



# **The potential and viability of establishing a Supervised Injecting Facility (SIF) in Melbourne**

**Position Paper - October 2009**

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*A community based response to alcohol and other drug issues*

Yarra Drug & Health Forum

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## **Executive Summary**

The following provides a summary of evidence generated through a review of published and unpublished literature and key expert consultation. It outlines a position on the potential and viability of a Supervised Injecting Facility (SIF) in Melbourne.

### **Research evidence**

The following emerged from the literature as essential activities and approaches.

- Development of political and community support:
  - Strong relationships with other service providers such as local government, community and welfare services are essential;
  - Police relationships are particularly important;
  - Strong supporters and champions needed in government;
  - Community understanding of the role and purpose of a SIF needs to be built through education and participation.
- Focus on rigorous evaluation:
  - Explore impact on public health via overdose and disease prevention;
  - Calculate cost savings to health and emergency services;
  - Review acceptability by target group and access to, and utilisation of, the service;
  - Monitor provision of referrals to drug treatment.
- Providing a range of accessible services:
  - Employ a range of workers including nurses and social workers;
  - Provide fixed site and outreach services;
  - Locate SIF near existing drug markets;
  - Provide an integrated range of health and welfare services;
  - Provide spaces in which client engagement for referral and other assistance can occur.

### **Identification of need**

In other locations, conditions which have led to the establishment of a SIF include the following:

- Prominence of public injecting;
- High rates of hepatitis C amongst injecting drug users;
- High occurrence of serious and potentially serious injecting related injuries and disease amongst injecting drug users;
- High numbers of fatal and non-fatal overdoses occurring in public places;
- Community concern around publicly discarded injecting equipment.

These conditions currently prevail in areas of Melbourne.

### **Position in alcohol and other drug sector**

- A Melbourne SIF could operate within existing needle and syringe programs and primary healthcare facilities for injecting drug users as an integrated facility.
- Both mobile and fixed site SIFs are supported by the key expert consultation and could potentially be suitable for Melbourne.

### **Recommendations for action**

- Development of an advocacy strategy will be imperative in gaining community and political support:
  - Build on current media attention on needle and syringe programs which has followed the release of the evaluation of the cost-effectiveness of needle and syringe programs in Australia (NCHECR, 2009);
  - Review political climate to determine potential for renewed support for a SIF following former Premier Steve Bracks' comments that a SIF would not be funded during the life of the Victorian Labor Government.
- Investigating the cost-benefit of a potential Melbourne SIF:
  - Determine whether funding a SIF would impact negatively on existing funding for current harm reduction services;
  - Develop a minimum standard for operations which details the funding that would be required to run a SIF in Melbourne.
- Investigating the viability of integrating a SIF with existing harm reduction and treatment services:
  - Explore locations such as needle and syringe programs and primary health care settings as potential sites;
  - Explore at least one possible pilot site and seek agreement for participation in a pilot service.

## ***Introduction***

This project has been funded by the Yarra Drug and Health Forum to gain collective input for the purpose of developing a position paper on the potential and viability of a SIF in Melbourne. The project aims to outline the social, environmental, and public health conditions which would precede the introduction of a SIF. Social conditions include factors like homelessness, access to services, engagement in sex work and incarceration history. Environmental factors may include the nature of the drug market, physical and geographical location of drug use and public amenity levels. Public health conditions may encompass mortality and morbidity rates associated with injecting drug use and potential cost savings of utilising particular service approaches. The paper will also discuss how a SIF might be introduced to Melbourne and considerations about how it might operate on a practical level in the current context.

SIFs have been operating around the world for over twenty years. This paper provides a brief review of published and unpublished literature relating to SIFs worldwide and is accompanied by a summary of key expert consultation. This includes responses to questions about local issues which might influence the success of a SIF in Melbourne and factors that contribute to the success of SIFs in other locations. A series of recommendations about further actions to be undertaken in relation to the potential and viability of a SIF in Melbourne is provided at the end of the paper.

## ***Literature Review***

### **Legal, law enforcement and policy implications**

Australia is a signatory to a number of international covenants and treaties which influence our legislative processes and obligations in relation to domestic drug policy. While there are no specific covenants which prohibit the establishment of SIFs in UN member countries, the International Narcotics Control Board (INCB) has opposed the establishment of SIFs in the past. The INCB is the controlling body for UN drug policy.

Recommendation 99 - *'The Board notes with concern that drug injection rooms continue to operate in a small number of countries, mainly in Europe. The Board urges the Governments of countries where such facilities are operated for the purpose of administering illicitly obtained drugs, to put an end to such practice and provide appropriate evidence-based medical services and facilities for the treatment of drug abusers'*

Report of the INCB pursuant to the Twentieth Special Session of the General Assembly, Fifty-first session Vienna, 10-14 March 2008.

However, despite this opposition, SIFs have been established in a number of European countries, Canada and Australia for many years. In light of the growing acceptance of harm reduction strategies internationally, this opposition to SIFs may not be particularly significant in the Melbourne context.

The legality of a proposed SIF may be influenced by a range of factors. The relationship between federal, state and local laws is important, as the jurisdiction within which the SIF is established can determine how open it may be to judicial or political challenges (Beletsky *et al.*, 2008). Furthermore, the political and judicial climate at the time may affect the outcome of any challenges. Therefore, engaging government stakeholders is crucial to the process of establishment (Beletsky *et al.*, 2008; Schneider & Stover, 2000). Local authorisation may be possible, but this is considered most open to legal challenge as compared with state authorisation (Beletsky *et al.*, 2008; Roberts, *et al.*, 2004). Explicit state authorisation is considered the best approach; this may occur through health authorities (Beletsky *et al.*, 2008).

Relationships between police and SIF service providers can impact on the success or otherwise of a proposed SIF (Broadhead *et al.*, 2002; Schneider & Stover, 2000; Rhodes *et al.*, 2006). In other contexts where SIFs operate, police support has been found to be important, but

inconsistent (DeBeck *et al.*, 2008). It is recommended that an approach similar to that fostered by needle and syringe programs (NSPs) is utilised in the SIF context (Broadhead *et al.*, 2002). In some countries, standard agreements between NSPs and police often dictate that clients should not be targeted when using the NSP (Broadhead *et al.*, 2002). Similarly, police should not monitor the entrance or exit of a SIF (Kerr *et al.*, 2003). Nevertheless, it is important for police to be available if staff feel unsafe and require assistance inside the SIF (Wood *et al.*, 2004a).

Policing activity is known to displace public injecting to other locations, rather than contribute to its cessation (Kerr *et al.*, 2005). An effective and sustainable law enforcement approach can include providing referral to a SIF for injecting drug users (IDUs) found injecting in public places (DeBeck *et al.*, 2008; Kerr *et al.*, 2005).

### **Identification of need**

Many conditions have contributed to the establishment of SIFs around the world. These include risk behaviours (such as overdose and sharing of injecting equipment) amongst IDUs, political factors, environmental conditions and drug market characteristics. Where these conditions have intersected, SIFs have been considered a viable intervention to help reduce harms amongst IDUs and improve public amenity.

One common factor preceding the introduction of SIFs is high rates of public injecting (Rhodes *et al.*, 2006) and the consideration of the potential for SIFs to alleviate the risk of injecting-related harms (Broadhead *et al.*, 2002). Such harms include those which are a result of poor hygiene, due to a lack of clean water for washing hands and mixing drugs (Broadhead *et al.*, 2002; Kerr *et al.*, 2005; Rhodes *et al.*, 2006); others may arise from rushing the injecting process due to fear of being discovered by local residents, business owners, passersby or police (Broadhead *et al.*, 2002; Kerr *et al.*, 2005; Rhodes *et al.*, 2006). Rushing when injecting may lead to injection-related injury and disease (IRID) and elevated rates of sharing equipment which can increase blood-borne virus (BBV) transmission (Broadhead *et al.*, 2002). Hurrying the injecting process may also contribute to greater likelihood of overdose as IDUs are less likely to test the potency of drugs by using a small amount first (Broadhead *et al.*, 2002).

Public injecting is also associated with inappropriately discarded injecting equipment, which reduces public amenity in particular areas (Rhodes *et al.*, 2006). This perceived reduction in amenity may also be influenced by crime, violence and loitering caused by an illicit drug market operating in a public space (Rhodes *et al.*, 2006). Another factor which may contribute to the



need for a SIF is the prevalence of illegal shooting galleries operating in a particular location. Illegal shooting galleries are private spaces where people can inject drugs. Spaces and injecting equipment may be used for a fee. They have typically been described as squalid, unsafe and unhygienic places (Kimber and Dolan, 2007).

In addition to illegal shooting galleries other forms of injecting spaces have been found to exist. 'Supervision' of injecting occurs in a number of different ways. Formalised SIFs of the type considered in this review engage trained, largely professional (although this varies according to the actual model employed) supervisors to monitor and oversee the practice of injecting in the context of a dedicated facility. However, supervision of injecting does not occur in these facilities alone, with varying levels of supervision afforded to the practice of monitoring of injecting drug use and related harms.

Indeed, Fitzgerald et al (2004) noted that in Melbourne in 2000, there were at least two models through which informal supervision of injecting took place in what they termed 'quasi-supervised' facilities. These facilities offer limited supervision that can provide some degree of safety from harms that can occur in public using environments such as violence and overdose. In the first model, outreach workers from a health service in the Melbourne CBD monitored a laneway adjacent to their service for signs of overdose or other harms. In the second model, attended public toilets served as 'safe' environments in which the attendants were instructed to monitor overdose occurrence and respond to save lives as required. These represent two documented forms of 'quasi-supervision' – it is likely that many other services in contact with drug users (eg. treatment service providers) have provided similar environments over time. These 'quasi-supervised' models indicate a need for more formal services.

## **Community support**

Public support is integral to the successful establishment of a SIF (Roberts, *et al.*, 2004). It is known that poor public perception decreases with understanding of the role of a SIF (particularly in relation to the public health benefits) and following implementation of a SIF (Broadhead *et al.*, 2002; Schneider & Stover, 2000; Thein *et al.*, 2005). Furthermore, local stakeholders are more likely to endorse the SIF if they fully understand its role and benefits (Broadhead *et al.*, 2002). The exact title of the service will also play a role in public support (Beletsky *et al.*, 2008).

Engagement with key stakeholders throughout the processes of needs assessment, planning, implementation and evaluation is critical (Beletsky *et al.*, 2008; Broadhead *et al.*, 2002; Schneider & Stover, 2000; Kimber *et al.*, 2005; Rhodes *et al.*, 2006). In particular, the needs

assessment and planning process should reflect local concerns about reduced public amenity (Roberts, *et al.*, 2004).

Peer support and participation throughout all stages is integral, so that acceptance amongst IDUs can be developed (Broadhead *et al.*, 2002; Rhodes *et al.*, 2006). This acceptance will influence the willingness of IDUs to utilise a SIF, if one was to be implemented (Kimber and Dolan, 2007; Wood *et al.*, 2003; Wood *et al.*, 2004a). In addition, acceptance by health professionals may be cultivated through the development of referral and support networks and memoranda of understanding with other AOD services (Broadhead *et al.*, 2002; Schneider & Stover, 2000; Rhodes *et al.*, 2006).

Attitudes of local businesses near the Medically Supervised Injecting Centre (MSIC) in Kings Cross, Sydney were evaluated in 2000 (one year before opening), 2002 (one year after opening) and 2005 (four years after opening). In 2005, 68% agreed with the establishment of the centre which was an increase from 63% in 2002 and 58% in 2000 (NCHECR, 2006).

In the National Drug Household Survey in 2004 and 2007, community participants were asked about their support for measures relating to the use of heroin. In 2007, 50% supported regulated injecting rooms, which was an increase from 2004 (40%) (AIHW, 2008).

## **Location**

The physical location of a SIF is significant in relation to both acceptability amongst IDUs and broader community support. It is important that SIFs are located near public injecting sites (Schneider & Stover, 2000; Thein *et al.*, 2005), drug markets (Schneider & Stover, 2000; Rhodes *et al.*, 2006) and high risk drug using populations (Rhodes *et al.*, 2006). However, they must also be located away from residential areas, children and young people (Thein *et al.*, 2005). This could potentially impact on the success of a SIF as it may mean locating it away from areas of public injecting and street-based drug markets.

Where the size of the drug using population is not large enough to warrant a fixed site SIF, alternatives should be considered to ensure equity across regions and between metropolitan and rural areas (Schneider & Stover, 2000). Integration and co-location of SIFs with other health and welfare services should also be considered. . These issues are of particular relevance for the establishment of a SIF in Melbourne, given the existing network of IDU primary care sites and the dispersed locations in which injecting drug markets exist.

The concept of mobile SIFs was to be part of this literature review, however no published

English language literature specifically relating to mobile SIFs was found through this review. Discussion on the advantages and disadvantages of mobile SIFs is included in the Addendum at the end of this paper.

## **SIF services**

SIFs typically provide multiple services to IDUs. Their main purpose is to offer a place where drug injecting can occur, which is staffed at all times by health professionals (Broadhead *et al.*, 2002). The primary role of SIF staff is to provide safer using education to clients without directly assisting the clients with injecting their pre-obtained drugs (Fast *et al.*, 2008; Schneider & Stover, 2000; Kimber *et al.*, 2005). In particular, safer using education is provided to clients identified as being at greatest risk for BBV transmission or IRID due to factors such as homelessness or engagement in sex work (Wood *et al.*, 2005). This approach is reported as being valued by clients as it allows clients to raise health and welfare concerns during the injecting process (Fast *et al.*, 2008).

Other services commonly provided by the staff at SIFs include overdose response, counselling, outreach, safe disposal of used injecting equipment, NSP, opportunistic brief intervention, access to primary health care, and referral to other health and social services (Broadhead *et al.*, 2002; Kerr and Palepu, 2001; Kimber *et al.*, 2005; Wood *et al.*, 2004b).

Overdose response within SIFs focuses on reducing the morbidity and mortality associated with overdose (Van Beek *et al.*, 2004). Outreach services offered by some of the existing SIFs include transportation to appointments, syringe retrieval, safer using education and provision of information about SIFs (Kerr and Palepu, 2001; Kimber *et al.*, 2005; Wood *et al.*, 2004b). Some examples of primary healthcare provided in SIFs include assessment and treatment of IRID, wound care and post-hospital care (Kerr and Palepu, 2001; Kimber *et al.*, 2005; Wood *et al.*, 2004b). Several European SIFs report having a contact café, a place designed to encourage clients to stay following injection which further facilitates engagement between staff and clients (Broadhead *et al.*, 2002).

## **SIF environment**

A SIF commonly includes an intake area, a waiting area, injecting spaces, availability of medical equipment for overdose, a contact café, primary healthcare space, toilets, an alarm, a telephone, and, in some cases, a smoking/inhalation room (Broadhead *et al.*, 2002; Kimber *et al.*, 2005). In the intake area, clients register before being admitted to the waiting area (ideally a large area). The intake area needs to be monitored for overcrowding to ensure client flow into

the waiting area and to prevent congregation outside the facility, which may compromise the anonymity of clients (Broadhead *et al.*, 2002), and attract negative attention.

Typically there are 10-12 injecting spaces in a SIF. A hand-washing area is also provided. Clients are generally allowed a time period of around 30-45 minutes to inject. A space may be available for clients who wish to stay at the facility after injecting (Broadhead *et al.*, 2002).

Ideally, the opening hours of a SIF should be developed in accordance with local needs, however this will be dependent on the resources and staff available at the individual SIF (Broadhead *et al.*, 2002; Schneider & Stover, 2000). There are many documented rules and regulations within SIFs. Clients commonly register on arrival to the service and client confidentiality is maintained. SIFs may place restrictions on the age of clients, injecting assistance by staff, clients assisting one another, sharing of drugs, tobacco or other drug smoking, heavily intoxicated clients using the service and the use of particular injecting sites (e.g. neck or groin) (Kimber *et al.*, 2005; Zajdow, 2006). Some SIFs do not allow pregnant women to use the facility or permit communication between injecting booths (Zajdow, 2006).

In some SIFs, sanctions and banning are in place for breaches of rules (Schneider & Stover, 2000). However, it is worth noting that too many rules or restrictions may reduce access to the facility for those most in need.

## **SIF clients**

Common characteristics have been observed amongst SIF clients. Many SIF clients experience marginalisation, not just in the broader community, but within the IDU population (Rhodes *et al.*, 2006). Marginalisation from the broader community may be experienced through a lack of access to services (Wood *et al.*, 2003). Many SIF clients report experiencing discrimination and stigma in conventional care settings (Krusi *et al.*, 2009).

SIF clients tend to be homeless (Rhodes *et al.*, 2006), engaging in sex work (Wood *et al.*, 2003) and/or injecting frequently (Wood *et al.*, 2003). SIF clients are also most likely to be those engaging in public injecting, which may occur as a result of homelessness or frequent injection (Wood *et al.*, 2003).

In the Australian context, a sub-group of SIF clients has been identified as being at greater risk of overdose. They are likely to be older, homeless, have a history of incarceration, inject frequently, be poly-drug users and have a history of overdose (Van Beek *et al.*, 2004).

Keeping records of SIF clients is undertaken to some degree by all SIFs (Broadhead *et al.*, 2002). One essential element of the record-keeping process is preserving the anonymity of clients (Schneider & Stover, 2000; Wood *et al.*, 2004a). This may be done through the use of unique identifiers or handles (Wood *et al.*, 2004a). Recording demographic characteristics of clients is also considered important, particularly gender and age statistics (Kerr *et al.*, 2006). Record keeping around service utilisation, client contacts, episodes of care, referrals and responses to adverse events is also important. This will provide useful information for reporting to key stakeholders, building public health evidence for SIFs and advocacy. For example, Kerr *et al.* (2006) reported on 336 on-site overdoses in the Vancouver SIF, explored predictors of overdose and reported that none of the on-site overdoses resulted in fatalities.

### **SIF staff**

A SIF should be staffed in such a way as to both provide a safe space for clients in medical terms and to provide maximum opportunities for client engagement. The employment of qualified, full-time, permanent staff will encourage relationship development with clients and the likelihood of the provision of more on-site services, as opposed to referral. On-site services are more likely to be taken up than referrals to external services (Broadhead *et al.*, 2002).

The qualifications of staff at SIFs currently operating worldwide are predominantly in social work, counselling or nursing (Kimber *et al.*, 2005; Van Beek *et al.*, 2004). Most SIFs also have sessional doctors (Kimber *et al.*, 2005) however some experts consider it important that the SIF avoids over-medicalising service delivery in favour of a balance of disciplines (Schneider & Stover, 2000). Non-judgemental attitudes among staff and experience working with IDUs are essential (Fast *et al.*, 2008; Schneider & Stover, 2000). Training in recognising the signs and symptoms of overdose are also necessary (Van Beek *et al.*, 2004), as is the presence of one staff member in the injecting area at all times (Fast *et al.*, 2008).

### **Potential benefits**

Research and evaluation has demonstrated that SIFs have a range of benefits for both SIF clients and the broader community. Some of these benefits are outlined below.

#### *Harm reduction*

One of the clear benefits of a SIF is the ability to provide and observe the use of sterile injecting equipment. Observation of injecting practices within SIFs has found that SIFs directly contribute

to an increase in safer using practices, with less or no sharing of equipment having been observed in several SIFs (Beletsky *et al.*, 2008; Fast *et al.*, 2008; Navarro and Leonard, 2004; Strathdee *et al.*, 2007; Editorial, 2006; Wood *et al.*, 2004a; Wood *et al.*, 2006b).

While disease surveillance statistics may not immediately register the effect of these changes, there is some evidence that SIFs can impact on rates of BBV transmission. A reduction in HIV risk behaviours (Kerr *et al.*, 2003) and a reduction (Kerr and Palepu, 2001; Wood *et al.*, 2004b) or no increase (Wright *et al.*, 2004) in HCV and HBV transmission have been reported in the literature. Fast *et al.* (2008) suggest that this may be due to safer using education.

A reduction in IRID incidence among SIF users is described repeatedly in the literature (Broadhead *et al.*, 2002; Krusi *et al.*, 2009; Rhodes *et al.*, 2006; Wright *et al.*, 2004). Some authors ascribe this to safer using education (Fast *et al.*, 2008; Wood *et al.*, 2005).

Another significant benefit of the introduction of a SIF is a reduction in fatal overdose (Kerr *et al.*, 2003; Kerr and Palepu., 2001; Navarro and Leonard, 2004; Rhodes *et al.*, 2006; Wood *et al.*, 2003; Wood *et al.*, 2004b). Furthermore, there has been no fatal overdose reported at any SIF (Kerr *et al.*, 2006; Kimber *et al.*, 2005; Editorial, 2006; Van Beek *et al.*, 2004; Wood *et al.*, 2004a; Wood *et al.*, 2006b). Reductions in non-fatal overdose numbers and severity have been reported (Broadhead *et al.*, 2002; Kerr and Palepu., 2001; Rhodes *et al.*, 2006), and some SIFs have been shown to improve psychosocial functioning amongst clients (Kerr *et al.*, 2003; Rhodes *et al.*, 2006).

#### *Demand reduction*

SIFs have an important role to play in decreasing demand for illicit drugs in the community. This occurs through providing referral into treatment. An increase in the number of referrals to treatment within a particular catchment, following the implementation of a SIF, has been reported by a number of sources (Broadhead *et al.*, 2002; Rhodes *et al.*, 2006; Roberts, *et al.*, 2004; Wood *et al.*, 2004a; Wood *et al.*, 2006b; Wood *et al.*, 2007; Wright *et al.*, 2004). In addition, increased uptake of treatment after referral from a SIF has also been described (Editorial, 2006; Wood *et al.*, 2004b; Wood *et al.*, 2006b; Wood *et al.*, 2007).

#### *Public safety and amenity*

SIFs have been unequivocally associated with reduced public injecting (Beletsky *et al.*, 2008; Bradley-Springer, 2003; Kerr *et al.*, 2003; Kimber *et al.*, 2005; Montaner *et al.*, 2006; Navarro and Leonard, 2004; Strathdee *et al.*, 2007; Thein *et al.*, 2005; Editorial, 2006; Wright *et al.*,

2004; Wood *et al.*, 2004b; Wood *et al.*, 2006b). Similarly, significant reductions in publicly discarded injecting equipment have been observed (Beletsky *et al.*, 2008; Bradley-Springer, 2003; Broadhead *et al.*, 2002; Kerr *et al.*, 2003; Kimber *et al.*, 2005; Montaner *et al.*, 2006; Navarro and Leonard, 2004; Strathdee *et al.*, 2007; Editorial, 2006; Wood *et al.*, 2006b; Wright *et al.*, 2004).

Improved public amenity (Bradley-Springer, 2003; Roberts, *et al.*, 2004; Wood *et al.*, 2006b) and gains in public safety (Bradley-Springer, 2003; Wright *et al.*, 2004) have also been found. These include reductions in crime in the area where SIFs are located, and reduction in public injecting and discarded injecting equipment. Kerr *et al.* (2005) note that gains in law enforcement due to displacing injectors are short term, but a SIF can have a longer term affect on public amenity. Kimber and Dolan (2007) found that the number of illegal shooting galleries operating in the vicinity of Kings Cross, Sydney significantly decreased following the implementation of a SIF.

### *Public health*

SIFs have been found to lead to a reduction in healthcare costs due to early intervention in both IRID and overdose (Broadhead *et al.*, 2002; Van Beek *et al.*, 2004). Early intervention in IRID and overdose reduces the health impact on individuals (Kerr *et al.*, 2003; Van Beek *et al.*, 2004; Wood *et al.*, 2004a). Early intervention in overdose also reduces the burden on other health services to respond (Broadhead *et al.*, 2002; Editorial, 2006).

Overall, SIFs improve access to healthcare and treatment for SIF clients (Bradley-Springer, 2003; Broadhead *et al.*, 2002; Navarro and Leonard, 2004; Rhodes *et al.*, 2006; Wood *et al.*, 2004b). This occurs through the building of relationships of trust with staff (Fast *et al.*, 2008; Krusi *et al.*, 2009) and through providing on-site services (Broadhead *et al.*, 2002). Further public health gains are made through attracting marginalised clients and improving the health of those experiencing the most significant disadvantages (Navarro and Leonard, 2004; Stoltz *et al.*, 2007; Roberts, *et al.*, 2004; Wood *et al.*, 2003; Wood *et al.*, 2004b; Wood *et al.*, 2006b).

### **Potential issues**

SIFs should not be thought of as a panacea, rather as part of a continuum of services which includes peer-based and social interventions (Rhodes *et al.*, 2006; Wright *et al.*, 2004). SIFs cannot be expected to solve all of the drug-related problems within a particular area, but can contribute to their reduction or minimisation.

Public order concerns have factored in some of the opposition to SIFs. Research and evaluation

of several SIFs show a small increase in criminal activity in the vicinity of one site (Kimber *et al.*, 2005). Conversely, there was no significant increase in crime in the vicinity of a number of other SIFs (Beletsky *et al.*, 2008; Broadhead *et al.*, 2002; Montaner *et al.*, 2006; Roberts, *et al.*, 2004; Wood *et al.*, 2003; Wood *et al.*, 2006a; Wright *et al.*, 2004). One study reported a reduction in crime in the area surrounding a SIF (Wood *et al.*, 2003).

Another issue with SIFs is that changes in drug markets may displace injecting away from the location of a SIF, particularly where this is a fixed building (Rhodes *et al.*, 2006). Mobile facilities may partly address this problem,

In addition, those opposed to SIFs have been concerned with what is known as the 'honey-pot' effect, whereby SIFs have been thought to attract IDUs to the surrounding area (Wood *et al.*, 2004b). In the case of the SIF in Sydney, evidence suggests this did not eventuate (Thein *et al.*, 2005). Evaluation of the SIF in Vancouver showed that drug dealing, drug acquisition crime and rates of new IDUs have not increased in the surrounding area since the opening of the service (Wood *et al.*, 2006a; Wood *et al.*, 2006b).

Opposition to SIFs has commonly been based on a belief that SIFs encourage ongoing drug use rather than reduction or cessation (Strathdee *et al.*, 2007; Wood *et al.*, 2007). An evaluation of the Canadian SIF reported no substantial decrease in rates of injecting cessation, nor was there a substantial increase in relapse rates, indicating no significant positive or negative impact on rates of injecting drug use (Editorial, 2006).

Another issue identified in relation to the operation of SIFs is that individuals requiring assistance with injection may not be able to access the service due to restrictions on staff physically assisting with injection. These clients may become further marginalised and more at risk of BBV transmission and contracting IRIDs (Montaner *et al.*, 2006; Wood *et al.*, 2006b). It has also been argued that providing assistance with injection in SIFs may save more lives (Strathdee *et al.*, 2007).

Some have argued that non-SIF users may become more stigmatised by making the choice to continue injecting publicly. This may compound marginalisation of particular population sub-groups (Dovey *et al.*, 2001).

This brief review of the literature has outlined key evidence relating to existing SIFs. The following section of this paper will provide a discussion of the history and conditions in Melbourne which relate to injecting drug use and the potential need for a SIF.



## ***The Melbourne Context***

Victoria first engaged in public debate about SIFs in 1998, during a time when the daily 'heroin toll' was listed alongside the road toll in one of the state's most prominent newspapers. Fatal and non-fatal overdoses were at levels previously unseen; this and the visibility of active illicit street drug markets across Melbourne drew increasing public attention. The possibility of implementing SIFs to help reduce the deaths and harms caused by heroin overdose was proposed by health workers, researchers and other professionals as part of a wider public health response.

The Liberal Government's Drugs and Crime Prevention Committee (DCPC) called for investigation into the establishment of SIFs in Victoria in 1997. The DCPC released a discussion paper outlining the purpose and impetus of a potential SIF, the role of SIFs in addressing harms, publicly expressed concerns about SIF operations, legal issues and potential models of operation.

In the midst of increasing public attention to the 'heroin problem', Victoria held a state election in September 1999; the Liberal Government was voted out of office and replaced by Labor, led by Steve Bracks as Premier. SIFs were a part of the pre-election campaign put forward by both the Labor and Liberal parties.

The Bracks government appointed the Drug Policy Expert Committee (DPEC) in November 1999, chaired by Professor David Pennington. The DPEC was to provide two staged reports to government on drug policy including:

- Stage 1: The development of local drug strategies and the implementation of a trial of SIFs in five municipalities identified as areas of high drug use.
- Stage 2: Drug prevention, treatment and control strategies, taking into account Government policy, national and international developments, and the mix of interventions required to achieve the Government's drug policy aims.

The DPEC undertook research into SIFs, informed by overseas experience, local sub-committees and working groups and numerous public submissions. Consultations were conducted with Victoria Police, culturally and linguistically diverse communities, service providers, drug users, youth workers and local government. A considerable amount of scoping was also conducted by various researchers and community groups. Such work included

consultations with IDUs conducted by Turning Point Alcohol and Drug Centre (Craig Fry), Western Region AIDS and Hepatitis Prevention (Sandra Fox), and VivAIDS, the Victorian Drug User Organisation (now Harm Reduction Victoria).

Money was allocated under the Saving Lives Initiative to establish five SIFs and the *Drugs, Poisons and Controlled Substances (Safe Injecting Facilities Trial) Bill* was tabled in parliament in June 2000. The Bill was subsequently voted down in the Legislative Assembly which put an end to the Victorian trial going ahead. In addition, two of the five earmarked local governments voted against establishment of SIFs in their local area. Premier Steve Bracks commented at the time that a SIF would not be funded during the life of the Victorian Labor Government.

Today, Melbourne continues to experience the kind of conditions that have led to the establishment of SIFs in other locations. Some statistics on drug issues in Melbourne are presented here to illustrate the current situation.

### *Overdose*

In terms of overdose, Figure 1 shows the rates of non-fatal overdose attended to by ambulance in Melbourne over the past two years. Overdose rates have fluctuated, however, for the preceding few months up until March this year, the rate has remained consistent at around 110 non-fatal overdoses per month. Of the non-fatal heroin overdoses attended to by ambulance in January, February and March 2009, 64% occurred in public places (McElwee & Lloyd, 2009). The areas of local government where overdose most frequently occurred were in Yarra (22%), Melbourne (11%), Maribyrnong (10%), Brimbank (8%) and Greater Dandenong (6%) (McElwee & Lloyd, 2009).

Figure 2 shows the yearly number of these non-fatal overdoses since 2000.

**Figure 1. Frequency of non-fatal heroin overdose attended to by ambulance in Melbourne by month**

and year: 04/2007 – 04/2008 (McElwee & Lloyd, 2009)

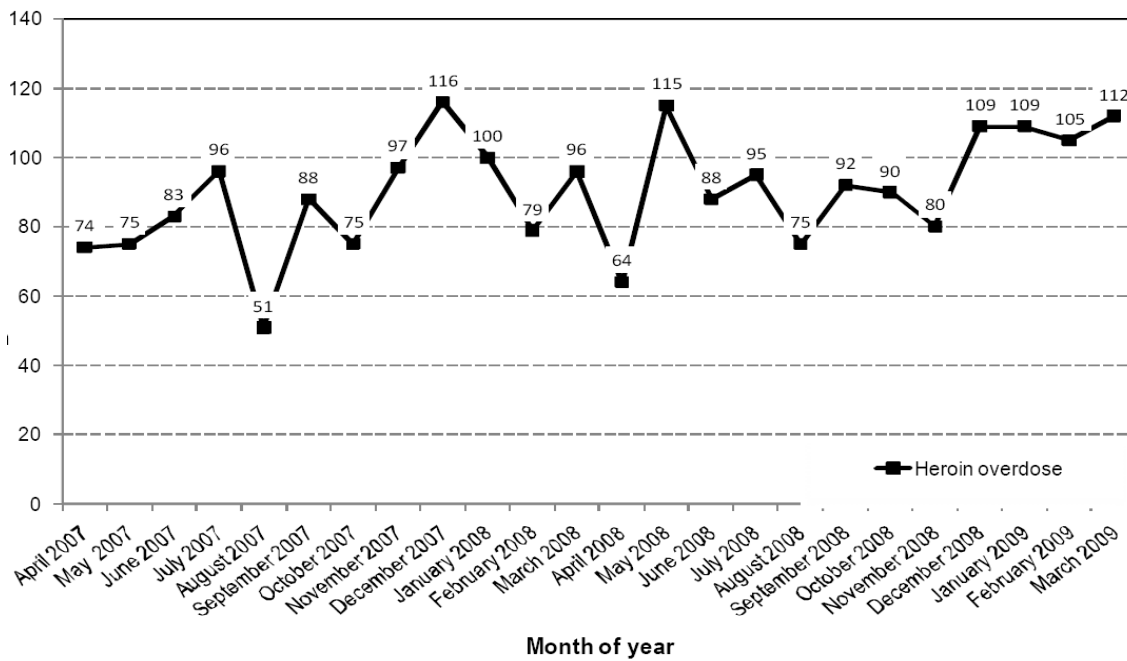
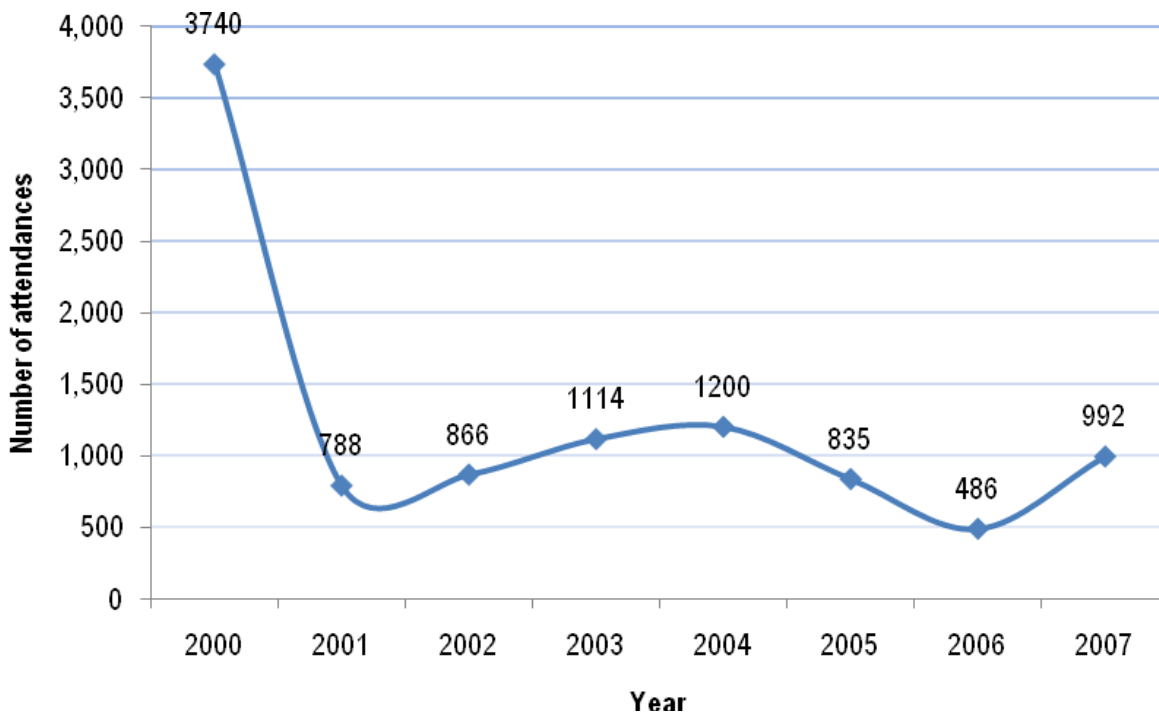


Figure 2. Annual non-fatal heroin overdose ambulance attendances in metropolitan Melbourne, 2000–2007 (McElwee & Lloyd, 2009)



There were 76 heroin-related deaths in 2007, which was more than twice as many as the

number reported in 2006. Over the past ten years heroin-related deaths have fluctuated greatly, with no clear trend of increase or decrease (Department of Human Services, 2009).

### *Public injecting*

IDU participants reported the location of their last heroin injection in the Melbourne Injecting Drug User Cohort Study (Burnet Institute, 2009, unpublished data). Results from baseline interviews have shown that 62% of these took place in a public location. Different types of locations were: street/park (28%); car (18%); public toilet (10%); and other (e.g. stairwell of a building, 6%). In the Victorian arm of the *Illicit Drugs Reporting System* (IDRS) in 2008, injectors were asked the location of their last injection. Of the 149 people surveyed: 13% reported that it took place in the street, park or beach; 12% in a public toilet; 9% in a car; and 3% in another public location (e.g. stairwell of building) (Quinn, 2009).

In the 2008 *Australian NSP Survey*, 281 injectors in Victoria reported all of the places they had injected in the previous month. Thirty nine percent reported injecting in a car; 39% in a public toilet; 33% in the street, park and/or beach; and 11% in a squat. Of the 281 Victorian injectors in the study, 72% tested positive to HCV, indicating significant health needs and the importance of ongoing engagement with health services (NCHECR, 2009a).

### *Injecting-related injury and disease*

The incidence of IRID in a Victorian sample helps to illustrate injecting related harms that could be ameliorated through the introduction of a SIF to Melbourne. In *The IRID Project*, 51% of the sample from Victoria, New South Wales & Queensland were using sites other than the 'crook' of the arm for injecting in the four weeks prior to the survey. All injecting sites other than the 'crook' of the arm are considered high risk for the development of IRIDs (Dwyer *et al.*, 2007).

Of the Victorian participants, 36% had experienced significant bruising in the last 12 months and 43% had experienced significant scarring. Across the entire sample (Vic, NSW and Qld), 54% had ever experienced a potentially serious or serious IRID and 28% had experienced one in the last 12 months (Dwyer *et al.*, 2007).

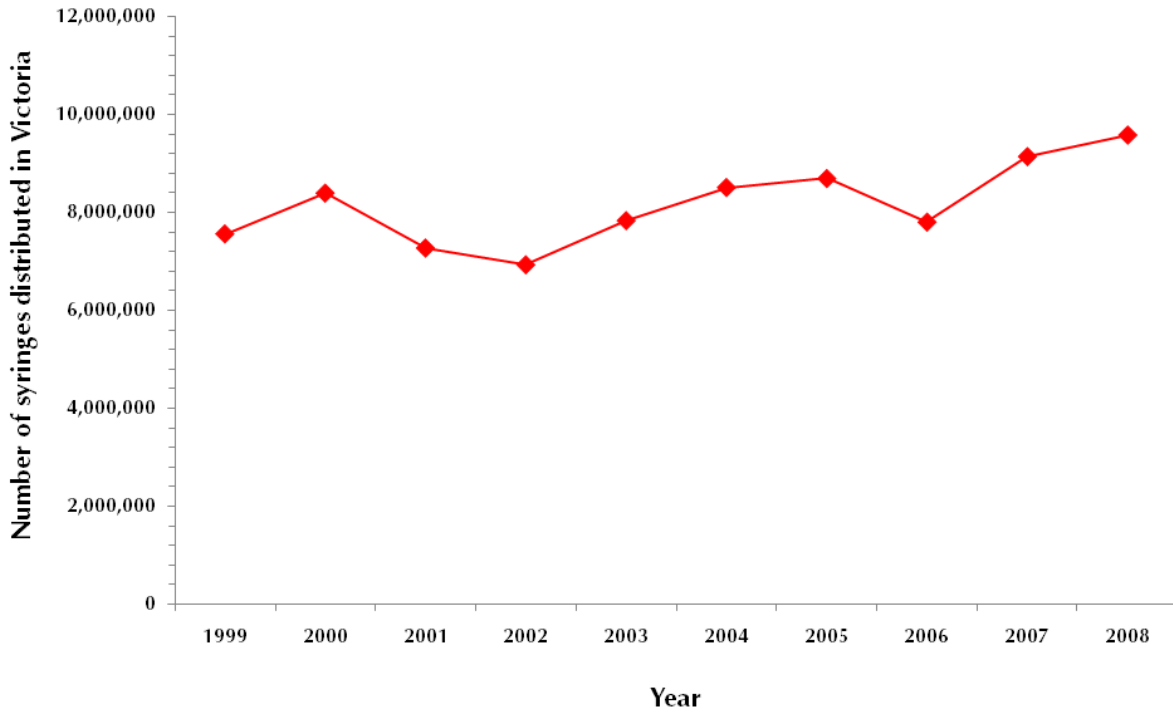
In addition, 63% of the 149 Victorians surveyed in the 2008 IDRS (Quinn, 2009) reported experiencing at least one type of IRID. These included: prominent scarring/bruising (47%); difficulty injecting (39%); dirty hit (15%); thrombosis (10%); and abscesses/infections (7%).

### *NSP Distribution*

Overall there has been an upward trend in needle and syringe distribution in Victoria (NCHECR,

2009b), which alongside the above information demonstrates that injecting is well established in Victoria (Figure 3).

**Figure 3. Number of needles and syringes distributed in Victoria (1999-2008) (NCHECR, 2009b)**



## ***Key Expert Consultation and Review***

### **Introduction**

Input was invited from selected experts as part of the process for developing this position paper. Key experts from Melbourne, Sydney and cities around the world where other SIFs are located were consulted and asked to review a summary report of the literature and to respond to a series of questions seeking to elicit their opinions regarding the establishment and operation of SIFs. Experts were selected in order to gain input from individuals with a range of knowledge and experience. Those selected included service providers (NGO and government), academics, policy advisors, other relevant agencies and individuals. Local experts were geographically spread across Melbourne. Attendees at a recent national conference were also consulted via a participatory workshop. A summary of responses from key experts follows.

### **SIFs in other locations**

The factors contributing to the development of existing SIFs in other settings were described by selected key experts who work directly with a SIF. The presence of a street based drug scene was seen as a key precedent for the establishment of a SIF. This was coupled with increasing rates of overdose deaths and blood-borne virus incidence and a high concentration of street-based IDUs in a particular neighbourhood. Public amenity issues also contributed to the need for a SIF in these locations, with reports of community complaints from witnessing public injecting and inappropriately discarded injecting equipment. Illegal 'shooting galleries' were operating in these areas and exemplified the need for a SIF due to risks relating to the unhygienic and unsafe nature of shooting galleries. Also highlighted was the importance of SIFs being designed to attract the most marginalised IDUs, specifically those who were homeless and did most of their injecting in public spaces. These factors which generated the initial need were also the elements which influenced their successful operation.

The panel identified the five key factors which contributed to the success of currently operating SIFs as;

- acceptability and support from drug users;
- support from the community, police, health and non-government sectors
- political and bureaucratic support from all levels of government;
- a harm reduction perspective/framework; and
- adequate funding.

In addition, it was noted that positive media could enhance the success of the SIF through providing education to community leaders.

Key experts who were involved with currently operating SIFs described their services' models. A mixture of clinical and community components were mentioned. Specific SIF services included safer injecting advice, basic first aid, overdose management and access to referral to other services. In terms of staffing, employing a range of disciplines, such as nurses and counsellors, was common. The SIFs described were operated by health authorities and/or non-government organisations, open every day and were configured with a reception/assessment area, injecting area and an aftercare area. In relation to the purpose of the SIFs, public health aims and increasing public amenity were reported as being high priorities. Public health aims included overdose prevention, safer using, disease and injury prevention and referral to treatment and other services.

## **SIFs in Melbourne**

Key experts agreed that a SIF implemented in Melbourne should sit within a harm reduction framework and operate in conjunction with existing harm reduction strategies. Suggestions of integration with IDU primary health care services and alongside existing NSPs were common. The establishment of SIFs in Melbourne was seen as necessary to enhance the NSP sector and support the welfare of drug users including via the early management of drug overdose, reducing the potential for inappropriate disposal of injecting equipment and providing an entry point to health services for the most vulnerable drug users. Although consensus regarding the appropriateness of a SIF in Melbourne was evident from the responses, panel members highlighted that there are challenges associated with gaining community and political support. One suggestion was that the implementation of a SIF may be more expedient following a crisis, such as an increase in overdose rates or a rise in heroin supply as seen during the 1990s.

In terms of a rationale for a potential SIF in Melbourne, key experts identified harm reduction, safer injecting, disease prevention and overdose management as specific reasons for the development of a SIF. Public amenity was also highlighted as an important element in the reasoning for the implementation of a SIF. Other benefits included reducing demand on police and other emergency response services and linking IDUs to other health services. While the harm reduction approach was favoured by key experts, it was also suggested that there may be benefits in orienting the service towards a medical model (primarily treatment referral and overdose management).

Specific issues regarding the impact of street-based drug scenes on areas of high density public housing were raised during the consultation process. Public housing estates were identified as the areas of greatest need for a SIF in Melbourne due to the occurrence of public injecting, public overdose (fatal and non-fatal) and inappropriately discarded injecting equipment. It was highlighted that the existing disadvantage and marginalisation experienced by public housing residents could be compounded by the considerable impact on public amenity that street-based drug scenes produce in these areas both due to criminal activity and public drug use.

Several points were raised by key experts in regards to identifying the groundwork that would need to occur prior to implementing SIFs in Melbourne. The difficulty in mobilising enough community and political support without there being a 'crisis', such as a rapid increase in death from overdose, was one concern. Political and community support were identified as critical to the success of a SIF in Melbourne. Specifically, support from political parties, key bureaucrats and local communities were commonly identified. In addition, it was proposed that working in collaboration with sympathetic journalists may assist in shifting community perceptions. Consideration was also given to the need for further research, such as examining data on the prevalence of public injecting in various locations. In addition, the development of a well structured description of the cost effectiveness of SIFs was also recommended. The importance of planning an advocacy strategy and getting the notion of a Melbourne SIF on key policy agendas such as national public health strategies was identified by key experts.

Key experts were asked to consider how a SIF in Melbourne would be positioned in relation to the broader alcohol and other drug sector. Implementing SIFs as part of the NSP sector was a common recommendation given they are an already existing service. Although consensus was established for a SIF to take a harm reduction approach, several key experts further highlighted the importance of referral to treatment and other health and welfare services within this framework. Also noted was the importance of a SIF being geographically removed from drug treatment services to reduce contact for those trying to reduce or cease drug use. The need for thorough evaluation of SIFs was also emphasised as an important factor in terms of continuing legitimacy as one of the many interventions operating within the alcohol and other drug sector.

Potential models and locations of SIFs in Melbourne were discussed by key experts. These included whether SIFs could exist as mobile or fixed sites and how many sites would be required. Key experts on the whole felt that a mobile service would be the most acceptable to the wider community and would be able to adapt quickly to the changing nature of the Melbourne drug market and shifting police activity. It may also serve to somewhat mitigate the 'honeypot effect' feared by some in the community, though not supported by evidence.



However, experts also described the importance of a SIF in Melbourne ‘presenting well’ to the community, indicating that this would most likely occur within a fixed site with a sense that IDUs were being supported within an integrated service which could address a range of needs.

Regardless of being fixed or mobile, it was commonly identified that SIFs should be positioned where street-based drug scenes currently exist. The consensus was that multiple SIFs would need to be developed due to the dispersed nature of Melbourne’s drug scene. Ideally, these would be integrated within facilities that currently provide services to IDUs (NSPs and primary health care settings) with one suggestion that this be complemented by additional small facilities operating throughout hospital and community health settings. Concern was raised that SIFs should ultimately be planned with similar capacity to NSPs in Victoria, however it was agreed that this was unlikely to happen. Many smaller secondary NSPs in Victoria are currently unacknowledged as a key frontline public health service by health service boards and senior management. This indicates a climate of resistance to providing integrated services to IDUs. This may be particularly evident in rural and regional areas. However, key experts suggested that at least one regional SIF site should be considered.

Key experts discussed the importance of the accessibility of the services to the target group. This included the acceptability of the model to IDUs and the significance of providing low-threshold services which do not necessarily require clients to engage with staff beyond their injecting episode. This was considered similar to the model under which NSPs operate.

Whilst there was consensus amongst those consulted that a SIF should be established in Melbourne, there was disagreement as to whether it is the ‘right time’ to begin strongly advocating for establishment. There were concerns raised that the introduction of SIFs may divert funds away from other effective harm reduction strategies, rather than more funds being added to the sector.

## ***Conclusions and Recommendations***

While the evidence in support of a SIF is clear, questions remain as to the political acceptability, funding and type of SIF that would be suitable for Melbourne. More exploratory work in these areas needs to be undertaken before advocacy activities can be prioritised. Specific focus on the recommendations outlined below will assist in creating an environment in which a SIF could be successfully established in Melbourne.

Recommendations for developing a SIF in Melbourne, generated primarily from the key expert

consultations and supported by the literature review, are outlined below.

- Development of an advocacy strategy will be imperative in gaining community and political support:
  - Build on current media attention on needle and syringe programs which has followed the release of the evaluation of the cost-effectiveness of needle and syringe programs in Australia (NCHECR, 2009);
  - Review political climate to determine potential for renewed support for a SIF following former Premier Steve Bracks' comments that a SIF would not be funded during the life of the Victorian Labor Government.
- Investigating the cost-benefit of a potential Melbourne SIF:
  - Determine whether funding a SIF would impact negatively on existing funding for current harm reduction services;
  - Develop a minimum standard for operations which details the funding that would be required to run a SIF in Melbourne.
- Investigating the viability of integrating a SIF with existing harm reduction and treatment services:
  - Explore locations such as needle and syringe programs and primary health care settings as potential sites;
  - Explore at least one possible pilot site and seek agreement for participation in a pilot service.

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## **Addendum**

A mobile supervised injecting facility is a relatively new concept which allows the facility to attend several locations. No published literature in English on mobile SIFs was located through the literature review process, so the concept was explored with key experts. Consultations found that there were perceived advantages and disadvantages associated with mobile SIFs and that they may be suitable for the Melbourne context.

### **Advantages**

A mobile SIF can respond to changes in the drug market through being flexible in the geographical areas it services. It may also provide improved access to services as it could service a number of key locations, however planning of service availability according to the needs of IDUs would be key to providing an accessible service. Accessibility would be critical in the Melbourne context, given the dispersed nature of drug markets and public injecting. Providing services in multiple locations would be essential to maximising the benefits of the service in Melbourne.

Mobile SIFs may also mitigate the previously described 'honeypot' effect as a result of not having a fixed location. Key experts perceived that a mobile SIF would be more widely accepted by the community in Melbourne, as compared to a fixed site, given that it would not be permanently fixed near particular businesses or homes, thus responding to concerns regarding the public amenity of allowing drug users to congregate in a particular area.

### **Disadvantages**

There are concerns that mobile SIFs may not present well as a health service due to the fact that they are not physically institutionalised. Concern has also been raised that mobile SIFs may have a low throughput given their size and the need to continue supervising injectors following injection. Furthermore, mobile SIFs may have limited capacity to provide referral and engagement with users given throughput pressures. Given the number of potential service users in Melbourne, particularly those with high or complex needs such as individuals who are homeless or have considerable mental health issues, throughput of the service would be a major issue. Providing appropriate referral and engagement with service users would be as essential to the service as responding to overdose. A mobile SIF environment could potentially compromise these important aims in the Melbourne context.

As mentioned above, accessibility of the service would be critical to its success, both in terms of



acceptability to service users and public health benefits. While other mobile health and welfare services, such as soup vans and the 'street doctor', operate in Melbourne, these services do not address risk behaviours in the same way that a SIF would. The benefits of being able to provide a supervised injecting space can only be realised if the service is offered according to the drug use patterns of its clients. This means operating consistently across a number of hours in the day in order to cater for frequent injectors, as well as occasional or less frequent injectors who may not plan their drug use according to the limited availability of a SIF in their area. A mobile SIF could also potentially be difficult for clients to find when it moves from one location to the next and many potential clients would lack the resources to travel to wherever the SIF is located at a particular time, given Melbourne's urban sprawl and the distance between various areas where the mobile SIF may be located.

A mobile SIF may be overly conspicuous to the broader community. Given the public acceptability concerns raised by key experts, this would be a particular disadvantage for establishing a mobile SIF in Melbourne.