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Legal and Social Issues Committee
Supervised Injecting Facilities
Parliament House, Spring St
EAST MELBOURNE VIC 3002
injectingcentrebill@parliament.vic.gov.au

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To the Committee,

NRCH welcomes the opportunity to submit to the Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

Our submission will comment on;

1. Recommendations in Coroner Hawkins' Finding – Inquest into the Death of Ms A, delivered on 20 February 2017 and other relevant reports;
2. Nature and extent of current, relevant regulations;
3. And nature and extent of associated, relevant policing policy.

Intro/summary

North Richmond Community Health (NRCH) provided a submission to the Coroners Court of Victoria in relation to the investigation of the death of Ms A. The findings from this inquiry are fully supported by NRCH, some of which will be explored in detail in this submission.

NRCH has also provided a submission for the recent Drug Law Reform Enquiry. In summary NRCH believes that there needs to be wide and swift reform that encompasses legalisation, and decriminialisation of illicit drugs, particularly heroin, explore heroin prescription programs and adequately resource services to meet the needs of those that continue to use drugs.

NRCH views both of these inquiries, along with this inquiry as pivotal to meeting and being able to better address the needs of people who use drugs.

Background

NRCH is located amongst the local public housing estate in inner Melbourne, providing a wide range of health and community-oriented services that caters for a great diversity of clients. However, it is through our alcohol and other drug (AOD) program that we encounter people with the greatest levels of marginalisation and vulnerability. A recent evaluation by Burnet Institute found that: over 90% of participants were unemployed; less than 20% had completed year 12; 57% have mental health issues; and 37% live in unstable housing. Yet a more visceral sense of this vulnerability and hardship comes from working closely with this cohort, especially as many people's health visibly deteriorates over time. A non-exhaustive

North Richmond Community Health
23 Lennox Street, Richmond
T 9418 9800
F 9428 2269
nrch@nrch.com.au
www.nrch.com.au

list of this deterioration relates to: Stigma and discrimination; living long term with blood borne viruses; injecting related injury and disease; mental health degeneration; medical and drug treatment service models that are not equipped and don't meet the needs of the client group.

The local area has high levels of both street-level drug dealing (predominantly heroin) and of public injecting. The AOD program's Needle and Syringe Program (NSP) functions to provide sterile injecting equipment to a significant portion of the people who obtain their drugs in this area, many of whom subsequently inject in the surrounding neighbourhood. The above-mentioned evaluation found that an average of 150 clients accessed the NSP each day, and a further 25 were engaged via the AOD program's outreach efforts. However, the general perception among staff is that our client base is on the increase, with an associated increase in the number of contacts we see per quarter. The amount of syringes handed out via the NSP ranges from 60,000 to 70,000 per month.

Due to the high levels of public injecting, an important role at NRCH is overdose response. Overdose response can range from monitoring clients who are observed to be at risk of a potential overdose (approx. 8 hours per week), to suitably trained staff administering the overdose reversal drug naloxone. Between 2014-2015 NRCH had responded to 101 overdoses within close proximity to the centre. When directly intervening in an overdose the outreach team manages the situation – which includes supporting the person and people close to them and bystanders - until an ambulance arrives. An important part of our overall overdose response plan is to train clients of the AOD service in administering naloxone themselves. In these training sessions our staff provide general overdose education including prevention, specific training on how to administer naloxone, assist clients to obtain a prescription for naloxone (through a NRCH GP) and cover the cost of obtaining the naloxone so that clients leave the training sessions with naloxone in their hands. NRCH provides further support by helping clients obtain more naloxone in the event that they have needed to use it and an opportunity to debrief after what is generally a very stressful experience.

Addressing the Recommendations of Coroner Hawkins' Finding – Inquest into the Death of Ms A

This submission will focus primarily on the first two recommendations of Coroner Jacqui Hawkins in the Coroner's Court report from 20 February 2017. That is, the recommendation to (1) *take the necessary steps to establish a safe injecting facility trial in North Richmond* and to (2) *take the necessary steps to expand the availability of naloxone to people who are in a position to intervene and reverse opioid drug overdoses in the City of Yarra*.

Increased access to naloxone is welcomed, but not enough

NRCH believes the Victorian government should be duly recognised for their action on the latter recommendation by Coroner Hawkins in order to increase access of naloxone to potential bystanders in both the City of Yarra and in other hot spots across the state. We

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receive regular reports from our clients that they have successfully administered naloxone to their peers, and any measure that facilitates or expands their ability to do this is a positive factor. This measure is a very important step in preventing the deaths and other adverse effects from opioid overdose.

Yet, I wish to bring attention to a quote from the overview of the 2014 World Health Organization Report *Community Management of Opioid Overdose:*

"While naloxone administered by bystanders is a potentially life-saving emergency interim response to opioid overdose, it should not be seen as a replacement for comprehensive medical care."[1]

That is, while the recommendations in the WHO report are unreserved in terms of insisting that *all* people who are likely to witness an opioid overdose should be trained in and have access to naloxone - overdose response is a broad and complex phenomenon that requires a comprehensive/wide-ranging approach to mitigate. Indeed, as noted above, we currently provide education and training to our clients on naloxone and assist clients in obtaining this life saving drug – but this measure, while an important and necessary component of any overdose management plan, is simply not enough to maintain the health and wellbeing of our clients (or other people who inject drugs) in a context where opioid overdose is unacceptably high.

- Our perspective at NRCH is that it must be recognised that naloxone is not an absolute panacea. There are limitations with bystanders being tasked with the administration of Naloxone which include; being responsible for overdose reversals can amount to a lot of pressure for some individuals. We are wary of the impact of providing multiple reversals for many clients over time and the potential impact of unsuccessful reversal outcomes. Standalone Naloxone does not address poly-drug overdoses where, for example, benzodiazepines and alcohol are heavily involved. These situations require specialised medical care, potential transport to a tertiary site within the health system, close observation and rely on the usage of skilled airway management techniques.
- This is better achieved in controlled conditions and undertaken by trained staff with access to appropriate equipment.

Crucially, in areas where public injecting is high, people are much less likely to adhere to some standard overdose prevention strategies such as to 'never inject alone'. An ethnographic research project conducted in St Kilda in the early 2000s found that many (street-based) people who inject drugs did not follow this advice – not because they were ignorant of it, but because often there can be trust issues with peers and injecting heroin can put a person in a

[1] World Health Organization 2014, *Community management of opioid overdose,* World Health Organization, Geneva, accessed 6 April 2017, <http://www.who.int/substance_abuse/publications/management_opioid_overdose/en/>.

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very vulnerable state.[2] Situations where trustworthy peers are unavailable become even more risky when a person is injecting in public, as the need to be discreet can lead a person injecting drugs to do so at a location where it is unlikely that they will be seen by a passers-by or other peers – making bystander administered naloxone unlikely.

At NRCH we see this kind of situation frequently. Whenever possible staff attempt to create safety plans for those who access the NSP who they identify and those who self-identify as being at risk of overdose. These plans are not robust, are far from ideal and are not without risk. Staff often feel this is relatively tokenistic when someone's life is at risk.

The benefits of a SIF – overdose management, broader health improvements and public amenity

- We want to be absolutely clear that our position regarding a SIF is that it is *a public health imperative in order to save people's lives*. Supervised consumption of illicit drugs has historically been implemented in response to local situations – particularly those with high levels of public injecting - and the case in North Richmond is no different.[3]
- In Victoria, 190 people died from heroin-related overdose in 2016. This is up from 173 in 2015
- According to the State Coroner, heroin deaths are at their highest levels since the late 1990s
- About 20% of those deaths in 2015 were related to heroin use in the North Richmond/Abbottsford area

The evidence regarding drug consumption rooms (inclusive of SIFs) as an effective intervention for overdose prevention/management is clear: over three decades of their existence and across 76 facilities worldwide (74 of which are located in Europe, one in Vancouver, Canada and the one in Sydney), there has not been a single death due to overdose.[4][5]

There are further health issues beyond overdose that would be addressed with the introduction of a SIF. Having a secure, clean place to inject is integral for ensuring that veins are not damaged, that people do not acquire bacterial infections (particularly abscesses), and that blood-borne viruses (BBV) such as HIV or Hepatitis C are not transmitted between persons. The equipment used to prepare the drugs will be clean/sterile (including the water), the injecting area wiped first with an alcohol and chlorhexidine swab, hands will be washed

[2] Moore 2004, 'Governing street-based injecting drug users: a critique of heroin overdose prevention in Australia', *Social Science and Medicine,* vol. 59, no. 7, pp. 1547-1557.
[3] European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence*, European Monitoring Centre for Drugs and Drug Addiction, accessed 6 April 2017, <http://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms>.
[4] Ibid.
[5] Schatz, E & Nougier, M 2012, *Drug consumption rooms: evidence and practice,* International Drug Policy Consortium, London, accessed 6 April 2017, <http://www.drugsandalcohol.ie/17898/1/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf>.

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before and after injection, used equipment properly/safely disposed of, and that during this process none of the equipment will be shared. Currently this is difficult to achieve when the person injecting is in a precarious situation in which they are doing so in unsanitary conditions and have to be alert to the possibility of arrest. Access to running water is beyond reach to most of the clients we work with who publicly inject which has serious health repercussions for themselves and potentially the wider community.

Looking outwards to the broader community, many residents have rightly argued that a SIF would lead to improvements in public amenity.[6] The syringes and other paraphernalia that are frequently left in the community, the intrusions into people's yards by people who inject drugs in order to obtain water (for mixing their drugs) and in order to find a (private) place to inject, people injecting in their cars, and the occasional user passed out in laneways, etc. are all undesirable traits that are currently the reality in the North Richmond area which would be greatly improved if people had a place to inject.

NRCH fields many such concerns and complaints from local residents, including the neighbouring primary school. There is little our staff can do in these situations except listen and document concerns and grievances. So, while the introduction of a SIF would be a compassionate health-oriented approach for the people who inject drugs in the area, it would also be a compassionate approach to those who live and work in the area.

The negative outcomes of a heavy public injecting scene in North Richmond are further exacerbated during periods of increased police presence, which is especially the case during a police 'blitz'/'operation'. During these periods people who inject drugs often do so in more of a hurry than usual. Safer injecting steps are rushed or skipped altogether, people use in less accessible and often less hygienic places, and are more likely to leave used syringes and other paraphernalia in the area. Records kept at NRCH have found that spikes in overdose have coincided with (intensive) local police blitz operations.

There would also likely be a cost saving through the introduction of a SIF. The reduction of health-related issues that stem from public injecting (outlined above), reduction in costs of ambulance and fire brigade attendances to overdose, reduction in the waste of sterilised injecting equipment that is obtained by clients but not required (often discarded as litter) would all contribute to this. This is in line with an economic evaluation of Sydney's MSIC which estimated that it saved more money than it cost to run.[7]

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[6] For example: Cage, C 2017, 'Richmond's heroin problem has gone from tragic to absurd', *Age,* 4 April, viewed 6 April 2017, <http://www.theage.com.au/comment/richmonds-heroin-problem-has-gone-from-tragic-to-absurd-20170404-gvdd1q.html>.

[7] SAHA, *Economic evaluation of the medically supervised injection centre at Kings Cross (MSIC),* NSW Health, Sydney, accessed 6 April 2017, <https://uniting.org/__data/assets/pdf_file/0008/136439/MSIC-Final-Report-26-9-08-Saha.pdf>. This evaluation considered the savings due to: the prevention of BBV; prevention of overdoses; the on-site and referral services that they provide that would be provided elsewhere at potentially a higher cost; and the other agency services that were no longer required due to the operation of the MSIC (such as police and coroner investigation of overdoses).

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Our AOD team leader has referred to the injection-related services provided at NRCH as 'bookending'. There is the sterile injecting equipment provided through the NSP to begin with and the overdose response at the end, yet there is no service (other than prior education) that addresses the act of injecting itself. The introduction of a SIF would fill this gap in order to provide a comprehensive course of care that covers all the major stages of injecting.

Specific considerations for implementing a SIF

Any introduction of a SIF would need to take into account the local area in which it is located, and the particular needs of the cohort that will be using it. In doing so there are many complexities which require careful consideration and for which there are no easy answers. Therefore, any legislation that is passed regarding the piloting or introduction of a SIF needs to be broad enough that such local complexities can be adequately addressed. Based on our experience providing services to people who inject drugs, numerous aspects would need to be taken into account in the operation of a SIF.

Although NRCH is in full support of an injecting facility that is supervised, we firmly argue against the requirement that the director or chief supervisor of the facility is to be a medical professional. This said, it will be important that a SIF will have access to medical staff for some/certain needs (for example, attending to injecting-related wounds and injuries). At minimum, all people who are operating the facility should be trained in CPR advanced life support/airway management and the administration of naloxone. A peer[8] component to the program should be included on whatever level is practical (for reasons of respect, to keep up to date with local trends, a direct connection to the perspectives of service users, etc.).

It is important that there are not restrictions on the types of drugs that are to be used in the facility. For example, one drug that is popular among the service users at NRCH is the over-the-counter anti-histamine Unisom. Restricting the use of drugs such as this would lead to the exclusion of some of the local people who inject drugs, thereby undermining the benefits that the introduction of a SIF would have. Further, it would open up more opportunities for education and demonstration of safer injecting practices for these substances, something which is proving difficult in the present environment.

Another crucial consideration for a SIF is whether to allow clients to inject in whatever site on the body they require. As many people who inject drugs in North Richmond have been doing so for long periods of time - many for decades – the more preferred sites on the body have been damaged to the point that they are no longer usable for injecting. NRCH makes all attempts to educate on safer injecting techniques, and often works with clients in order to help them find healthy, suitable veins to inject in with the aim of reducing injection-related harm. Further, we have invested in a venoscope to help locate veins and are in the process of developing a practice where an occupational therapist delivers training to clients regarding fine motor skills in order to enable clients to inject with each hand (rather than only one) and

[8] That is, a person with lived experience of drug use who is locally known and respected.

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in doing so increase their ability to access healthy veins on the other sides of their body. However, in the interest of providing a client-centred approach, and realising that a person injecting will be better off injecting in less suitable sites of the body such as the neck, groin or foot in a SIF than on the street, we feel that this aspect needs to be strongly considered. If certain injecting practices were allowed (groin injection for example) there would need to be areas/booths within the facility that had extra space in order to cater for these kinds of habits.

We know from experience that many clients do not have the ability to inject drugs themselves, and therefore whether a SIF would allow clients to inject others within the facility or not is another difficult but important consideration. This can range from people with physical disabilities who simply do not have the ability to inject themselves (through conditions such as having only one arm, missing fingers, or having Tourette syndrome) to those who are simply unskilled. For the latter, there is the possibility for staff to provide education (peer workers would be particularly suitable) thus empowering clients – especially where being dependent on others to inject them has led to them maintaining unhealthy relationships with others. However, in the case of the former, it may be a breach of duty of care to turn away people to be injected by others in potentially unsafe and unsanitary positions simply because SIF legislation and/or policy may not have adequately catered for their particular needs. A SIF will need to be culturally sensitive and responsive to cater to those from LGBTI, CALD or Aboriginal and/or Torres Strait Islanders wishing to utilise the service.

Any SIF will need to be large enough to cater for the turnover of clients whilst minimising delays. A significant proportion of people who will use a SIF will be injecting opiates. Many of these clients will be in, or on the verge of, withdrawals by the time they access the service. Opiate withdrawal is characterised by the onset of a variety of unpleasant to intolerable physical symptoms which require urgent attention. If a SIF is unable to provide clients with instant access there will inevitably be people who will leave the service in order to inject publicly.

Whilst we realise that a high level of caution would be exercised regarding the introduction of a SIF as an intervention for reducing drug related harms in the community, NRCH has reservations about introducing only one of them. Even though evaluations of other legally sanctioned facilities where illicit drugs are consumed (including the Sydney MSIC) have found that there has not been associated increases in local crime,[9] it may be difficult to accommodate all the people who require the use of a SIF with a single facility. Some of the countries who are more experienced in drug consumption rooms have many: for example, the Netherlands have 31 across 25 cities, and Germany has 24 across 15 cities.[10] Likewise, there should be state-wide coverage for SIFs. A pilot that allows for several facilities to be

[9] European Monitoring Centre for Drugs and Drug Addiction, *Drug consumption rooms: an overview of provision and evidence*, European Monitoring Centre for Drugs and Drug Addiction, accessed 6 April 2017, <http://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms>.
[10] Ibid.

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trialled simultaneously in various hot spots would give a better indication of genuine outcomes and would mitigate concerns of a 'honey-pot' effect.

Feedback from clients

As part of this submission to the committee we consulted with our client group. We surveyed 61 people. All of the sample size said that they would try a supervised injecting facility. Clients indicated that they felt it would keep the streets clean, would be safer for children, reduce the likelihood of the spread of disease and respond to overdose in a safe way. Clients said that in the event that they did overdose that they would feel more reassured if they were to overdose in a supervised injecting facility having appropriate trained staff respond.

Why NRCH is well placed to provide a SIF in North Richmond

In the event that a SIF pilot goes ahead in the North Richmond area, our organisation is in an ideal position to be providing this service. In part, this is because we have current/long term experience in providing the associated services that will likely be provided alongside supervised injection.[11] Yet, more importantly, we have developed strong relationships over decades with clients and other providers of health-related and other community services that are crucial in effective service provision.

Due to the high levels of stigma faced by many of our clients it typically takes time to build trust. Doing so is a high priority for our staff and something that we pride ourselves on. We feel that it is the high level of respect that we give to those who walk through our doors that help us to earn theirs. We have observed that many of the clients have developed a sense of belonging here and therefore feel a level of ownership towards the service.

In conclusion, permitting a supervised injecting facility in Victoria is an opportunity to provide health care and human rights seen in other progressive countries. It is an evidence based opportunity to improve health outcomes for those that use drugs, reduce the likelihood of death, improve amenity and link those that most need it into the appropriate services.

[11] As outlined in section 98L (1c) of the *Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017.*

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In the event the committee does conduct key interviews, I would like to participate in this process. This document can be made available on the public record.

If you require further information please contact me on the details below.

Regards

[redacted]

Demos Krouskos
Chief Executive Officer
North Richmond Community Health Limited
Director
Centre for Culture Ethnicity and Health
North Richmond Community Health
23 Lennox Street, Richmond, Victoria, 3121
P: [redacted] **M:** [redacted] **F:** 03 9428 2269
E: [redacted] I **W:** www.nrch.com.au
@nrchAUS I facebook.com/nrchAUS