T R A N S C R I P T

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

Melbourne — 7 June 2017

Members

Ms Margaret Fitzherbert — Chair
Ms Nina Springle — Deputy Chair
Mr Joshua Morris
Mr Daniel Mulino
Ms Fiona Patten
Mrs Inga Peulich
Mr Adem Somyurek
Ms Jaclyn Symes

Participating Members

Mr Greg Barber
Ms Georgie Crozier
Mr Nazih Elasmar
Ms Colleen Hartland
Mr Gordon Rich-Phillips

Witnesses

Mr Geoff Munro, National Policy Manager, and

Ms Daisy Brooke, Head, Program Development and Evaluation, Alcohol and Drug Foundation

The CHAIR — Okay we might recommence, thank you very much. I understand you have been watching proceedings, so I will not reintroduce people; we have name cards here.

I do need to mention that all evidence taken at this hearing is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you go outside and repeat the same things, those comments may not be protected by this privilege.

We have about half an hour and we have been asking people, if they choose to do so, to give a brief 5-minute statement. If people have brought statements, if they are willing to put them into their evidence, that would be useful rather than reading them. That would give more time for discussion and questions. So I am in your hands. If you wish to make a few introductory comments, I invite you to do so.

Mr MUNRO — Thank you very much. On behalf of the Alcohol and Drug Foundation I would like to say we do appreciate the opportunity to speak to the committee and follow up on our submission. I would like to make some introductory comments. I do not want to repeat what is in the submission necessarily, but I would like to begin by just reminding the committee about the role of the Alcohol and Drug Foundation.

It is one of the oldest non-government organisations in Victoria, having been formed in 1959 by a number of medical doctors, including Weary Dunlop, to minister to people who were then known as alcoholics. That was at a time before Victoria had specialist treatment clinics. In the time since the organisation has changed its orientation over the decades, and we are now pretty much focused on drug prevention — what we would call primary prevention and early intervention. We are funded by the Department of Health for a drug information service which is known as DrugInfo, which provides alcohol and drug information in various platforms to the alcohol and drug field, to professionals working in the alcohol and drug field but also to all professionals working in all other human service fields, and to the general public, including parents, young people and of course people who use alcohol and other drugs.

The bulk of our work is focused on assisting the community to create a safe and healthier community, and we have programs that are based in the workplace and in sporting clubs. Our largest program is the Good Sports program, which assists community-based sporting clubs to address, firstly, the control of alcohol in their clubs. That has now been expanded to assisting sporting clubs to address illicit drugs. There are over 7000 clubs across Australia in the Good Sports program and 2500 in Victoria. We have just been funded by the federal government to establish over 200 local drug action teams, which are aimed at assisting local communities to address local drug issues, the issues that they see affecting their communities. We have just embarked this year on that process.

So with that introduction, I think we would like to say that we understand the Victorian Parliament's desire to assure Victorians that drug policy is robust and is aimed at protecting the community from alcohol and drug harm, and of course we absolutely agree with that.

You will see from our submission that we support Coroner Hawkins's views and her conclusions and we believe that a trial of a medically supervised injecting centre is required urgently in Victoria. I have to say that we think that the Victorian people respect the coroner's office. They rely on her expertise, they value her capacity to consider issues comprehensively, to weigh evidence and to come to justified conclusions. We think that this committee, and more broadly the Parliament, would be justified in accepting her recommendations. She has said that in her view a trial of a pilot is essential in North Richmond, and we concur with that view.

I have to say that the Alcohol and Drug Foundation is somewhat troubled and even bewildered by Victoria's inability to establish such a centre given the success in Kings Cross in Sydney and given the success, as we have heard from previous witnesses, of over 90 such centres around the world. We are really concerned not only about the current situation but by the fact that the police forces around Australia and the federal police force report that there are even more powerful drugs now, opiate drugs, being used in Australia — fentanyl and carfentanil — which are many times stronger than heroin. They pose an even greater risk than the use of heroin.

The previous witnesses remarked about Melbourne's sad history in 1999 when it was literally the heroin overdose capital of the world. We do not want to see anything like that return. We are really surprised and bewildered by the fact that, and I think the previous witnesses said it as well, we can provide injecting drug users with needles and syringes with the intention of making their injection as safe as possible, recognising that it cannot be safe but as safe as possible. That occurred in the 1980s in response to the HIV crisis. Exactly the

same debate took place and exactly the same fears were exposed. People worried that providing needles and syringes would be seen to condone illicit drug use and might encourage that very unsafe practice. Those fears were not realised and the provision of needles and syringes is now seen as a public health triumph all around the world. Australia has one of the lowest rates of HIV use amongst injecting drug users. Injecting drug use did not increase as a result of those programs. It is still very much a minority behaviour. So we do not understand how Victoria can provide needles and syringes for people to inject but we cannot provide that safer space, and so we condemn people to injecting on the streets, in public spaces and semi-public spaces.

The other point I think I would like to make is that not providing an injecting facility does not mean that people do not inject — they continue to inject, but in the most dangerous circumstances. I might just finish these remarks by quoting from a petition at Change.doc. This petition was signed by a resident of North Richmond, Lorraine Little, and I might quote her. She said:

> As a long-time Richmond-Abbotsford resident (25+ years), I am getting to the point where I want to sell my apartment and move away from the daily confrontations with drug use, the refuse associated with such use and the state government's refusal to accept international and Australian evidence on the benefits (health, economic and resident amenity) a medically supervised consumption rooms.

I do not think I can do better than that. Thank you.

Mr MULINO — With many pilots there are potential risks. I am just wondering: do you see any risks that we should think through as we are designing a pilot and trying to manage any risks that have arisen in overseas experience?

Mr MUNRO — I think that we have a lot of excellent examples of such centres not only in Sydney but around the world, and I could not think of a better model and a better way of going about it than to model a pilot in Melbourne on the Sydney centre. I think the risks are that we do not do it carefully, that we do not call upon experts and that we do not take note of the Sydney model and look very closely at why that centre works so well, as we have heard from other witnesses. Nobody has found substantial reasons to criticise that centre. As we have heard, there have been no deaths and no deaths at other centres. So I do not see a huge risk in the practical administration.

I think perhaps the risk is that we would need to make sure that the community understands very well why a trial of a centre is being established but I suspect the community is going to understand. This really is a public health crisis. I would compare it to the recent parliamentary decision to make medicinal cannabis available in Victoria — two drugs that have been illegal, two drugs that cause a good deal of damage, but the community has come to see the value of medicinal cannabis. People do not die acutely from using cannabis. No-one dies from using cannabis acutely, but we have got people dying in Victoria nearly every day from heroin. So I think there is a more powerful motivation to act to make people safe who are injecting drugs. As I say, I think the biggest risk is that we do not make sure the community understands the need and the fact that it is a careful trial that is being evaluated rigorously.

Ms SYMES — Thank you for your evidence this evening. I guess following on from Mr Mulino's question not so much about risks but I guess considerations, yes, there is a lot of vocal support from the North Richmond community for a trial in that community. Is there any considerations about a location that would be relevant? For example, I assume you would not want to put a facility next to a school or a childcare facility perhaps. I am just interested if there are considerations like that that you think would be relevant to consider.

Mr MUNRO — Certainly I think the location is very important. We would not want to see it next to a school or kindergarten, but I imagine it would not be too difficult to find an appropriate location. It has to be accessible to the people who are going to be using it obviously. But I would not think that that would be a huge stumbling block. I imagine that in every suburb, particularly a busy one like Richmond with good transport services, such a place could be located.

Ms PATTEN — You mentioned the emergence of new opiates coming onto the market, certainly much stronger ones like fentanyl. I was wondering if you could expand on that little bit. Is that what you are seeing from colleagues in other jurisdictions where I understand fentanyl and similar products have become a lot more prevalent?

Mr MUNRO — What we understand is that fentanyl is a much stronger opioid than heroin.

Ms PATTEN — Is it being used by heroin users?

Mr MUNRO — The problem is that it has been mixed with heroin so that people on the street may inadvertently, because they are unaware exactly of the constituents of the product that they are injecting, inject fentanyl, which is far more potent and therefore much more likely to result in an overdose and a fatality. So people may not actually understand that they are taking an even greater risk than normal through the use of fentanyl.

Fentanyl originates from China, and it is being distributed through south-east Asia and Australia as well as other countries around the world. It is particularly cheap to produce apparently. That is partly why to some degree it is being substituted for heroin. So it is an extremely dangerous substance, and there is an even stronger version — carfentanil is also available in some countries. So we are extremely concerned about that.

I think that just underlines the need for a place for desperate people who are now injecting on the street. If they were injecting in a supervised facility staffed by medically trained personnel, obviously they would receive help much quicker and more efficiently if they overdosed. I think that is another reason to consider such a trial.

Ms SYMES — While you were talking about fentanyl I was just doing my own little Google research. Just some clarification in terms of the evidence that it is being used to lace heroin, the National Drug and Alcohol Research Centre, at Sydney University I think they are, said that there is no evidence that it is actually in Australia in relation to access but it is certainly available in other countries. Are you expressing a view of a future issue, or are you hearing that there are instances of fentanyl-laced heroin now in Australia?

Mr MUNRO — We have heard reports that it is in Australia, but in any case I think given that it is being distributed through south-east Asia, it would not be surprising —

Ms SYMES — That it will emerge?

Mr MUNRO — That it will emerge. But we have heard reports that it has made its presence known in Australia.

Ms SYMES — I was just wondering whether it was — —

Mr MUNRO — We referred in our submission to literature which talked about the use of fentanyl.

Ms SYMES — Great, thank you.

The CHAIR — I see in the submission you made there are a number of recommendations about use of naloxone; I think I have pronounced that correctly. Could you run me through what are the current limitations on its distribution, if any?

Mr MUNRO — Naloxone is available on prescription, but for many people it is not subsidised, so it can be very expensive to purchase. The value of naloxone is that it provides an instantaneous resuscitation of a person who has overdosed on an opioid. It cannot be used to receive a high and people cannot overdose on it because it reverses the effect of an opioid. It actually saves lives, but the problem is that people need to have access to it and they do need some training in it. I know the health department is considering ways of distributing it through the community, but the issue is to whom does it go. We would say family and friends of injecting drug users as well as injecting drug users themselves. But we believe it should be subsidised because this is a way of saving people's lives even if they are not in a safe or supervised injection facility. They could be at home, they could be in a friend's house or they could be on the street. We think it is important to distribute naloxone using the key vectors.

The CHAIR — When you say it is expensive, can you give me some indication of cost?

Mr MUNRO — I would properly have to be careful, but I think it may be as much as $80.

The CHAIR — Per use?

Mr MUNRO — I think, and people may get two or three ampoules for that amount of money.

The CHAIR — It is always injected, I assume?

Mr MUNRO — Pretty much. Yes. Like an EpiPen. But I would have to take perhaps your question about the cost on advisement and clarify the cost.

The CHAIR — If you would like to do that, that would be very welcome. Thank you.

Mrs PEULICH — I have two questions if I may. The Kings Cross overdose reports, according to the crime stats, were down. However, at the same time heroin overdoses in New South Wales have increased since injecting rooms have been operating. How can you explain that?

Mr MUNRO — Sorry, could you repeat that?

Mrs PEULICH — The claims are that the Kings Cross overdoses were down. But at the same time, according to the crime stats, heroin overdoses in New South Wales have increased since so-called safe injecting rooms have been operating. How can you explain that?

Mr MUNRO — There is only one injection room in Sydney, obviously at Kings Cross, and people will be injecting drugs across New South Wales.

Mrs PEULICH — What sort of a dent would a single facility make on the problem as you perceive it?

Mr MUNRO — We have got something like 25 deaths in North Richmond now on an annual basis. If we were to assume that perhaps all of those or many of those people would use a facility in North Richmond, many of those deaths I would expect to be prevented.

Mrs PEULICH — But you did not answer my question. How could you explain the fact that there were drug injecting facilities being used at Kings Cross but at the same time there was an increase in the overall number of heroin overdoses in New South Wales?

Mr MUNRO — I thought I did say that — —

Mrs PEULICH — No. You only tackled one part of the question.

Mr MUNRO — I thought I said that people are injecting drugs across New South Wales and they are not able to use a facility. That might be an argument for more facilities.

Mrs PEULICH — More facilities in the suburbs. Right. A quick question. According to my reading, the cost modelling shows that an injecting facility would cost about $6 million to $10 million per annum to establish. Let us operate on the lower figure, on the $6 million. A drug treatment bed costs $100 000 per annum. So at $6 million this would fund 60 drug treatment beds. Given that there are only 238 in Victoria, an extra 60 would be a 25 per cent increase in existing treatment beds. In your view — —

Ms PATTEN — Can you clarify where you got that figure of $6 million to $10 million?

Mrs PEULICH — I certainly can, but I will not at the moment. In your opinion, which would you prefer — a drug injecting facility or that money to be directed to establishing an extra 60 beds or a 25 per cent increase in existing treatment beds?

Mr MUNRO — Obviously I would like to say I would like both —

Mrs PEULICH — No, you can only have one.

Mr MUNRO — but if I was to choose one, I would take the supervised injection facility because that will save, I believe, dozens of lives a year. I suspect that, sadly, we will never have enough beds to cater for all of those people who would like to make use of one. But one of the problems of drug dependence is that they do not all want a bed at the same time. If they did, we would never be able to afford them. But people move in and out of the perception that they want to take up drug treatment.

Mrs PEULICH — Are you able to tell me, based on your experience, how many drug-dependent persons would use a single bed over a period of one year?

Mr MUNRO — I would not be able to give you that — —

Mrs PEULICH — Do you want to take an educated guess?

Mr MUNRO — No, I do not because my organisation does not work in the clinical services area. It depends on the nature of the residential facility. Some people might stay in a facility for more than a year at a time, other people will stay for shorter periods.

Mrs PEULICH — So the potential is to actually help many, many people with that sort of increase in beds.

Mr MUNRO — There is no doubt that residential beds are important and we would like to see more of them, but we do understand that there is a limit to the state's capacity to do that. We do think, on your question, that the supervised injection facility is a greater priority because there are already hundreds of beds in Victoria.

Mrs PEULICH — No. There are 238 beds.

Mr MUNRO — 230? We think that — —

Mrs PEULICH — New South Wales has over 800.

Mr MUNRO — I am very happy for Victoria to create more beds, but, as I say, the supervised injection facility we know is going to save many lives. We think that is the first priority, and at least have the trial to see what the value is.

Mrs PEULICH — I guess my dilemma is this. I speak to a lot of families who are affected by the use of ice in particular, which is ripping families apart and associated often with high levels of violence, including domestic violence, because of the nature of the drug and the length of the episodes during which the user is affected. What they want is rehabilitation, because it gets people off drugs.

Unfortunately injecting rooms facilitate drug use, so I am actually really surprised that you should say that. We heard in evidence earlier that according to the coroner's report many of those who are using heroin have been using heroin for over 20 years, whereas many of those who actually need to be taken off drugs are often young users, so I am surprised that an organisation such as yours would deem to have a higher priority placed on safe injecting facilities to facilitate drug use for people who have been using drugs for a number of decades as opposed to focusing the resources on interventions which can actually get young people off drugs. I am very surprised by your answer.

Mr MUNRO — We do not think it is an either/or. Clearly Victoria already has an extensive drug treatment system, and it is not only focused on residential beds. According to my understanding, mostly people who have come off crystal methamphetamine, or ice, do so without attending residential rehabilitation programs; they do it at home with the support of a doctor or a community health nurse and with their family. I think one of the problems we have at the moment, by the constant focus on talking to the community about the need for residential beds, is the belief that people need to go to a residential rehabilitation program to come off drugs. Most people do not do that; most people come off at home, and I think we can help people who use drugs by emphasising that they can come off the drug at home much more easily than they imagine. Many people, as I am sure you know, who enter a residential rehab program do not stay very long; they change their mind after a week or so. The beds issue is not a panacea. While we need them for some people, beds are not a panacea either.

I do not think we need to make a choice. Our organisation would like to see many more resources into drug prevention so we can help people deal with problems and difficult situations in their lives without turning to using a drug, whether it is alcohol or it is a pharmaceutical or an illicit drug. That is where we would like to see the bulk of the budget. But we understand that right now people are dying unnecessarily in Melbourne and in Victoria, and that they could be saved, we think, should be the current public health priority. We are not denying the need for beds, we are not denying the need for treatment — nobody is — but we need both.

Mrs PEULICH — So you are saying drug prevention and safe injecting rooms for users who have been using drugs for decades, and then the ones in between, which is rehabilitation, are of lesser emphasis. Is that my summation of your priorities as an organisation?

Mr MUNRO — No, I do not think you are being fair, really. Clearly a health system needs prevention, and it needs drug treatment, it needs law enforcement and it needs to help people survive. We know that if people

survive injecting drugs — the most hazardous ones like heroin and crystal methamphetamine — long enough, most of them will decide to stop using, and then they can resume what we would call a normal life. So one of the priorities is to keep them safe, to keep them alive, while they are using, and eventually most of them will recover one way or the other, whether it is through a residential program or whether they do it at home.

The CHAIR — I have one last question, and that is just going back to the issue we were talking about earlier with the naloxone. Do the recommendations you have made in your submission align with current practice elsewhere?

Mr MUNRO — Yes, they do. I would probably have to take that on advisement as well, but naloxone is recognised around the world as an efficient and humane response to drug overdose.

The CHAIR — If you would not mind following up, it would be really useful. Just something short that outlines where this is used and perhaps some indication of success or measurement would be really helpful.

Mr MUNRO — We would be very happy to do that.

The CHAIR — Thank you. We are going to have to finish the session now, but on behalf of the committee I would like to thank both of you for attending tonight and for the assistance you have offered. We will provide a transcript within a few weeks for you to review. Thank you.

Mr MUNRO — We thank the committee for your time.

Witnesses withdrew.