (which constitutes over 90% of the total MSIC clients) accept referrals to drug treatment or non-drug treatment services. This demonstrates that referrals for the treatment of drug addiction are not a priority of the MSIC nor are they a priority of the majority of those who visit the MSIC.

3. Public Amenity?

In the first trial phase, telephone surveys targeted towards residents and Kings Cross business owners were conducted before and after the opening of the MSIC to gauge perceptions of different forms of public annoyance due to illicit drug use (e.g. negative image, crime and safety, discarded syringes, attracting drug users, harassment or begging and drug dealing). These results were initially published in the 2003 report, though a further telephone survey was conducted during the second phase of the trial in 2005, which was

then published in an interim report¹⁶. This survey was repeated in the third phase of the trial in 2010 and published in the 2010 KPMG report.

Both the 2003 and 2005 reports indicate that the main types of public annoyance most frequently reported by local residents were publicly discarded syringes, negative image to the area, crime and personal safety, tragedy of drug use, harassment or begging and public injecting (pg. 113 and pg. 14 respectively). The 2003 report states that whilst the residential respondents were consistent in what they regarded as major forms of public annoyance, there were some significant changes in the way business owners responded. Whilst negative image, crime and safety, and public injecting annoyances remained the same between 2000 and 2002, there were large increases in the citing of other public annoyances. For example, almost twice as many respondents reported crime and safety to be a public annoyance, three times as many cited the attracting of drug users to the area to be an annoyance, almost six times as many reported drug dealing to be an annoyance and almost twice as many cited the ineffectiveness of control as an annoyance (pg. 112-114).

Of the local residents surveyed in the first trial phase, 84% (in 2000) and 86% (in 2002) reported having seen syringes discarded in public places. Similar proportions of business respondents also reported having seen syringes discarded in public places, 90% (in 2000) and 87% (in 2002) (pg. 115). The 2005 report indicates that there was a slight decline in the reports of residential respondents (78%) and business respondents (82%) (pg. 12-13). There were further declines reported in the 2010 KPMG report with residential respondents (76%) and business respondents (80%) (pg. 174).

Higher levels of publicly discarded syringes are also an indication of public injecting therefore syringe counts conducted can also serve as a measure of public injecting. Independent syringe counts were performed by the Kirketon Road Centre (KCR) Clean-up Team, The National Centre in HIV Epidemiology and Clinical Research (NCHECR), and the South Sydney Council during 2000 to 2002. As discussed in the 2003 report, they all reported that there was a rapid short term increase in the number of publicly discarded

syringes after the MSIC opened. However, there was an overall decrease in the average number of syringes collected per month after the opening of the MSIC compared with the previous year, though there was subsequent trend of gradual increase (pg. 117-120). There were no significant changes in the number of syringes that were distributed in Kings Cross (pg. 121-123).

The data on syringe counts published in a 2007 interim report¹⁷ indicate that the overall trend of lower numbers of publicly discarded syringes observed after the MSIC opened continued through to 2007, an overall reduction of 48% (pg. 33). The 2010 KPMG report states that when comparing the needle counts 2003 to 2004 and 2008 to 2009, there has been an overall reduction of 55% (pg. 168).

Whilst there was a significant decrease in publicly discarded syringes after the opening of the MSIC and marginal decreases in local residents and business owners who reported fewer sightings of episodes of public injection and discarded needles, a major caveat to this study was the fact that there was a heroin shortage (as mentioned previously) that began in the months prior to the opening of the MSIC. This is acknowledged in the 2003 report (as well as the interim reports).

Syringe counts in Kings Cross by the Needle Clean-Up Team, researchers and the Council, were generally lower after the MSIC opened than before, although increased levels were recorded at some sites, and there was a subsequent trend of gradual increase detected"... it was not possible to determine whether the decrease in discarded syringes was due to the prolonged reduction in the availability of heroin that commenced several months before the MSIC opened rather than any reduction in public injection due to the MSIC. (Pg. 124).

After the first trial phase of the MSIC, the conclusion regarding the effect that the MSIC had on public nuisance associated with discarded syringes and public injecting, as stated in the 2003 report, is as follows:

Even though the number of syringes discarded on the streets of Kings Cross subsequent to

¹⁶ *Interim Evaluation Report No 2: Evaluation of Community Attitudes towards the Sydney MSIC, March 2006.* [http://www.nchechr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_Rep1/\\$file/INT_EVAL_REP_+1_SYD_+MSIC.pdf](http://www.nchechr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_Rep1/$file/INT_EVAL_REP_+1_SYD_+MSIC.pdf)

¹⁷ *Interim Evaluation Report No 4: Evaluation of service operation and overdose-related events, June 2007.* [http://www.nchechr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/\\$file/EvalRep4SMSIC.pdf](http://www.nchechr.unsw.edu.au/NCHECRweb.nsf/resources/Interim_eval_rep_2/$file/EvalRep4SMSIC.pdf)

the establishment of the MSIC decreased marginally, it is difficult to discount the contribution of the reduced availability of heroin. It was also not possible to determine whether fewer syringes on the street reflected a reduction in episodes of injection in public places. Certainly local residents reported sighting significantly less episodes of public injection as well as less syringes discarded in public places. (Pg. 125).

As far as the role which the MSIC may have played in helping reduce the numbers of publicly discarded syringes, the KPMG report is reluctant to draw any conclusions.

It is important to bear in mind that the data provided below are entirely from the period following the opening of the MSIC. In the absence of needle collection data for the period prior to the opening of the MSIC, it is not possible in this analysis to comment directly on the impact of the MSIC on needle collection following its opening. (Pg. 168).

Another confounding factor to bear in mind is the tougher police enforcement (with the aid of sniffer dogs) in Kings Cross that began in May 2002 (12 months after the injecting room opened), which may have pushed drug users and dealers further away¹⁸. Furthermore, nursing staff of the MSIC were also interviewed to gauge their opinions on the report and one in particular stated that any reduction in the level of publicly discarded syringes or public injection "could also be due to the police sniffer dog campaigns which has pushed people to darker corners further away" (pg. 30).

4. Reduce The Spread of Disease?

The number of newly diagnosed incidences of HIV (Human Immuno-Deficiency Virus), HBV (Hepatitis B Virus) and HCV (Hepatitis C Virus) infections in the vicinity of the MSIC (Kings Cross, Darlinghurst and Surry Hills) was investigated and compared with the number of cases reported from the rest of Sydney and NSW. The results are presented and discussed in the 2003 and 2010 KPMG report. (The interim reports do not provide any specific data or discussion on this objective).

¹⁸ <http://www.abc.net.au/news/newsitems/200205/s559063.htm>

The 2003 report indicated that there was a steady trend of increased notification of HIV infections from the Kings Cross postcode, increasing 15% per year from 1998-2002 (pg. 69). However, it is stated that the most common mode of transmission of HIV is due to homosexual activity amongst men rather than injecting drug use (pg. 79). The 2010 KPMG report indicates that after 2002 there was a modest downward trend in notifications of HIV infections for the Kings Cross postcode, compared with a slight upward trend for the rest of NSW (pg. 36).

Notifications of HBV infections remained stable from 1998-2002 in the surveyed areas whilst there was an increase in the rest of Sydney (pg. 71-72). The 2010 KPMG report does not present any specific data on HBV infections.

The 2003 report indicates that notifications of newly diagnosed HCV infection remained stable in the Kings Cross postcode, but increased in the surrounding Darlinghurst/Surry Hills postcodes and the rest of Sydney. Interestingly, the 2003 report states that there was a trend of increased HCV prevalence among injectors surveyed in Kings Cross as well as those who reported use of the MSIC. However, the report speculates that:

It is likely that the high prevalence of HCV among this group reflects the client base and target population of the MSIC, that is older people who have been injecting for longer periods of time and those with high levels of dependence and injecting risk behaviours. (Pg. 80).

The 2010 KPMG also reports a higher prevalence of HCV among new MSIC clients. However it is suggested that this could also be due to the greater potential for transmission of the Hepatitis C virus, that it is able to remain viable outside the body for a longer period than HIV or Hepatitis B (pg. 81). Whilst the 2003 report concedes that there was an increased prevalence of HCV (as discussed above), it concludes that there is no discernable increase in HIV or HBV infections among injecting drug users (pg. 80).

The 2010 KPMG report presents data over a longer period of time and claims that from 1999-2009 there was an overall downward trend in the notifications of HCV in both the Kings Cross postcode and throughout NSW. However, the downward trend in the Kings Cross postcode only represents a 21% decrease as opposed to

the 41% decrease measured for the rest of NSW (pg. 36-37). However, the 2010 KPMG report is reluctant to draw any conclusions with regard to this objective stating that:

The rates of Hepatitis C, HIV and Hepatitis B infection recorded for MSIC clients is consistent with the rates found in previous studies. However, it is difficult to assess the impact that the MSIC has had, if any, on the rates of infection of these viruses. (Pg. 81)

The MSIC's provision of injecting and vein care advice aims to reduce the risk of transmitting blood borne diseases that arise due to poor injecting technique and syringe sharing. Reports from all three trial phases indicate that MSIC clients generally practice safer injecting behaviour and are less likely to inject in public places which places them at greater risk of contracting diseases. Combined with the small proportion of drug treatment and health care referrals that clients receive, this data suggests that the MSIC is providing a contribution towards decreasing the spread of blood borne diseases transmitted through promoting and educating drug users on safer injecting practices. However, given that the reports provide no evidence of any significant decreases in the incidence of HIV, HBV and HCV in the Kings Cross postcode, there is no evidential basis upon which to claim that this objective has been achieved.

Summary

The reports from all three phases of the trial concluded that the operation of the MSIC in the Kings cross area was feasible and that the MSIC should continue its operations. However, it is clear that this is not justified because of the lack of any evidential basis upon which the MSIC can claim to have achieved any of its four main objectives to any substantive degree.

The results of the reports clearly acknowledge that firstly, the reduction in opioid overdoses could not be attributed to the operations of the MSIC due to the co-occurrence of a nation-wide shortage of heroin supply. Despite this acknowledgment, the 2003 report makes the speculative claim that "the MSIC probably did reduce opioid overdoses amongst those who used the facility", estimating that 4 deaths per annum were averted (pg.203). Yet the KPMG report is reluctant to draw any conclusions about the role the MSIC may have played stating that "the absence of opioid-related

death data for the period prior to the commencement of the MSIC means it is not possible to comment on the impact the MSIC has had on opioid-related deaths" (pg. 185).

Secondly, whilst the report does conclude that the MSIC provides a "gateway" to drug treatment for a small proportion of MSIC clients, this is a very modest outcome. The 2003 report itself states that the rates of referral from the MSIC "fall within the lower bounds of the range reported for IDU (injecting drug users) seeking drug treatment referrals in needle and syringe programs and community health settings" (pg. 203-204). It is likely that the majority of the clients of the MSIC are not interested in seeking any kind of drug addiction treatment referrals at all.

Thirdly, due to the heroin shortage, the observed reductions in discarded needles and syringes and public injecting cannot be solely attributed to the operations of the MSIC, despite the claims made in the reports that the MSIC played a role in improving public amenity. The 2010 KPMG report could only speculate that "it is reasonable to assume that at least a proportion of the 604,022 injections conducted at MSIC in the last 10 years would otherwise have occurred in public places" (pg. 31). Increased police law enforcement within Kings Cross is likely to have pushed drug users away and thus may have contributed to decrease in discarded needles and syringes as well as preventing an escalation in drug related crime. One cannot therefore discount the potential of the MSIC to attract drug related crime.

Fourthly, the 2003 report concludes that there was no evidence of an increase or decrease in notifications of HIV, HCV or HBV in the Kings Cross area attributable to the MSIC. However, there was an increase in HCV prevalence among injectors Kings Cross as well as those who reported use of the MSIC. The 2010 KPMG report suggests that the MSIC may not have had any impact on the prevalence of those diseases at all.

Conclusion

Whilst the results of the studies presented at the end of the first trial phase (in the 2003 report) clearly demonstrate that there was no evidence that the MSIC had achieved its objectives, one could have been warranted in claiming that further studies were required. This was indeed the basis upon which the NSW government decided in 2003 to legislate for an extension of the trial

period until 31st of October 2007, thus constituting a second trial phase¹⁹. In a speech made by Ms. Reba Meagher (Cabramatta—Minister for Health) on the 5th of September 2003, she discusses the impetus for the Bill which would grant an extension on the trial period of the MSIC²⁰ (emphasis added).

All aspects of the current licence, the terms and conditions for operating the centre and the trial remain unchanged for the additional period. However, in line with this Government's evidence-based approach to drug policy, the trial over the next four years will continue to be carefully monitored...The extension will also provide an opportunity for information and data to be collected over a longer period and to take account of any changes in the drug market, such as any changes in the supply of heroin.

At the end of this second trial phase there was still very little evidence presented in the interim reports to establish whether the MSIC had achieved its objectives. The status of the efficacy of the MSIC in 2007 was essentially no different to 2003. In a subsequent speech to parliament²¹ made by Ms. Reba Meagher on June 7th 2007 she states:

A further trial period will also enable a longer term evidence base to be established as to the effectiveness of the centre. This is of particular importance, given the long-term drug use of its client group and will inform any future decisions on permanency of the centre.

This would be the third and final trial period of the MSIC, though as it turns out the trial phase would be attenuated a year before its conclusion by the introduction of new legislation to allow the MSIC to operate on a permanent ongoing basis.

When introducing the Bill to parliament²², Ms. Carmel Tebbutt (Marrickville—Deputy Premier and Minister for Health) stated that:

The Government has made the decision to continue the Medically Supervised Injecting Centre as an ongoing program following strong evidence from numerous independent evaluations that the centre is achieving those objectives.

As discussed in this report, it is clear that there is no evidential basis upon which the MSIC can claim to have achieved its four objectives. Therefore this decision does not reflect an evidence-based approach to drug policy but rather it is likely to have come from an agenda aimed at promoting and implementing a harm reduction strategy regardless of the results of the trials.

The official policy concept underpinning national and state public health strategies is "Harm Minimisation" (as discussed in the National Drug Strategy 2004–2009 and the 2010–2015 draft)^{23 24}. The core aims are to reduce supply and demand for drugs as well as reduce the levels of harm associated with drug use. These "harm reduction" strategies constitute one element of the harm minimisation concept. They are designed to prevent or limit specific harms arising from the use of drugs. The aim of a harm reduction strategy is to avoid exacerbating harm caused by misuse of drugs without necessarily condoning or endorsing drug use. However, a significant conflict emerges from this equivocation. Many advocates of the harm minimisation concept tend to accept that people choose to use drugs, and therefore they are not interested in whether drug users have made a prudent choice. Their focus is solely on reducing harm due to the risks associated with drug use. Therefore, it follows that the only recourse that they believe is available to drug users is to ensure that harms are not made worse

19 Drug Summit Legislative Response Amendment (Trial Period Extension) Bill 2003

20 Extract from NSW Legislative Assembly Hansard and Papers - NSW Hansard Articles : LA : 05/09/2003 : #6 [http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/7bd7da67ee5a02c5ca256e67000c8755/3158d0c4666ff079ca256d9500366221/\\$FILE/A4703.pdf](http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/7bd7da67ee5a02c5ca256e67000c8755/3158d0c4666ff079ca256d9500366221/$FILE/A4703.pdf)

21 Extract from NSW Legislative Assembly Hansard and Papers Thursday 7 June 2007. [http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/0/3b87d96596ec7beaca2572f3002d5e0c/\\$FILE/LA%201707.pdf](http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/0/3b87d96596ec7beaca2572f3002d5e0c/$FILE/LA%201707.pdf)

22 Extract from NSW Legislative Assembly Hansard and Papers Wednesday 22 September 2010. [http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/0/51e975631477f96fca2577a6001a6823/\\$FILE/LA%208110.pdf](http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/0/51e975631477f96fca2577a6001a6823/$FILE/LA%208110.pdf)

23 The National Drug Strategy: Australia's integrated framework 2004–2009. <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/framework0409>

24 The National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco, illegal and other drugs. Consultation Draft December 2010. <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/consult-draft>

for them by providing them with safer equipment to use (e.g. clean syringes) and safer environments to inject (e.g. the MSIC). In contrast to harm reduction, an alternative perspective that is based on a broader and more internally consistent harm minimisation concept is one that is defined in terms of non drug use as the primary goal rather than harm reduction. This is simply because abstinence gives rise to the lowest possible level of harm associated with drug use, as well as the lowest possible level of supply and demand.

Whilst it may have been expected that the MSIC would contribute to reducing overdose related harms and prevent transmission of blood borne diseases, there is no substantive evidence to demonstrate that the MSIC has achieved any of these harm reduction goals in its 10 years of operation thus far. The operation of the MSIC during its decade long trial phase is still regarded as an experimental approach to harm reduction as stated in the recent draft of the National Drug Strategy 2010-2015, but it will be interesting to see what the final version has to say about the outcome of this experiment.

In relation to injecting drug use, needle and syringe programs have been the main harm reduction approach, helping to slow the spread of blood-borne viruses like HIV and hepatitis C. Readily available needle disposal facilities and other strategies as simple as well-lit streets have helped to improve community amenity in areas where injecting drug use takes place. Some jurisdictions have experimented with other approaches,

including a medically supervised injecting centre in one jurisdiction. (Pg. 25)

Clearly, the decision to have the MSIC operate on a permanent ongoing basis is more likely to reflect the government's harm reduction agenda. Though, one wonders whether it also demonstrates that the community (particularly the local residents and business owners and injecting drug users of Kings Cross) is content to have this drug issue swept under the rug rather than properly dealt with.

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Date: August 17-20, 2011

Venue: Zurich, Switzerland

This conference will be organised by the European Society for Philosophy of Medicine and Healthcare (ESPMH) and the Institute of Biomedical Ethics, University of Zurich, Switzerland.

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