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Public injection rooms, a help to heroin addicts?

Background

The Nineties saw a dramatic rise in problems associated with drug use in Norway. Estimations performed by the National Institute for Alcohol and Drug Research (SIRUS) show that the number of injectors rose across the decade from 4–5,000 in 1989 to 9–12,000 in 1999 (Bretteville-Jensen & Ødegård 1999). Estimates for 2001 indicate that this figure is between 10,500 and 14,000. At the same time, drug-related deaths rose from about 60 at the end of the Eighties to 338 in 2001. The number of heroin users seeking medicine-assisted rehabilitation has long since exceeded estimations set out when the Norwegian Parliament made this type of treatment available in 1997 as an element of the rehabilitation programmes for substance abusers. At the turn of 2001, about 1,500 heroin users were in such programmes; 650 were on the waiting list or waiting to have their applications dealt with. This situation is extremely worrying. A variety of measures concerning treatment/rehabilitation, care and harm reduction need to be given urgent consideration.

In the international debate on harm reduction, the injecting room has been promoted as one of several measures, and different types of injecting rooms are already in place in cities like Frankfurt and Zurich. Proposals to establish injecting rooms in Norway have been put forward on different occasions. For example, a question was raised on the issue in a parliamentary question-time debate in 1999. Subsequent to this debate, the Government launched 13 drug policy initiatives. The Norwegian Storting requested the Government to explore the possibility of creating 'injecting rooms' staffed with trained health workers. In her response, the then Minister of Health Magnhild Meltveit Kleppa referred to an opinion given by the UN International Narcotics Control Board to Danish authorities that concluded that the establishment of injecting rooms was in contravention of UN conventions on narcotics and that, on that basis, injecting rooms would not be established in Norway.

Recently, the idea has attracted more attention among professionals and politicians. For instance, an Oslo-based centre for sex workers (ProSenter) put in place late in 2000 a limited-access injection room. Oslo City authorities told the centre, however, to

close the facility, which it did in February 2001. Despite this reaction, it is well known that several care-based services for substance abusers in Oslo accept that clients inject on the premises. In Bergen, the Oslo City Mission and the Bergen Clinics Foundation both want to build combined injecting / health rooms as part of a resource centre for substance abusers. Further, four parliamentarians proposed a national crisis programme to address the "overdose epidemic", and mention injecting rooms as a possibility.

Harm reduction

Initiatives aimed at supply reduction and demand reduction are the staples of traditional anti-drugs work. During the Nineties, a third group of measures - harm reducing measures – were viewed with greater and greater urgency. Opinions differ concerning whether harm reduction should be seen as a supplement to demand-reducing measures or as a distinct approach. Although the term 'harm reduction' has generally not been applied in connection with substance abuse in Norway, it is not unknown. Several initiatives for elderly, marginalized and ostracised alcoholics aimed originally at reducing or alleviating harm as an immediate consequence of drinking. Examples are hostels where users could find a place to stay in the winter and the system of sheltered, supervised homes which followed the rescinding in 1970 of the Vagrancy Act, which sentenced abusers to forced labour. When drug use rose in the mid-Sixties, provoking the initiation of an overall strategy, the young age of the users was one of the main factors behind hopes for successful treatment. The same optimism related to the possibility of successful treatment probably explains why so many within the treatment and rehabilitation sector long remained unconvinced by the idea of harm reduction and drug medicine rehabilitation.

The main reason for the call in the 1980s to make harm reduction measures available to drug users was the burgeoning HIV epidemic and the fight to limit the dissemination of the lethal virus which was spread through contact with blood (cf., for example, Stimson 1990). One of the primary objectives was to work out ways to stop needle sharing among drug users. It was the discussion around different ways of organising needle delivery that sparked the international debate on harm reduction as a drugs policy method. As we have seen above, harm reduction was employed as an umbrella designation for different types of measures aimed at cutting and alleviating the immediate harmful effects of drug use, such as, for instance, communicable infections and drug-related deaths. It might therefore be useful to look more closely at what harm reduction means in practice.

'Harm reduction' means reducing the immediate harmful effects of drug use, but without necessarily expecting or requiring that drug-use diminish or stop altogether. Seen in this light, harm reduction can be said to be based on a pragmatic approach and philosophy (Ervik 1996). We know from experience that there will always be larger or smaller groups who either do not wish to stop taking drugs, or believe themselves capable of doing so. For this group, society needs first of all to reduce the risk of damage to health and to improve their quality of life. Besides reducing damage to the individual drug user, reduction of wider harm to the community is also a desired element.

While helping drug users to stop generally represents long-term commitment, harm reduction targets the practical, short-term

initiatives or improvements irrespective of whether they have any impact on the habit itself. Harm reduction means, in other words, recognition that drug use is actually happening but also that the drug user has a right to be respected as a person. Harm reduction should be seen as an important addition to different treatment/rehabilitation regimes, irrespective of whether they include or exclude the use of methadone or other drugs (Buning 1990). Besides hassle-free access to clean needles, which is a service that is already in place in Norway, examples of harm reduction measures are: easy access to detoxification, food supplies, first aid training to inform users how to help each other in overdose cases, uncomplicated access to health services for vaccination against hepatitis, treatment of physical injuries etc.

An increased emphasis on harm reduction does not mean, on the other hand, that goals of a more idealistic nature, i.e. that as many as possible shall escape from their addiction, are put on the slow burner. Services providing harm reducing measures need first and foremost to be seen as a signal to the individual user of respect for his/her situation and concern for the health-related problems that situation gives rise to. This will doubtless have a positive impact on the motivation and determination of many users to get to grips with their habit.

Harm reduction has a long history within the health sector. While social services generally attempt to focus on people's overall condition, health services attend to and treat acute injury without dealing with the underlying causes there and then. To the degree that society's commitment to substance abusers has rehabilitation as its single ultimate goal, offers of clean needles, hepatitis vaccines, treatment of injuries, nutritious food, a warm bed, clean clothes, bath, might be met with the argument that the authorities are 'sewing cushions' under the arms of substance abusers and thereby propping up the addiction. Obviously, this outcome should not be brushed aside, but there is little evidence that anybody has stopped taking drugs because they find it difficult to get hold of clean needles or hepatitis vaccines or first aid. Nor is there any evidence suggesting that people turn to drugs because it is easier to get hold of clean needles.

But it is difficult to avoid the fact that harm reducing measures for substance abusers, taken in context with the wider aims of current drug policy, do involve various dilemmas, dilemmas society needs both to engage with and to tolerate. Just as other citizens of the country, drug users have a right to necessary health care to avoid undue suffering. Viewed in light of Norwegian drug policy, it is difficult to see how measures aiming at reducing immediate drug-caused damage could be interpreted as a wholesale acceptance of drugs and drug use.

So initiatives like injecting rooms, what defence can be offered on their behalf as a harm reducing measure in the Norwegian setting?

What is an injecting room?

In a word, an injecting room is a place where drug users can inject narcotic substances in a supervised environment without risking police interference. But services provided by injecting rooms can also be expanded to include hygiene-enhancing information, offering clean injection equipment, the presence of trained health workers and injection advice. When the setting up of injecting rooms is discussed in Norway, what is meant is specially outfitted

rooms either standing alone or as part of a wider activity and/or care service for drug users, where heroin users can inject under the supervision of trained health staff and where guidance and advice is readily available. 'Health room' may therefore be a more apt designation of the possible future function of this initiative, and, in the Norwegian debate, the two names are used more or less in equal measure. One essential precondition underlying the establishment of injecting/health rooms is that the people who make use of them shall avoid risk apprehension by police authorities in connection with the injection process (possession and use of drugs).

Why have an injecting / health room?

The steep rise in drug-related deaths in Norway over the past decade is the most frequently cited justification for setting up injecting rooms. The reasoning is that if users can inject under supervised conditions and be dealt with if they suffer acute toxic reactions, this will prevent deaths by overdose. It is pointed out that many users feel that injecting in public places (on the street, in doorways, parks, toilets etc.) is a stressful experience, with an increased risk of 'blowing a shot' and injecting wrong doses. It is also said that injecting rooms would curb problems associated with used needles being discarded 'on the spot' in parks and doorways.

Gradually, however, issues surrounding users' general health and dignity have claimed a more central place in the debate. It is pointed out that a staffed injecting / health room will have a positive impact on health due to the guidance that can be given injectors which in turn will reduce the number of failed attempts. Why stand in the way of introducing injecting rooms when needles are being handed out anyway in large numbers? Injectors are people in need, it is emphasised, who should be helped with the means available however 'reprehensible' (the principle of the Good Samaritan) their actions. Users, it is said, should not be required to change as a condition to get access to assistance. Injecting rooms would be a way of lending a helping hand to users in the circumstances they are in – then and there. A further argument is that injecting/health rooms could give health personnel an opportunity to get in touch with users and that, at some future time, users may eventually open up to the idea of tackling their habit.

It might be useful at this juncture to look at the various types of motivating factors behind the desire to put this measure in place. Are injecting rooms a logical consequence of the already adopted system of distributing clean needles? Does current knowledge allow us to say that injecting / health rooms will have the claimed positive effects?

Needle exchange – injecting room

When it became clear around the mid-Eighties that injectors were a HIV/AIDS high-risk group because of their tendency to share needles, making clean needles available became a key issue. As needles and syringes were already freely available on the market in Norway – obtainable without a doctor's prescription from chemists and hospital supplies businesses – there were no formal obstacles in the way of finding other distribution methods. The most well-known initiative in this connection is the AIDS Information Bus, generally known as the "Needle Bus", in Oslo. It has been on the roads on a daily basis since October 1988. The bus is run jointly by the munici-

pality of Oslo and the Norwegian Board of Health. It provides free clean needles and condoms to users who retain the right to remain anonymous. At various times the bus has offered HIV tests. Its purpose is simply to prevent the spread of communicable diseases. It does not aim at providing counselling or referrals to other health service facilities. While the number of needles supplied rose steadily during the first decade, over the past three years the rate levelled off at just below the two million mark. In addition, needles are supplied through other care and treatment centres in Oslo. Other municipalities have different ways of distributing clean needles too. For instance, the Strax Centre in Bergen handed out about 140,000 needles in 2000. Some municipalities have put needle vending machines in place.

Drug policy initiatives contain many paradoxes and give rise to difficult ethical dilemmas. Given that the Norwegian drug strategy is relatively restrictive and the non-medical application of narcotic substances is totally forbidden in Norway, an initiative like the Needle Bus must present something of a paradox. It is therefore all the more strange that it met with relatively little protest when it was put in place in response to the acute need to make needles as easily available as possible arose. Despite needles being a freely tradable commodity, and the distribution of them considered a preventative measure, it nevertheless facilitates the use of drugs. Questions can also be raised with regard to the basic difference between handing out clean needles and providing a place to inject in at the same time. Would not an injecting/health room represent a natural extension of the Needle Bus? One argument against this position could be that they should be considered separately, as initiatives in their own right. It would be insupportable if saying 'yes' to one measure meant that others had to be adopted in consequence. It would be tantamount to straitjacketing oneself with respect to future decisions. So, having said 'yes' to the provision of free needles must not mean that 'yes' must follow for injecting rooms, just as little as a 'yes' to injecting rooms must mean by necessity a future 'yes' to supplying legal heroin to users.

Injecting rooms and drug-related deaths

Drug-related deaths trends

There is no universally accepted definition of what is to be counted as a drug-related death. The evidence, however, indicates that such deaths are relatively frequent in Norway in comparison with other countries. There are two public registries in Norway for drug-related deaths: Statistics Norway (SSB) and the National Bureau of Crime Investigation (KRIPOS). SSB's material stems from forensic autopsy reports issued by the various police districts. Frequencies reported by KRIPOS have occasionally exceeded those of SSB, but, in the main, they both reveal the same trend. As there are no data from SSB for the past two–three years, KRIPOS figures will be used here.

The first deaths from illicit drug use were recorded in Norway in 1976. At the start of the 1980s, the number was relatively stable, at around 40 deaths per year. In the latter half of that decade the figure rose to 50–60. In 1990 it reached 75, and, with the exception of certain years, has risen since (Table 1). It is worth noting that while most of the deaths used to occur in Oslo, records now show that there have been more deaths elsewhere in recent years. In 2001, for example, deaths caused by illicit drug use were recorded in 41 of the country's 54 police dis-

Table 1. Drug-related deaths in Norway

	Oslo	Outside Oslo	Men	Women	Total
1985	17	36			53
1986	22	33			55
1987	25	35			60
1988	30	33			63
1989	24	40			64
1990	43	32			75
1991	55	41	84	22	96
1992	73	24	78	19	97
1993	48	47	77	18	95
1994	81	43	102	22	124
1995	79	53	108	24	132
1996	104	81	159	26	185
1997	95	82	149	28	177
1998	134	136	226	44	270
1999	104	116	181	39	220
2000	131	196	264	63	327
2001	109	229	286	52	338

Source: KRIPOS

tricts as against 36 in 2000. KRIPOS also reports a rise in the seizure of illegal substances by police and customs authorities. The trend in seizures is rising in both volume and frequency. Further, heroin now appears to be available throughout the length and breadth of the country.

Different theories have been put forward to explain this steep rise in drug-related deaths in Norway. In a study of drug-related deaths, Bretteville-Jensen (1994) noted different explanatory factors such as age, interaction, market changes, suicide, quality of heroin, inexperience of new users, greater numbers exhibiting lower tolerance levels. There appeared to be no clear-cut reason for the rise, it was concluded, but several factors may have worked in combination, such as poorer general health among the older population of drug users and a greater tendency to use heroin with benzodiazepines.

Norway's – and Oslo's – relatively high number of drug-related deaths is the subject of an interim report made available by a project studying historical drug-related deaths in four cities, Oslo, Amsterdam, Copenhagen and Frankfurt (Reinås & Waal 2001). The stage at which the cities find themselves in what the authors call the development of the heroin epidemic is posited as one possible explanation. It is pointed out that heroin-related problems emerged in Amsterdam and Frankfurt before they did in Oslo. The frequencies of drug-related deaths in the two former cities peaked around the mid-1980s (Amsterdam) and early 1990s (Frankfurt) and fell thereafter. The reason why the heroin epidemic struck Oslo at a later date is put down to the city's growing population of older users who, precisely due to age and insufficient knowledge about 'safe' ways to administer heroin, are more sensitive to overdoses.

A further possible explanation put forward in the report concerns the relatively easy access to places at detoxification and long-term rehabilitation institutions etc. that, in spite of everything, are available to drug users in Norway. It means that a relatively large proportion can have shorter or longer breaks from their drug habits. The report points out that the consequence of such breaks is increased vulnerability to overdoses on leaving the institution. In Oslo/Norway, we also find that relatively many drug users spend time in prison either for custodial purposes or to serve a sentence. The result is, as above, the development of vulnerability to overdoses.

A third explanation discussed in the report for the high number of drug-related deaths is that practically all heroin users in Oslo/Norway administer the drug by injecting it, while only a minority do so in Amsterdam.

Will injecting/health rooms prevent deaths from illicit drug use?

As mentioned at the start, the prevention of deaths from illicit drug use is one of the most important reasons put forward to establish public injecting/health rooms. Such establishments would give heroin users the opportunity to inject in a hygienic environment under the supervision of trained health staff; possible toxic reactions could be dealt with on the spot either by administration of an antidote or calling for assistance. This preventative effect is based on the assumption that toxic reactions occur relatively quickly after the heroin dose has been administered. The numbers of heroin users who would avail themselves of an injecting/health room will clearly also be of importance in this connection.

Autopsies performed in connection with drug-related deaths show consistently low morphine levels. There is a connection here between the time the drug was injected and the time of death. A review of Norwegian and international studies of deaths caused by illicit drug use shows that sudden deaths that transpire between one and twelve hours after injecting make up 22–51 per cent (Hilberg 1999). Unless heroin users want to remain in the injecting room for some considerable time after injecting, staff at injecting rooms will only be able to detect possible toxic reactions in the time bracketing the actual injection process.

A review published by Oslo City Alcohol and Drug Addiction Service shows that most deaths occur within what would have to be called the private sphere (either at one's own home or that of others, in hostels, institutions) (Table 2). In 2000, only 21 per cent of all drug-related deaths happened in public places. What we do not know is where the people in question were when they administered the heroin. On the basis

Table 2. Places from which bodies are collected in connection with drug-related deaths. Oslo

	Public place		Private place		Other/ unknown	
	N	%	N	%	N	%
1998	43	32	77	58	13	10
1999	25	25	68	67	9	9
2000	28	21	93	70	11	8

Source: Alcohol and Drug Addiction Service, Municipality of Oslo

of what has already been said on the period elapsing between injecting and time of death, death could have occurred within a longer time frame after administration of the drug than injectors will probably find it reasonable to remain in the injecting room. There may therefore be more – but also fewer (some could have injected in a private setting and then gone out) – than the 21 per cent who inject in a public place. It is clearly impossible to estimate how many of the users who inject today in public places would do so in injecting rooms if they were available.

Availability is another factor that would limit the use of injecting rooms in the effort to prevent deaths from illicit drug use. Heroin addicts generally 'burn the main line' several times a day. 'Shots' are also made more or less immediately after the heroin has been acquired. Experiences from the pilot injecting room run by ProSenter in Oslo showed that the maximum time set aside for each user of 45 minutes (including talking about injecting, preparations for "shooting" etc.), was often too little (ProSentret 2001). Unless more injecting rooms are made available in Oslo, for instance, and they remain open day and night, there is good reason to expect that only a small percentage of all injections that are administered in public will be administered in the supervised environment of the injecting room. As Table 1

shows, over the past few years, the number of deaths recorded outside Oslo has exceeded those recorded in the city. Apart from what has already been said, this indicates that if injecting /health rooms are to have any impact on efforts to prevent drug-related deaths, then they will have to be introduced in all municipalities which have heroin addicts. In other words, we would be facing a major investment.

The previously mentioned report on drug-related deaths in Amsterdam, Frankfurt, Copenhagen and Oslo, it may be said, has discovered no connection between such deaths and the use of injecting rooms. For example, mortality associated with illicit drug use peaked in Frankfurt in 1991, while the first injecting room was opened in 1994, that is, three years later (Waal 1999). The primary reason why Amsterdam and Frankfurt have a relatively lower OD deaths than Oslo seems mainly to be that heroin is smoked rather than injected.

On the basis of the above, if injecting/ health rooms are to prevent overdoses:

- Users must remain on the premises for a relatively long period after administering the drug;
- A large majority of heroin addicts will have to visit the injecting/health room every time they are going to inject;
- An injecting/health room will need to be opened in every municipality with heroin addicts;
- Access to injecting/health rooms will have to be virtually unlimited both in terms of capacity and opening hours.

Injecting/health rooms – A contribution to heightened sense of dignity?

In Norway, putting injecting rooms in place appears increasingly to be motivated by concern for addicts' sense of dignity. It is said that injectors should enjoy a greater sense of dignity and that it is the absence of a sense of dignity that characterises the life of many users.

It goes without saying that it is far from dignified for users to inject in parks, streets or doorways. The same applies to the conditions under which many of the heaviest users live. Housing is often pitiful, for instance; addicts do not get adequate help for their many health problems; many finance their habit through prostitution, begging, crime etc. There are many aspects of life as a drug user that are plainly characterised by a lack of dignity. There are good grounds therefore to explore in greater detail the relationship between dignity and drug use.

A person's sense of dignity interacts closely with their sense of self-respect. One acts with dignity, or one bears one's circumstances with dignity. One speaks of 'holding up one's head', maintaining one's dignity despite old age, illness or severe problems. A person's sense of dignity is connected, moreover, to his or her respect for their own integrity in the sense that he or her is not hindered from influencing events, and that responsibility for own actions and life is duly accorded them. Dignity is not only about rights, but duties too. The notion of human dignity, for most of us, is in this light closely associated with our interactions with, but not necessarily subjection to, our surroundings, whether the term signifies other people or chemical substances such as drugs.

A sense of dignity or self-respect can not be acquired from or through others. Our own sense of dignity is something we all have to work to build through, among other things, taking responsibility for how we want to live. There is no exemption here for drug users. It may therefore sound facetious to say that the care system can never do this for people. Each person must determine for

themselves how they want to live their lives. The care system can, and should, however, do what is necessary to ensure that people in need of help get the help they need. The job of the authorities here is to provide a functional care and rehabilitation system. A system which, for its part, must demonstrate that it respects users by letting skilled professionals treat them and by providing varied and adequate support measures, and, not least, by meeting each individual with the expectation that he or she will be able to make an effort to deal with their habit.

Now, if injecting/health rooms are to help people build their sense of dignity, it will in any event be only to a very limited extent. Although open injecting/health rooms will be able to reach some users who inject in public places, it is, as mentioned above, difficult to imagine them staying open 24 hours a day or injectors visiting them every time they need to inject. Since many of the most entrenched addicts inject several times a day, an injecting room will evidently not be able to be of use for more than one such process per day for those who decide to avail themselves of it.

Nor can the dignity of a drug user be a question of access to injecting/health rooms or other relief measures alone. For most users, the lack of a sense of worth will most often be linked to dependency on the substances involved and the problems involved in obtaining them. Dependency on a chemical substance that is not defined as a medicine will, for most people, be associated with a sense of shame.

Dignity is closely bound up with a sense of self-respect. One-sided dependency on other people, dependency on alcohol or other chemical substances negatively defined by society would, for most people, undermine their sense of self-respect, and impact negatively on their sense of self-worth. Substance abusers' sense of dignity will be restored only to a limited extent by helping them to live with their addiction. In fact, it is an open question if dignity has anything in common with providing help to drug addicts to administer drugs.

The illicit nature of the drugs must also influence drug addicts' sense of dignity. Since the substances need to be obtained illegally, many drug addicts will be obliged to enter into negative relationships with sellers by dint of necessity. For most, obtaining drugs will be experienced as a shameful pursuit. Because only the tiniest minority of drug users have legal incomes to pay for their drugs, the majority are forced into criminality and/or to sell sexual services to obtain the money necessary. It is not easy to see how actions of this nature contribute to an increased sense of worth. If dignity is to be used as a benchmark/rationale for initiatives for heroin-dependent injectors, it is difficult to see how one, in this context, will be able to set limits by opening places where injectors can inject under professional supervision. From this point of view, the optimal method of addressing users' sense of dignity would be to offer needles along with free heroin that can be administered in a hygienic environment so that heroin addicts could avoid the painful situations they otherwise experience on a daily basis.

Injecting rooms as a health improving tool

Many substance abusers suffer from very bad health. This applies to both drug users and heavy drinkers. Their problems are partly due to high consumption levels of intoxicants (such as alcohol which causes liver damage, for instance), partly due to life styles which, in many cases, are a consequence of the substance abuse (poor standards of hygiene, infections, abscesses from

injection sores etc.). Many suffer from poor mental health too. Substance abusers therefore have wide-ranging needs for different types of health care services, both in terms of acute and more long-term conditions.

While substance abusers have the same right to health service provisions as anybody else (the Municipal Health Services Act § 2–1 states that "All citizens have a right to necessary health-related assistance"), practice shows, however, that substance abusers, due to the conditions they live in, often do not get the help they need or do nothing to obtain it.

It is evident on several counts that the health service works poorly in relation to the needs of substance abusers. This issue was discussed by a working group set up by the Municipality of Oslo to review measures to prevent drug-related deaths. One of the recommendations they made in their report concerned the establishment of a service which, in the way it worked and in its location, could reach the target group (Rusmiddeletaten 1998). The same recommendation appeared in an evaluation report on the AIDS Information Bus in Oslo (UtviklingsPartner 1998). The Municipality of Oslo implemented the recommendations in the form of a low-threshold service called "Field Care", which was allied to five accommodation/service providers for substance abusers. An interim evaluation after the first six months of operation concluded that Field Care reached substance abusers who otherwise would face problems gaining access to the ordinary health service (500 individual patients the first six months). The evaluation further concluded that the service had helped highlight the poor health suffered by substance abusers and shown that they as a group need especially targeted health care (UtviklingsPartner 1999). A poor physical condition and an increasing number of drug-related deaths are not limited to the Oslo area, however. The Ministry of Health and Social Affairs has therefore allocated grants to selected municipalities to put appropriate services in place. The Ministry asked a working group in 1999 to review the health and rehabilitation services available to substance abusers. They found it would be necessary to look more closely at how the health service can be empowered to deal with the health-related needs of the group (Arbeidsgruppe for å gjennomgå hjelpe- og behandlingstiltak til rusmiddelmisbrukere 1999). Experiences with drug-facilitated rehabilitation show that many municipalities face, at times, considerable problems in their efforts to engage the local health service, despite such collaboration being part of the intention of the endeavour.

It is clear that local health services have difficulties in providing adequate health care services to substance abusers. Could the health service become better at meeting this group's particular needs by letting injecting /health rooms perform this function to some degree at least? Despite the fact that health workers' primary task is to give advice on the most hygienic and risk-free form of injecting, they could also treat wounds, for example. The provision of health services in connection with injecting rooms would also depend on their individual capacity, the number created and geographical spread. There are grounds to believe, however, that the health services it would be feasible to offer would be limited in all events.

Based on current knowledge of substance abusers' general state of health, health services for this group must be better than an injecting/health room would be able to provide. Lessons learned from the above-mentioned low-threshold services provided in Oslo and elsewhere must be implemented to develop an accessible service for substance abusers. This could be done by upgrading

the primary health service to enable it to address substance abusers' special needs. Or efforts could be made to develop special health facilities for substance abusers. If the latter path is chosen, a decision would have to be made regarding how to organise them: either as part of the local health service or as an integrated aspect of local social/welfare services. Consideration would also have to be given to how the regular general practitioner scheme, introduced in Norway 1 June 2001, could help to improve health care for substance abusers.

Injecting rooms as points of contact

A further reason for introducing injecting/health rooms is that they could be a place for health workers to enter into dialogue with substance abusers to encourage them to make use of other aspects of the health and social services and to make necessary referrals. It has been suggested that injecting rooms, in addition to providing a quiet injecting environment, could also provide counselling, treatment etc.

This, in the main, represented the background to the establishment of injecting rooms in Frankfurt and Zurich. A primary aim was to remove addicts from the public parks and places where they tended to gather. The introduction of injecting rooms was perceived as an 'incentive' to get addicts to visit the contact centres that had been opened as part of a wider cleaning-up campaign (Reinås & Cron 1998). Given the absence of trust in the health and social services, the authorities believed that the contact centres would be seen as an attractive facility, and injecting rooms were included as part of this strategy.

Although there are groups of substance abusers in Norway of differing sizes who have no contact with the health and social services, the situation is nonetheless dissimilar. For one thing, there are more low-threshold facilities that could be utilised more profitably than is the case at present. They could be more active on the counselling and information front, not only with reference to the least harmful injecting procedures but also to other social and treatment/rehabilitation matters. For instance, consideration could be given to whether the Needle Bus in Oslo and similar initiatives elsewhere could widen their operations and become more active in the area of counselling and offering help to injectors. The Needle Bus' contact with substance abusers is today based on anonymity, and whatever advice and help is given – apart from handing out the clean needles – is spontaneous and generally only in response to inquiries from the users themselves. Needle distribution facilities probably meet a far greater number of users than injecting rooms would ever do. For instance, the number of visits to the Needle Bus in Oslo averaged at about 320 per day in 2000.

Nor is it very likely that users who are unknown to the health authorities would visit injecting/health rooms in great numbers. It is likely that some of these at least simply prefer to remain unknown to the health authorities for various reasons, and the presence of injecting/health rooms would probably not get them to change their mind.

Injecting rooms as a means of reducing the public nuisance level

Larger or smaller groups of addicts who hang about in parks, squares, market places or other public places are for many people a source of anxiety and insecurity. There are such groups in Oslo as in other Norwegian towns. Similarly, many do not like to see drug users begging on the street, something

that has become a permanent fixture of Oslo's street life.

Norway is not alone here, and, as mentioned, the introduction of injecting rooms in Frankfurt and Zurich must be viewed primarily as an effort to clean up the visible drugs milieu and get addicts off the streets (Reinås & Cron 1998). Both cities initiated measures to reclaim public spaces for the general public, cut drugs-related crime and get the users under control. As an example, all drug users apprehended by the police who were not registered as residents of Frankfurt or Zurich were sent back to their home towns. Both cities initiated different types of aid and treatment measures, among others methadone and heroin programmes (Zurich), for their 'own' heroin users, and, in connection with the contact centres, injecting rooms were put in place, as we have seen, to induce drug addicts to visit the centres. Nor are injecting rooms in Amsterdam based on a desire to reduce the rate of overdoses, but to address the sense of insecurity ordinary people feel at the sight of heroin addicts actively administering the drug. At the same time, injecting rooms give addicts a hygienic and supervised environment instead of the street when they need to inject.

Although the impetus in the Norwegian debate for establishing injecting/health rooms is based primarily on concerns related to health and dignity, and the 'law and order' perspective has been virtually absent, such an initiative could probably be assumed to have a positive impact on the wish to avoid addicts hanging out together in public places. However as long as no active attempt is made to dissolve the groups, injecting rooms will probably not make much of a difference. On the other hand, herding addicts away from their customary locations may not be an undivided good either. We know that addicts generally find new spots thus leaving the basic problem unsolved. In Oslo, after having been expelled by the police from one part of the main boulevard, Karl Johansgate, addicts have quickly regrouped in another part (from the park surrounding the royal palace at the culmination of the thoroughfare to a public square halfway down its length, then to the area around the cathedral and now down to the seaboard side of the main railway station). Further, if police know where the group is located they will use fewer resources finding them. The same can be said in principle about the outreach social services. Finally, it may enhance the drug users' own sense of security to keep to areas monitored by the police and where they can expect to come across social/health workers.

Injecting rooms – a helping hand

Another reason to establish injecting/health rooms may be that it could represent a helping hand to injectors. Since injecting is done in public toilets etc., it could be said that public injecting rooms are already in place, and that the point concerns replacing them with more appropriate and hygienic places. Apart from possible health benefits, the establishment of injecting/health rooms could, in this light, be interpreted as a signal from the wider community that it cares about addicts' health and well-being and wants to meet them half way. Injecting/health rooms could also be seen as a way to build up a sense of trust and confidence in users, which, in the next round, could pave the way for further social and health measures. Apart from the purely disease preventative aspect, it formed part of the reasoning behind the introduction of the Oslo's Needle Bus in 1988. It is not easy, however, to say if injecting rooms would build up confidence. With regard to the Needle Bus, the authorities have decided, as mentioned

above, not to expand the services offered by the bus with further assistance. And there is no way of telling if the bus has helped to enhance trust between the injectors and the health and social services.

Another aspect in this connection is the attitude of the drug users themselves to the idea of an injecting/health room. Is it obvious that it represents something drug addicts actually want and would use? Apart from the experiences gained from the trial run by the ProSenter (ProSenter 2001), we have little data to go on. Naturally, the opinions of the users of this service were generally positive. But it is far from given that injecting rooms is actually what the majority of heroin users would like to see put in place.

In some ways the issue might hinge on how it is organised. If the injecting/health rooms are associated with day centres run by the Salvation Army or the Mission to the City, for instance, the people who already avail themselves of these centres could hypothetically make use of the injecting rooms too. The presence of injecting/health rooms might also attract new users to this type of day centre, as happened in Switzerland and Germany. However this works out, there will probably remain a group that has no wish to have anything to do with any injecting room. How many may depend on whether anonymity is allowed, as practised by the Needle Bus, or whether users have to register, as in Switzerland and Germany. When considering this matter, consideration will have to be given to whether "everybody" who wants to use the injecting rooms will be allowed to do so, or whether entrance is restricted to people who fill certain criteria such as a certain minimum age and/or been an injector for a certain minimum period.

According to all the evidence, many heroin addicts will choose for various reasons not to use the injecting/health rooms. It may be because they want to be "left alone" when they inject the drug either because they think it is a private act or because they do not want to make an exhibition of their addiction or because they do not want other addicts to know that they have heroin. A further reason may be that they are not interested in having contact with any part of the social services.

Will injecting rooms promote the use of syringes and illicit substances?

Most heroin addicts in Norway take the substance by injecting it. On this point, Norway differs from many other countries, which report an increasing tendency to smoke heroin. In the Netherlands, for instance, only a small number of heroin addicts inject, which is most likely one of the reasons for the reported low figures on drug related deaths. Taking the substance with the help of a syringe is, as is well known, associated with a higher risk of damage to health and of overdosing than when smoked. Measures that encourage addicts to replace injecting with smoking could therefore have a positive effect on reducing the number of drug-related deaths and the damage to health associated with injecting. In this light, injecting/health rooms may even prove countereffective by underpinning a culture among users in which injecting is one of the main characteristics.

Since the smoking of heroin is less injurious than injecting, it would clearly be preferable to get heroin addicts to change their administration methods. It is difficult, however, to see how the setting up of injecting rooms could have any decisive effect here. Although there appears to be evidence that more persons today are starting their heroin careers by smoking the drug (Brette-

ville-Jensen, personal communication), the injecting culture is deeply entrenched in Norway. On the other hand, it might not be a bad idea to give some consideration to whether measures could be found that promote a change in administration methods irrespective of whether injecting rooms materialise or not.

A claim could also be made that injecting /health rooms signal acceptance of drugs by the authorities. An 'approval' of injecting rooms may be interpreted to mean that § 162 in the Penal Code and provisions in the Medicinal Drugs Act are no longer applicable and that society has started down the drug legalising road. It is also likely that injecting rooms would attract drug sellers, thereby setting the scene for illegal drug transactions. These factors also apply to other initiatives like the Needle Bus, however.

Many heroin addicts use the term 'to get better' when explaining why they have to have their daily heroin doses. 'Better' in this respect means countering abstinence symptoms by injecting a 'morning shot' for example and to get mental faculties working in the desired way. From this perspective, we can say that many heroin addicts view their heroin doses as essential medication. There will naturally be a range of views as to whether their terminological approach is appropriate in this connection. But the point is that the availability of injecting/ health rooms, where heroin doses can be injected in a sterile environment, may reinforce the notion entertained by some addicts of heroin as a medicine, which, in turn, would make them even less motivated to seek help to tackle their dependency.

As mentioned early on in this article, these issues are connected with harm reduction measures in general and as such highlight many of the dilemmas inherent in drugs policy. On the other hand, society's fight against drugs must not become a fight against people who use them, making their already difficult life even more difficult.

International law

The drug problem is international; it is therefore addressed by wide-ranging international efforts in which Norway partakes as well. Norway has ratified the three UN conventions on narcotics, and is therefore bound by international law to act in accordance with them.

Some countries have chosen to introduce various forms of injecting rooms (England, German, Switzerland, the Netherlands). In most countries, however, attitudes are definitely negative. In its final report, the Swedish Commission on Drugs maintained that injecting rooms would not lead to a reduction in heroin-related deaths because mortality among users was mainly a matter of life style and living conditions (SOU 2000:126). The Drugs Commission believes that injecting rooms could lead in the long run to a rise in the injecting rate because it underpins users' current methods of drug administration. The Commission also points to the possible danger of injecting rooms being used for buying and selling drugs.

The injecting room issue has sparked considerable and, at times, heated debate in Denmark. Against the background of a proposal launched by the parliamentary group of the Social Democratic Party in 1996, the Minister of Health asked the Drugs Council (expert committee under the Minister of Health) to give an opinion. The Drugs Council submitted a positive recommendation (1998). The Danish Ministry of Health, however, asked UN's International Narcotics Control Board (INCB) to consider the position of injecting rooms in relation

to the UN's conventions on drugs (Single Convention on Narcotic Drugs 1961; Convention on Psychotropic Substances 1971; and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988). INCB responded in a letter (dated 18 May 1999) which stated that putting injecting rooms in place would represent a violation of the 1988 Convention in which the parties agreed to take legal action against all non-medicinal use of narcotic substances:

> The Board's view is that permission given by any state or local authority for the establishment and operation of public injection rooms or shooting galleries would also facilitate and encourage illicit trafficking, while governments have the obligation to combat illicit trafficking in all forms. In fact, the creation of such outlets for illicit drug use is contrary to international drug control conventions. As opposed to any open drug scene which may escape from law enforcement actions, a Government, by sanctioning shooting galleries, would implicitly also enhance trafficking. (INCB 1999)

Given this response, the Danish Government decided to withhold approval of the establishment of injecting rooms.

In countries whose governments have approved injecting rooms, the preferred interpretation is that one is not in breach of UN conventions. A challenge, in other words, to INCB's interpretation of the conventions. The mandate of the INCB to monitor and, therefore, interpret what constitutes a violation of UN conventions is, however, established in the convention itself. Individual countries are therefore not entitled to form their own individual interpretations. Given these constrictions, if Norway went ahead and endorsed injecting rooms, it would be placing itself in an exceptional position internationally.

Legal concerns

Current Norwegian legislation states that the possession and non-medicinal use of drugs are forbidden (Norwegian General Civil Penal Code § 162; the Medicinal Drugs Act § 31.2). It would therefore be extremely difficult for the Government to sanction measures that meant that narcotic substances were injected under the public eye so to speak. Unless the police decided 'not to notice' what was going on, users could end up being arrested while in the process of injecting. This would clearly be an impossible situation. If the government does decide to give the go ahead to injecting rooms, it must also make it publicly plain that the possession and use of drugs will no longer be prosecuted.

Closing remarks

The situation with regard to heroin addicts in Norway gives cause for concern. The number of drug-related deaths is disproportionately high and many addicts live in miserable conditions. Efforts to alleviate and reduce damage caused by drug use is an essential part of and supplement to other types of help and rehabilitation/treatment for substance abusers. The question, however, is whether injecting/health rooms represent that kind of help.

Although the prevention of drug-related deaths has been presented as the most important reason to establish injecting/health rooms, little has been done to examine whether a drop in drug related deaths will in fact ensue. To the extent that injecting/health rooms could make a contribution in this area, then availability must be practically unlimited in terms of presence, capacity and opening hours.

With regard to the question of injecting rooms as a measure to enhance drug users' sense of dignity, their effect will also be limited because many other factors connected with their dependency do little to enhance their sense of worth: poor housing, involvement in crime etc. There is no evidence that injecting rooms will have any great impact in this area.

Injecting/health rooms may be able to improve injectors' general health and act as a point of contact between them and other social/treatment services. Consideration should be given, however, to whether an already existing low-threshold service might not be used for the purpose to a greater extent than it currently is.

Current legislation outlaws the possession and use of drugs in Norway. It is difficult to see how the authorities could endorse the injecting of illicit substances in public. Further, the establishment of injecting rooms is an infringement of UN conventions on drugs which state that narcotics should be only used for medicinal and scientific purposes.

The increasing gravity of the situation in Norway means that we are facing a socio-political choice with regard to measures for substance abusers. We can choose to meet head on the problems arising from the use of drugs with proper and effective measures or we can go in for easy solutions. The debate about the establishing of injecting/health rooms highlights this choice. While a concerted effort in the field of care-based housing would be a big step in the right direction to raise living standards for many users, for instance, it is difficult to envisage how injecting rooms could provide improvements of the same scale. Government acceptance/approval of injecting rooms would, on the contrary, be seen as opting for the easy way out and an indication of a lack of will to engage in initiatives that make a difference for a group of people who, everybody agrees, live extremely difficult lives.

Translation: Chris Saunders

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Summary

Astrid Skretting: *Public injection rooms, a help to heroin addicts?*

The situation regarding heroin addicts in Norway gives cause for considerable concern. Harm reduction measures are seen as an important supplement to current assistance and treatment provisions for drug addicts. Introducing public injection rooms has been proposed as a component of the overall harm reduction strategy. The article discusses arguments put forward in the Norwegian debate concerning the injecting room initiative. Will public injecting rooms reduce the relatively high number of drug-related deaths? Will public injecting rooms help improve the generally bad health of drug addicts? Will public injecting rooms contribute to enhancing drug addicts' sense of dignity and self-worth? One of the motivations behind the introduction of public injecting rooms is to enable the social and health authorities to get in touch with drug addicts. Is this realistic? Will public injection rooms facilitate the misuse of drugs? What about public injecting rooms in light of UN conventions on drugs and national legislation in Norway? Would public injecting rooms be of any real help in relation to the many problems heroin addicts face on a daily basis?

Key words: harm reduction, public injection rooms, Norway