The vein in Spain

viability of safe injecting rooms

Many countries are piloting a harm reduction initiative pioneered in Britain. Thirty years on and the UK is now resistant to the idea of safe injecting rooms. Andy Malinowski looks at the various systems around the world and asks, ‘do safe injecting rooms work?’

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N May of this year, I visited a two-year-old safe injecting centre on the outskirts of Madrid. Spain has the highest cumulative AIDS caseload in Europe, with 120,000 people HIV infected, most as a consequence of sharing equipment.

The Safe Injection Help Unit (SIHU) is situated on Madrid’s southern fringes in the shantytown of Las Barranquillas. It offers 24 hours service, 365 a year. Las Barranquillas has been described as the nearest thing to a state sanctioned drug hypermarket, where up to 5,000 Spaniards come every day to purchase heroin and cocaine.

As I made my way through the broken cars and police surveillance, a young man stood injecting himself in the groin. There was a steady stream of pedestrian and vehicle traffic to and from the shantytown. Quite what the police role was is not clear. The centre staff told me the police do not interfere in the daily ‘comings and goings’. They only intervene in serious non-drug related breaches of the law.

A VERY BRITISH AFFAIR

Safe injecting rooms have a short and chequered history in Britain. The Hungerford Project in Central London operated a ‘clinic/fixing room’ in the early seventies, and the Community Drug Project (CDP) in south east London provided a ‘fixing room’ in the late sixties. Other street agencies, such as the Blenheim Project in west London, did not have specific areas set aside for injecting, but instead allowed users to fix up in the toilet.

The need was well understood. In the absence of designated areas, users would use public lavatories and telephone boxes to inject, much to the alarm of local people. But there were problems.

Concern was expressed by Blenheim staff in 1974 as to the number of deaths primarily due to barbiturate use. Staff felt powerless because of inadequate facilities outside and inside the project.

CDP’s ‘fixing room’ was closed in 1978, following increasing confusion and disenchanted among staff as to their professional role. Users were allegedly turning up stoned and using CDP as a ‘crash pad’. This resulted in a struggle between social workers and attendees as to the project’s philosophy and ownership.

Now because of increased visibility of street-based heroin use, blood-borne diseases, deaths and more general public health concerns, ‘fixing rooms’ are back on the agenda. Paradoxically, Britain now lags behind several countries who have piloted initiatives in safer injecting. In the Netherlands, Switzerland, Spain and Germany there are 45 safe injecting centres. A pilot project is also underway in Australia.

MISSING OUT

The UK, however, is slowly awakening to the urgent need for such facilities. The Home Affairs Select Committee (HASC) recommended in its recent report ‘that an evaluated pilot programme of safe injecting houses for heroin users is established without delay and that if, as we expect, this is successful, the programme be extended across the country’.

The Home Secretary rejected this recommendation due to a lack of proper evaluation. This is further complicated by the International Narcotics Control Board (INCB) objection in 1999 that safe injecting houses may contravene international treaty obligations because they collude in criminal activity such as possession.

In light of the INCB’s legal argument, Germany and other European countries introduced national legislation on the grounds of public health imperatives. Likewise in the UK, there is a groundswell of opinion, including that of the HASC arguing for the amendment of Section 8 of the Misuse of Drugs Act, which regulates premises for the consumption of drugs.

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Before this happens, the government will need to be assured that the benefits of safe injecting rooms/centres outweigh the costs. Evidence, however, is patchy and mostly written in languages other than English.

The government's stance is steadfast – it will only offer its support if the research is carried out through the World Health Organisation, because of the uncertain legal status of safe injecting houses.

LESSONS FROM ABROAD

Back in Spain, the SIHU has the official endorsement of the Madrid Regional Government and the International Drug Supervision Commission, a consultative body of the United Nations. In 2001 it received £1,532,000 in state funding.

During its first year of operation, SIHU was visited by 2906 injecting drug users, 50,987 interventions were carried out and 19,261 self-injecting episodes took place. The doctors dealt with 302 ‘emergencies’ – 157 of them due to overdose, 113 for acute reactions to drug toxicity and 32 for other reasons. During this period, 231,200 syringes were given out and 194,886 returned.

Drug users can access sterile injecting equipment, drug testing kits, sharps boxes, water, cooking spoon and filters and condoms. Advice is also at hand from doctors, nurses, social workers and a lawyer on all aspects of health, referral and social and legal issues. An Emergency Centre also offers social and health programmes, hot food, showers, washing facilities, laundry and hostel accommodation for 50 people.

The rules are few, but include no weapons on site, no dealing, no one under 18 and self-injecting only. All staff are trained in ‘crisis management’, though I saw no violence.

In their own evaluation it is claimed that, this health resource has achieved a reduction in infectious pathology associated with intravenous injection, a reduction in transferable diseases, and has identified emerging pathways, brought down the number and the consequences of acute reactions to drugs and has enabled access to the social health network in general and specifically to drug related services.

In May 2001, a Medically Supervised Injecting Centre (MISC) was opened in Sydney, Australia. An independent report found that in six months, 1503 clients used the service, making 11,237 visits.

Cocaine was injected on 47% of the visits and heroin 45%. As little as 87 clinical incidents required medical attention, (0.8% of visits). Of these, 50 were overdoses from heroin, 28 were cocaine related, five were from benzodiazepines, and four were from a non-heroin opioid.

HOW SAFE IS SAFE?

So are safe injection centres effective? In principle, any facility that attempts to reduce morbidity and mortality should be embraced. But we need more research and evaluation.

We need a pilot programme that is properly resourced and has a distinct role to play. We also need to clarify the current legal position in order to level the playing field. And finally, the government needs to be persuaded that safer injecting rooms/centres, at least in principle, offer a way forward in addressing the various challenges that addiction currently presents. But however strong the evidence in favour, the prevailing political climate may still be an obstacle.

references