Supervised injecting centres

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The case for piloting supervised injecting centres in the United Kingdom is strong

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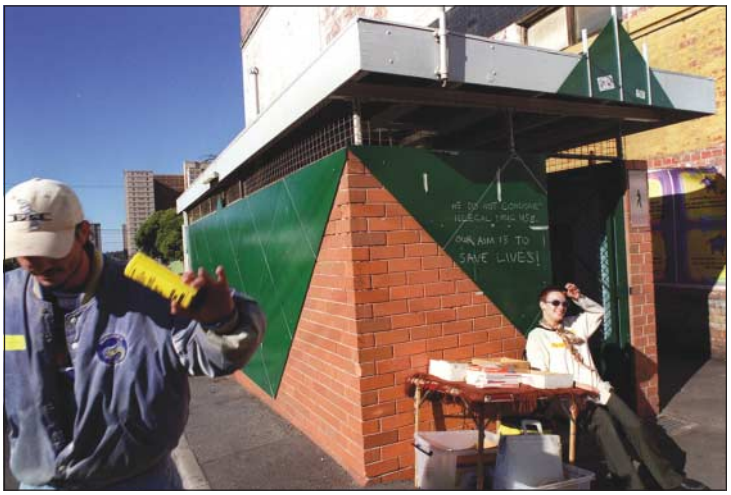
Medically supervised injecting centres are "legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injection drug use."[1] Their purpose is to enable the consumption of pre-obtained drugs under hygienic, low risk conditions (box).[1] They differ from illegal "shooting galleries," where users pay to inject on site.[2] Worldwide, medically supervised injecting centres (also referred to as health rooms, supervised injecting rooms, drug consumption rooms, and safer injecting rooms or facilities) are receiving renewed attention. In 2001, the first medically supervised injecting centre in recent times was opened in Sydney, Australia. By 2002, there were 16 centres in five German cities,[3] over 20 in the Netherlands, and some in Switzerland and Spain.[4]

The UK Home Affairs Select Committee recently recommended "that an evaluated pilot programme of safe injecting houses for heroin users is established without delay and that if this is successful, the programme is extended across the country."[5] However, the Home Secretary rejected this recommendation, stating that medically supervised injecting centres would be supported only as part of a heroin prescribing programme.[5] We argue that this decision should be overturned.



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Supervised injecting centres enable the use of pre-obtained drugs under hygienic, low risk conditions

Functions of medically supervised injecting centres

- Enable safe oversight by nursing staff of self injection of street drugs in an explicitly clinical setting. Does not entitle staff to help drug users inject drugs
- Open from morning to late evening to accommodate drug users who inject up to three times a day
- Full range of resuscitation equipment (including intramuscular naloxone) is available to nursing staff
- Ideally should form part of wider health promotion activities such as needle exchange, safer injecting advice, and training to prevent overdoses
- Alert users to other treatment services
- Ongoing liaison with local business, housing, and police services

Benefits of medically supervised injecting centres

The only comprehensive evaluation of a medically supervised injecting centre was conducted during the 18 month trial of the Sydney centre.[6] Staff intervened in 329 overdoses over one year with an estimate of at least four lives saved a year. There was no increase in reported hepatitis B or C infections in the area that the medically supervised injecting centre served despite an increase elsewhere in Sydney.

The report described a decreased frequency of injecting related problems among clients. Half the centre's clients reported that their injecting practices had become less risky since using the centre. Furthermore, clients were more likely than other injectors to report that they had started treatment for their drug use; 11% of clients were referred to treatment for drug dependence. An economic evaluation of deaths averted by intervention of the medically supervised injecting centre showed that costs were comparable to those of other widely accepted public health measures.

The centre also had benefits for the local community. Residents and business respondents reported fewer sightings of public injection and syringes discarded in public places, and syringe counts in the vicinity of the centre were lower after it opened than before. In addition, there was no evidence of an increased number of theft and robbery incidents in the area. Acceptance of the medically supervised injecting centre increased among both businesses and residents over the study period.

Little evaluative work has been conducted into supervised injection facilities in other countries. In Hanover, however, 98% of users of the medically supervised injecting centre did not encounter any negative experience with local residents and 94% reported no negative police encounters.[7] Research from Frankfurt showed that a drug user who overdoses on the street is 10 times more likely to stay in hospital for one night than a drug user who overdoses in a medically supervised injecting centre.[8] In addition, no one has died from heroin overdose in any medically supervised injecting centre. Therefore, establishing such centres in the United Kingdom is likely to reduce the number of drug related deaths.

Summary points

- Medically supervised injecting centres have been established in several countries
- Evidence suggests they reduce the risk of harm to drug users
- By reducing injection on the street they also reduce the risk to the general population
- A pilot project should be set up in the United Kingdom

Controversies

Despite such impressive outcomes over a relatively short follow up, controversy remains over medically supervised injecting centres. The United Nations International Narcotics Control Board views the centres as violating international drug conventions.[9] Others believe that such an approach turns a legitimate war on international illegal drug trafficking into a "war on drug users" with a negative effect on population health.[10] However, the strength of the centres is that they bring unsafe injecting practice into the open in a safe, structured clinical environment and integrate it with other harm reduction services such as needle exchange programmes.

Current policies regarding staff endorsement of injecting are pragmatic and credible in that staff are acting illegally only if they physically help a user to inject. Trained staff are able to offer safer injecting advice, which includes helping users move away from injecting. We believe that such a clinical approach is not condoning or promoting drug use. Indeed, similar arguments were used against needle exchange programmes in the 1980s.[11] However, such programmes are now part of accepted best practice and have demonstrably improved public health.[12]

The argument that medically supervised injecting centres promote drug use and related harm is not supported by the evidence. Whereas drug related death rates significantly increased throughout Europe during 1985-95, they fell in both the Netherlands and Switzerland, where medically supervised injecting centres were operational.[13] We would not claim that the fall was due solely to the presence of medically supervised injecting centres. Rather, that a comprehensive policy on health promotion with outcomes to reduce harm does in fact reduce mortality without increasing the prevalence of drug use.[14] For policy to be effective it needs to be integrated into service provision, of which medically supervised injecting centres are one important aspect of a range of harm reduction initiatives. We would argue that medically supervised injecting centres are not a panacea for drug related deaths but a proxy marker of a policy commitment to a broad based health promotion framework for working with drug users.

UK position

The Home Office has endorsed prescribable heroin centres rather than medically supervised injecting centres as the basis for future policy. We believe that neither is a panacea and that holistic provision should include both methods. Prescribable heroin is most appropriate for long term heroin addicts who have not responded to traditional treatment.[15] However, such users are different from the patient group targeted by a medically supervised injecting centre—people who are socially excluded and homeless. It is these vulnerable individuals who are least likely to access treatment services and most likely to inject unsafely in public places. In the Sydney evaluation report, the most common reason given for not using the medically supervised injecting centre was injecting in the privacy of their own home.[6]

By targeting homeless, drug using populations, medically supervised injecting centres also have the potential to resolve the current conflict for housing professionals working with homeless drug users. Current legislation places a responsibility on housing providers (for example, staff working in homeless hostels) to remove residents who inject illicit drugs on their premises.[16] This means that, currently, services providing care for homeless populations are able to dispense clean needles to drug users yet have a statutory responsibility to prevent injection in their services (whether housing, health, or social care services). Medically supervised injecting centres can help resolve this paradox and improve public health by minimising the risk of drug users injecting unsafely in public places.

Contributors and sources: NMJW has extensive experience working with homeless drug users who engage in risky injecting practice in public places. He has visited safe injecting centres in Australia, the Netherlands, and Germany. CNET performed the search for the paper.

Competing interests: None declared.

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Commentary: Supervised fixing rooms, supervised injectable maintenance clinics—understanding the difference

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Harm reduction policies and practices (where anything goes, if it actually reduces harm) have fundamentally altered our approach to the drugs problem. Two innovations were recently considered by the Home Affairs Select Committee—supervised injecting centres and supervised injectable maintenance clinics—but with unhelpful confusion between the two.[1] They have different target populations, potential benefits, and legal obstacles.

Supervised injecting centres (also known as supervised drug consumption rooms or fixing rooms) are essentially public access facilities, perhaps the injecting drug user's equivalent of a pub or bar, where the injection of unknown drugs by unknown persons should be safer by virtue of supervision and consequent speed of response in the event of overdose.[2] The target population is all injecting drug misusers—regardless of whether or not they are dependent or wish to change their drug taking habits. Perhaps providing this safer haven may lead some to seek treatment. But this is not the primary objective of the facility. Drug users bring their own chosen substances from the black market pharmacopoeia and choose their degree of intoxication and technique of administration. Workers within the facility may seek to influence their choice of drugs, dose, and technique—but it would be counterproductive to have rules that drive injecting drug misusers out of the facility. The supervised injecting centre is not for treatment of individual addictions—it is a public health facility.

The supervised injectable maintenance clinic may initially seem similar, but is profoundly different in concept, operation, and target population. It is usually considered only for the most entrenched heroin addict who has failed to benefit from first line treatment.[3 4] The attendee is a known patient, receiving treatment from their doctor, and self administering the prescribed injectable maintenance (for example, injectable heroin or injectable methadone) supervised by the nurse or other worker within the clinic—a comfortable fit within the concept of individual treatment. Randomised clinical trials of such injectable heroin maintenance have recently been conducted.[4] The only drugs are those prescribed by the doctor, albeit in consultation with the patient, and the doctor is also responsible for the dose and route of administration, notwithstanding that the patients themselves administer their drugs. Such treatment for the most severe heroin addicts would be a tertiary service. It would certainly not be open to attendees on an impromptu basis.

These two different proposals pose different organisational and legal challenges. For the open access supervised injecting centre, there are major operational issues. Should the attendee be prohibited from choosing certain drug mixtures, doses, or sites of injecting considered too dangerous—for example, injecting barbiturates or temazepam, or ground-up tablets of methadone, Diconal (dipipanone/cyclizine) or Ritalin (methylphenidate), or injecting dangerous doses, or injecting in femoral or neck veins? Would there be a lower age limit? When deaths occur (inevitable, eventually), where will medicolegal liability lie? Both action and inaction may leave the doctor and organisation liable. And what of charges (already made) of aiding and abetting, and even fostering more frequent and more excessive drug use? When dealing occurs (inevitable, to some extent), will agencies and staff be open to prosecution, as with the imprisoned staff from Wintercomfort day centre?[5 6] These obstacles may not be insuperable, but they cannot just be ignored.

For the supervised injectable maintenance clinics, there are major scientific questions about their worth, but the operational issues are simpler. The doctor prescribes treatment to a patient, with self administration supervised by the nurse. The extent and limits of liability are clear. There will be challenges with initial dose assessment, around patients with failing venous access, and with security, but the medicolegal context is clear.

Both proposals deserve serious consideration—but separately. Claims of "harm reduction" must be tested for both innovations. It is just not good enough to have good intentions; new approaches must be studied to establish whether they truly reduce harm,[5] and then either rejected as well intentioned bad ideas or, if successful, robustly supported. The United Kingdom is the only country with a substantial history of injectable opiate maintenance treatment; if finite resources force choices, the priority is a clear scientific answer to the worth of supervised injectable maintenance clinics.

Competing interests: JS chaired the working group preparing guidelines on injectable opiate maintenance treatment for the National Treatment Agency and Department of Health (2002/3) and has recently been awarded a research grant for randomised trial of injectable versus oral opiate maintenance treatment.

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Learning from Thailand's health reforms

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Providing all of Thailand's population with subsidised health care required radical changes in the health system

Thailand took a "big bang" approach to introducing universal access to subsidised health care. In 2001, after years of debate[1–3] and slow progress,[4 5] it extended coverage to 18.5 million people who were previously uninsured (out of a population of 62 million). This move was combined with a radical shift in funding away from major urban hospitals in order to build up primary care. Such an approach has merits but also risks. We discuss the implementation and some of the problems.

Formulating the change

Prime Minister Shinawatra obtained a landslide victory for his Thai-Rak-Thai (Thais love Thais) Party in 2001 on a platform including the "30 baht treat all" scheme for universal access to subsidised health care. Under the scheme, people pay 30 baht (£0.50, €0.7, $0.86) for each visit or admission.

Thailand previously had four public risk protection schemes (box 1) with widely differing benefits and contribution levels. These schemes protected a total 43.5 million people, leaving 18.5 million paying fees for care from public or private providers.

The initial plan was to merge resources from the four schemes into one universal coverage scheme to remove overlaps in coverage and improve equity. This met resistance from government departments running the other schemes and from civil servants and trades unionists benefiting from the two employment based schemes. The government therefore decided to fund the 30 baht scheme by pooling the Ministry of Public Health budgets for public hospitals, other health facilities, and the low income and voluntary health card schemes and providing some additional money. This could be done without legislation, enabling progress to be made while legislation was prepared and debated.

The National Health Security Act was passed by parliament in November 2002, creating new institutions to regulate the quality and financial elements of the scheme. It preserves all benefit entitlements for members of the civil service and social security schemes but places management of their financing

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The Hai healthcare system is dominated by hospitals

with the National Health Security Office, which runs the 30 baht scheme. The act allows for the civil service and social security schemes to be merged into a single universal coverage scheme by decree should that become politically acceptable in the future.

Factors required for implementation

In low and middle income countries, government capacity is often a key constraint on the design and implementation of policy change.[6 7] In Thailand, previous experience and investment in health care was essential for implementation of the universal coverage scheme.

Over several decades, comprehensive healthcare coverage had been achieved through developing infrastructure in rural areas, where two thirds of Thailand's

Box 1: Public risk protection schemes

Civil servants medical benefit scheme—introduced in the 1960s for civil servants and their dependants

Low income card scheme—introduced in the 1970s, providing free care to low income families and individuals, elderly people, children under 12 years, and people with disabilities

Voluntary health card scheme—predominantly rural; introduced in the 1980s and funded through equal matching of household and Ministry of Public Health payments

Social security scheme—introduced in the 1990s; it protects workers only and is mandatory for all private firms with more than one employee

P+ *Tables showing the costs of health care are on bmj.com*

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