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### ▶ [The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia.](#)



**Salmon A.M., van Beek I., Amin J. et al.**  
**Addiction: 2010, 105(4), p. 676–683.**

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*Evidence that the supervised injecting centre which opened in 2001 in Sydney's 'red light' district resulted in fewer opioid overdoses requiring an ambulance, relieving pressure on emergency services.*

**SUMMARY** Supervised injecting facilities enable drug injectors to inject their own illicitly obtained drugs under supervision in a hygienic environment. They have been shown to reduce harms associated with injecting, but as yet no study has assessed whether these benefits mean ambulance services are called to fewer overdoses.

The featured study addressed this issue in respect of ambulance attendances at overdoses related to [opioid](#) use, the main drugs injected at the [Sydney Medically Supervised Injecting Centre](#) which opened in May 2001 in the city's 'red light' district, also the historic centre of its street-based market in illegal drugs. Evaluators drew on officially recorded information on ambulance attendances, defining an opioid-related overdose as one where ambulance staff administered naloxone in accordance with the service's protocols. If after the centre opened, opioid overdose ambulance call-outs fell more steeply in the surrounding area than in the rest of the state, it would be evidence that the centre had reduced the burden on the local ambulance service.

**Key points**

Supervised injecting facilities enable drug injectors to inject their own illicitly obtained drugs under supervision in a hygienic environment.

One such centre opened in 2001 in Sydney's 'red light' district, a focus for drug use and drug dealing and an overdose hot-spot. The centre dealt with most overdoses on-site, rarely needing to call an ambulance.

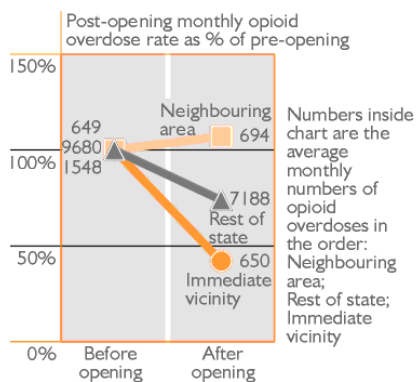
After its opening, ambulance call-outs for overdoses involving heroin and other opiate-type drugs fell more steeply in the immediate vicinity of the centre than elsewhere in the state, suggesting that its opening resulted in fewer overdoses requiring an ambulance and relieved pressure on emergency services.

The rationale for expecting a reduced burden is that in an area with the greatest concentration of heroin overdoses in Australia, in its first six years the centre supervised about 200 injections a day and treated 2,106 overdose incidents within the centre, most related to opioid injecting. Overdoses are diagnosed and responded to by specially trained nursing staff who can administer the opioid-blocking drug naloxone.

Experience led to protocols which meant that during the period of the featured study, only 18% of overdose cases required naloxone and under 1% were taken to hospital by ambulance for further observation.

#### Main findings

Probably largely due to the heroin shortage in Australia at the time, compared to the 36 months prior to the centre's opening, in the next 60 months attendances were fewer both near the centre and in the rest of the state, but the decreases were steeper in the immediate vicinity of the centre ▶ [chart](#). The difference was particularly great during the centre's operating hours, when in the immediate vicinity ambulance call-outs fell from an average of 626 per month to 210, while in a neighbouring area they fell only from 338 to 311, and in the rest of the state, from 6,779 to 4,382. Outside operating hours, the reduction was also steeper in the immediate vicinity of the centre, overdoses dropping from an average 922 per month to 440 while elsewhere they were relatively stable. The extra reductions in the immediate vicinity were statistically significant compared to the neighbouring area and to the rest of the state.

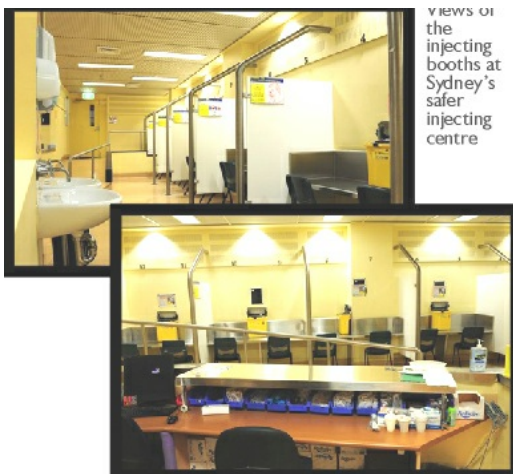


#### The authors' conclusions

By providing an environment where overdose risk-reduction education was provided, where injecting occurred under supervision, and which offered prompt treatment for overdoses, the Sydney Medically Supervised Injecting Centre reduced the overdose-related demand on ambulance services, freeing them to attend other medical emergencies. More than 1,700 overdose cases were treated at the centre during the study period, overdoses which might otherwise have occurred in the immediate vicinity, necessitating ambulance attendance. The findings suggest that safer injecting facilities may be most effective in reducing demand in areas of high-risk, concentrated drug use, suggesting this as the preferred type of location. However, this

preferred type or location. However, this reduction may be contingent on the nature of the centre; it may not be apparent where injecting centres implement protocols that require ambulance call-outs for back-up support and/or do not administer naloxone in overdose situations.

Interpreting these results is complicated by influences on the frequency of opioid overdoses other than the opening of the centre. The main influences were the availability of heroin in Australia, treatment availability and uptake, and changes in policing practices which might affect how willing people with the overdose victim were to call an ambulance. But as far as was known, these influences were the same in the immediate vicinity of the centre and elsewhere in the state, leaving the opening of the centre as the most likely explanation for the extra reductions in overdose call-outs in its immediate vicinity. In particular, the immediate and neighbouring areas were served by the same heroin market with comparable levels and modes of policing during this time. The state ambulance service's overdose protocols also remained the same across the state, and no other overdose prevention programmes were initiated in the area during this period.



**FINDINGS COMMENTARY** Centres where drug users can inject under clinical supervision are an established feature of several cities in continental Europe. In 2010 a report for the European Union's drug misuse monitoring centre concluded that they can contribute to a reduction in drug-related deaths across a city and improve the local environment by reducing public nuisance, in particular the level of drug use in public places. Informally Britain has had places where injectors were allowed to inject, but in the 1970s these arrangements fell foul of the chaotic behaviour induced by use of barbiturates and gave way to a more therapeutic ethos in the voluntary sector services where injecting had been allowed. In 2013 the former Conservative-led UK government ruled out any return to the practice, saying safer injecting centres were contrary to laws banning unauthorised possession of drugs controlled under the Misuse of Drugs Act. In fact the Act does not make it illegal to allow someone to inject controlled drugs on your premises, though it is illegal to allow their production or supply or the smoking of cannabis and opium.

The closest contemporary Britain comes to having safer injecting centres are the few clinics where patients inject legally prescribed heroin under clinical supervision. These clinics have to exercise the same sort of monitoring of patients and have the same capacity to respond to overdose incidents as safer injecting centres in continental Europe, Australia and Canada, providing an experience- and skills-base for such centres in the UK.

Whether safer injecting centres are accepted in the UK will probably depend largely on the degree of distress and nuisance caused by public injecting and the degree of concern over the concentration of overdose fatalities in certain localities. In Vancouver in Canada, acceptance of the facility was generated by the highly visible and, to local residents and workers, distressing and objectionable presence of public injecting and injecting-related litter. Both these concerns it helped reduce, consolidating public support. In Australia, despite the highly controversial history of the featured study's centre in Sydney, in 2013 most people (54%) who had never injected a drug were nevertheless in favour of such facilities. Around the centre residents and business staff became more supportive of the facility (78% and 63% were in favour) after it opened and injecting-related nuisance declined (1 2). The impacts of these centres seem highly localised, meaning in turn that they suit a situation where public injecting and overdose risk is highly concentrated in a small area, perhaps one where users are drawn because of the availability of drugs. It is unclear whether the UK any longer has areas of this kind which stand out to this degree and where the level of nuisance and risk is so great that an injecting centre would not just be tolerated, but welcomed by residents and businesses.

If the problems are more widespread in a city, not just one, but several injecting facilities will be needed to make an appreciable difference, allied with other initiatives such as needle exchanges, improved treatment access and anti-overdose programmes involving naloxone distribution. Though individuals who might otherwise have died will have been saved, even within the neighbourhood, the effect of a single small and limited facility may (as in Sydney in Australia) not be noticeable at the population level. In Germany a study found reductions in drug-related deaths relative to the national average in four cities which opened drug consumption rooms, but in two of the cities this occurred only after the opening of a third or fourth facility. In larger cities, only opening several conveniently located facilities with suitable opening hours and sufficient capacity can be expected to noticeably dent the death rate. The same limitation applies to their longer term lifesaving impact via reductions in the sharing of injecting equipment contaminated with infectious diseases such as HIV.

However, in one sense localised impact is a virtue because it means there is no 'honeypot effect'; few injectors travel any distance to use such facilities, so the locality does not suffer from an even greater concentration of drug dealing and use which might threaten support for a centre's continued operation.

*Thanks for their comments on this entry in draft to research author Professor Lisa Maher of the University of New South Wales in Australia. Commentators bear no responsibility for the text including the interpretations and any remaining errors.*

Last revised 18 June 2015. First uploaded 11 June 2015

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