

Parliament of Victoria  
Legislative Council Legal and Social Issues Committee  
Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot  
Medically Supervised Injecting Centre) Bill 2017

# UNITED FIREFIGHTERS UNION VICTORIAN BRANCH SUBMISSION

This submission is made on behalf of, and has been authorised by,  
the UFU Victorian Branch Committee of Management

“The consistent thing that stays with me from attending drug related turnouts is the loneliness”. We usually find them alone because their friends call it in, but are too scared to stay with them”. *MFB Leading Firefighter, 33 years of service.*

The contact person for this submission is:  
Mr Peter Marshall,  
State Secretary  
Victorian Branch of the United Firefighters Union

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## UFU VICTORIAN BRANCH SUBMISSION

The UFU makes this submission to the Legal and Social Issues Committee Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017.

### Terms of Reference:

- This submission addresses the term of reference that relates to the recommendation made pursuant to section 72(2) of the Coroners Act 2008, in Coroner Hawkins' Finding in the matter of the Inquest into the Death of Ms A, delivered on 20 February 2017.
- Specifically, the UFU supports the recommendation to the Honourable Martin Foley, MP and Minister for Mental Health take the necessary steps to establish a safe injecting facility trial in North Richmond made by Coroner Hawkins in that Finding.
- The UFU supports the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017.

### Scope of this submission

The UFU supports all aspects of the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017. In 2009, there were more than 90 such centres in Europe and Canada, as well as one in Kings Cross in Sydney (*Fitzgerald 2013*), and there has been a significant number of scientific and peer reviewed studies conducted into their efficacy. We are convinced by the body of international research and experience that such a centre will have significant benefits to the users of illicit drugs, the communities directly impacted by these activities on a day to day basis and the general public as a whole (*Woods 2014*). We note that we are not alone in this, and that a growing number of clinicians and counsellors with specialist knowledge and skills in this area, as well as local authorities whose communities are directly impacted, also support the establishment of such a centre. (*Nicholson, ADF 2017*).

We do not propose in this submission to restate the public and community benefits that such a facility would bring with it, as we believe that these have been well canvassed and explained by those with the appropriate level of expertise in this area. We do say however, that we believe that this bill will save lives, and that is core business for the UFU and our members.

Our submission focuses only on the UFU's area of expertise, which is the positive impact such a centre would have on the work our members do as first responders under the Emergency Medical Response System, and the associated benefits this would bring to the communities that our members protect and serve.

We note that one of the Objects of a Medically Supervised Injecting Centre at Section 98C of the Bill is the reduction in the number of drug overdose related ambulance attendances. We say that it will also reduce the number of firefighter emergency medical responses, thus freeing up significant resources to the broader community.

## The Basis for the UFU's Submission

- Metropolitan Fire Brigade firefighters have been co-responding to medical emergencies with Ambulance Victoria since 2000, and are often first on scene at drug related emergencies.
- The available data shows that the long-term trend for drug related emergency calls is that they are increasing rather than decreasing.
- The Victorian Branch of the United Firefighters Union represent professional firefighters, emergency call centre employees and fire agency corporate, administration, hospitality, technical and mechanical employees across the MFB and the Country Fire Authority (CFA), as well as in the private sector in aviation and defence. The majority of our members are either operational fire-fighters, or commenced their careers with the fire service agencies in an operational role.
- The Victorian Branch has a high level of union membership, with over 97% of the relevant workforce being members.
- The UFU represents our members industrially on a both individual and collective basis. We have a strong focus on the health, safety and welfare of our members, and regularly advocate on these issues to both government and the fire services. The UFU is also a strong and vocal advocate in matters of community and public service and safety, and has participated in numerous Inquiries, Coronial Inquests and Commissions of Enquiry into a range of matters over the years.
- As the union representing professional operational firefighters employed by both the MFB and the CFA, the UFU is uniquely placed to comment on this legislation. We hear the stories and the anecdotes, and see the direct impact responding to drug overdoses has on our members.
- In the course of preparing this submission, the UFU interviewed some of our members. Excerpts from those conversations appear in quotation marks – the direct experiences of firefighters who deal with drug overdoses sometimes on a daily basis demonstrate most eloquently why the UFU is supporting this Bill.

## An Introduction and Background to EMR

### The concept of EMR

The EMR program is part of an organised emergency medical system where firefighters respond simultaneously with Ambulance Victoria to all life-threatening medical emergencies. When a call is made to triple zero, and a patient is unconscious, not breathing or pulseless, firefighters co-respond with the nearest ambulance. This first responder role is designed to prolong life for the critical first minutes after a collapse, and before the arrival of paramedics, who are then able to provide more advanced medical responses, treatment and transport to hospital. Early intervention has been shown to be a critical positive component in improving the chain of survival in patients (*Cummins et al 1991*). Implicit in the term is that there will be a secondary response, and this is provided by the paramedics – firefighters do not administer drugs for example.

The fire services were identified as being uniquely able to take part in a first responder EMR program. Each station has a defined operating area within which they respond to calls, and a set maximum time within which they must respond. The crew of the responding appliance will return to station once they have completed a job, replenish any equipment used and are ready for the next call. An ambulance may be transporting the patient to hospital, and may have to leave their area to do so which impacts on the time it requires for each AV appliance to be ready to respond to the next call. A wide range of first responder programs were operating around the world prior to the MFB EMR program. The overseas evidence examined in the review of the MFB undertaken after the first 7 years was clear that first responder programs saved lives. (*Boyle et al 2010*). This research also found that the MFB response times over this period were comparable or better than other state and international responders, finding that the average response time was 6.14 minutes.

#### Firefighter involvement in Emergency Medical Responder (EMR) Programs

An EMR Program was trialled by the MFB in 1998, and became part of the organisation's core function in 2001. A review undertaken after the first 7 years of the EMR program by Monash University found that a total of 8227 incidents had been attended by MFB firefighters in the first 7 years, and that of these, 908 (11.03%) were drug overdose related calls.

The study also found that MFB was demonstrating better response times than the ambulance service, and that firefighters were spending an average of just under 5 minutes with a patient before handing over to paramedics. (*Boyle et al 2010*). The EMR program now operates at all 51 MFB fire stations.

In 2011, the CFA ran a pilot EMR program across 5 integrated (staffed by both professional and volunteer firefighters), stations. CFA have now received funding to progressively roll out an EMR program across all 35 integrated stations by June 2019.

#### EMR Training:

MFB and CFA firefighters take part in extensive and ongoing EMR training. 9 days of EMR specific training are delivered within the first 12 months of service, broken into two blocks with the initial block occurring during the 16 weeks of the Recruit Training course, and the later block when they have commenced in-service on station. While their role during the first 12 months, until they attain clinical certification is to observe, report and assist only, they are nevertheless exposed to the incident and situation in its entirety. Monthly on-station continuing education is provided by AV clinical instructors, and each firefighter is required to participate in a minimum of 4 of these sessions a year to maintain and update their EMR skills, EMR re-certification training of 2 days is required to be undertaken every 4 years. This program was developed and agreed after extensive consultation and input from the UFU and its members, and because of this input from operational firefighters, is seen as one of the leading training programs in both Australia and internationally in the EMR field.

*“there’s an acknowledgement that our metropolitan firefighters do the best and most effective CPR. This isn’t just about the training, it’s also because we have the most exposure and utilise our resuscitation skills constantly, and over a longer period of time. The average years of service for a metropolitan career firefighter is 30 years, for ambulance officers, I think it’s around 7 years”*. MFB Assistant Chief Fire Officer, 36 years of service.

EMR Staffing:

EMR crews consist of 3 firefighters, 2 of whom at a minimum must be EMR qualified.

Firefighters are an integral part of EMR

The role of firefighters as part of the EMR team has matured and developed over the years. They are now acknowledged as setting the standard in delivering CPR, due to their training and the increasing frequency with which they are required to apply and use that skill. In the early days of the MFB EMR program, our members' role in providing direct care to the patient would stop once the paramedics arrived. That is no longer the case – it has become the norm for firefighter first responders to continue providing CPR while the paramedics are diagnosing and administering medication. Anecdotally, our members tell us that they think this has led to an increase in the time they spend at each incident, and importantly, to better patient outcomes.

**The upward trend in drug related EMR calls.**

It should be noted that the UFU does not collect data on the number of EMR calls and the sub-set of drug related calls – this is the role of the fire service agencies who run the programs – the MFB and more recently, the CFA. There are also some discrepancies as to what is being captured and therefore able to be analysed. The MFB system at present relies almost solely on the Patient Care Record (PCR) form, which is filled in by the firefighters who attend each incident, and which can vary in terms of what is recorded. The priority of a first responder is to initiate EMR protocols to give the patient the best chance of survival, so the cause of their collapse at this stage is not the most relevant factor. If there are no obvious signs to indicate a drug overdose, such as the presence of drug injecting equipment, the incident may not be recorded as drug related. As first responders and non-clinicians, fire fighters are conscious that their role is not a diagnostic one, and this leads to some incidents being uncategorised. There is a very real potential therefore that there is an under-representation of drug related overdoses and incidents in the data.

The MFB also does not require firefighters to record the EMR calls where they are downgraded (told they are not required prior to reaching the patient), so there is only patchy data as to whether drugs were involved in these calls.

Between 2001 – 2009, MFB figures indicate that firefighters responded to a total of 8227 EMR calls. Of these, 908, or 11.03%, were recorded as drug overdose calls (*Boyle et al*).

The raw figures from completed PCRs (subject to all the limitations discussed above) for the last two calendar years indicate an increase in drug related calls. Completed PCRs are not total calls – they are completed only when the firefighter first responder crew attends the scene.

Year	Total PCRs	Drug Related	% of Total PCRs
2015	2273	277	16%
2016	2205	335	21%

In 2015, there were 277 drug related calls. In 2016, there were a total of 335. In 2015, drug related calls were 16 % of attended EMR calls. In 2016, they were at 21%, even though in that year, there were less EMR calls overall (due to changes in call categorisation). Even with this limited data, it is apparent that providing an EMR response to drug overdoses is becoming a larger component of the type of calls attended by firefighters as first responders. This increased trend is supported by what our members experience in their day to day work.

*“We always know when a stronger than usual batch has hit the streets – we go to more calls. Sometimes we know when we are going to an OD because we are given the information when we turn out, but whenever we are called to someone whose estimated age is given as between 15-35, you suspect that an overdose is what you may find”.* Leading Firefighter, 33 years of service.

*“We are often getting more drug calls now than heart attacks, sometimes 3 or 4 times a month just on my shift. If you multiply that by 4 to cover the other shifts, it could be quite significant”.* Leading firefighter, 19 years of service

### **Improvements to Drug User Safety**

These centres save lives. They supply clean injecting equipment, thereby having a positive impact on the spread of infectious diseases. They are staffed by qualified and experienced clinicians who can act as an immediate overdose team, thereby improving the patient’s survival chances. The Medically Supervised Injecting Centre (MSIC) in Kings Cross in Sydney has been operating since May 2001, and will in May 2017 mark 16 years of successful operation, firstly as a trial site and since October 2010 as an ongoing concern. Its operation and outcomes have been evaluated numerous time during its lifetime. MSIC data shows that there have been more than 965,000 injections and 5925 overdoses in the Sydney Centre since its inception. There have not been any fatalities. (*Uniting 2016*).

Since the MISC opened in Sydney, the number of ambulance calls to Kings Cross reduced by 80% (*ADF 2017*). In Victoria, the reduction in calls for the emergency services would also impact on firefighters because of their first responder role. This would also increase the access to these services by the broader community. One less EMR call to deal with a drug overdose relieves pressure on first responders and frees up an appliance and crew to respond to another medical emergency, resulting in potentially improved patient outcomes for a larger cohort of the public who suffer cardiac arrest, where every second counts. German research that indicates that a person who overdoses on the street is 10 times more likely to require a hospital stay, which adds costs to the healthcare system and places a perhaps unnecessary strain on limited beds and resources in the public health system. (*Wright & Tomkins, 2004*)

Injecting drug users are a hidden population, and many seek to hide their activity as it is illegal. This can lead to delays in emergency services being called to assist, and delayed response times, which affect patient outcomes.

*Some of the guys were telling me about a call they got to a carpark in a shopping centre at night. Firefighters and ambulance turned up, and there was no-one there. Minutes later, a car came screaming into the carpark, they dumped a young woman and sped off. They treated her. She had overdosed".* Leading firefighter 33 years of service.

A safe place to inject, with the appropriate police protocols in place as suggested in the Bill, will have the effect of reducing situations like this in the area where the MISC is located.

### **Improvements to Public Safety**

The available data on issues associated with high public drug use in the Kings Cross area of Sydney shows that there have been significant improvements since the inception of the Medically Supervised Injecting Centre (*Uniting 2016*). Local residents reported a reduction in visual public injecting, which also reduces the likelihood of members of the community witnessing an overdose and the EMR response which follows, both of which can be traumatic for members of the public, particularly children. Our members tell us that one of the hardest parts of EMR calls generally are dealing with distressed family members and witnesses or bystanders, and feeling apprehensive about how they will manage this aspect of the incident.

The Kings Cross MISC has been demonstrated to improve public safety – residents reported a steady reduction in discarded drug injecting equipment, which has the effect of lessening the likelihood of needle-stick injuries from abandoned syringes and the possible transmission of infectious diseases, and improves public hygiene and amenity (*Uniting 2016*)

### **Impact on Firefighter Occupational Health and Safety**

#### Physical Hazards

Any attendance at a drug related EMR call carries with it a risk of needle-stick injuries and the possible exposure to a range of infectious diseases that are transmitted through the blood and other bodily fluids. Often, patients present as unconscious, with syringes still embedded in their bodies, or discarded close by. Blood, vomit and other bodily fluids are also commonly present on scene. While strict safety protocols and risk management strategies are in place, it is impossible to completely eliminate the risk as the environment in which the work on the patient is being done is not within the first responder's control.

Our members tell of being called to overdoses in laneways, stairwells and disused buildings, and having to work on a patient in conditions which are unhygienic and at times dangerous, as well as on occasion having to contend with other drug users on the site who are panicked and distressed and may also be unpredictable in their behaviours.

Circumstances can also change very quickly, for example if a patient becomes violent or aggressive when paramedics arrive and administer medication to reverse the effect of the drug which caused the overdose.

*“There is always a moment of hold your breath when the ambos administer the narcan, as you wait for the person to come out of it, and prepare to deal with all of their possible reactions. Even if it all goes well, you still get the fear”.*

Discarded drug injecting equipment can also pose a risk to firefighters in aspects of their work outside of the EMR function, as well as members of the general public who live and work in the area.

*“We were called to a fire a while ago at the Collingwood flats, and when we set about doing our job, we found dozens of used syringes which had been tossed on top of the awnings on the windows by the people using in and around the flats. It posed a serious risk, and impacts on you being able to fight the fire”* Leading Firefighter, 33 years of service.

### Psychological hazards

In January 2013, researchers asked focus groups of Victorian firefighters to identify the types of call outs they considered to be stressful. 81% of respondents identified drug overdoses as stressful incidents.

*“It hits you the worst when they are young. You get a feeling of helplessness, because you pull them back, but you know that in an hour, a day, or next week it is going to happen again”.*

*“One I will never forget is a call to the Collingwood flats. He was a young man, and he was in a stairwell, stripped to his underpants and socks. Usually, they are by themselves, because their friends call it in and then disappear because they are frightened, but this time, a friend had stayed. They were drug affected. I asked where the guy’s clothes were, and the friend said that the others had thought he was dead, so they had stolen his money, clothes, everything”.* Leading Firefighter, 33 years of service.

This 2013 research was part of an independent study commissioned by the UFU and conducted by Beth Cook and William Mitchell of the Centre of Full Employment and Equity, titled *Occupational Health Effects for firefighters: The extent and implications of physical and psychological injuries*.

PTSD is one of the most widely researched subject in relation to firefighters. An extensive literature search was conducted as part of the independent report cited above, and it found that while there were variations in the levels of PTSD experienced by firefighters in different countries, what was consistent was that PTSD rates were consistently above that of the general population. (Cook and Mitchell 2013).

Similarly, there is a sufficient body of research to show that multiple exposures to traumatic events over time have a cumulative effect and are one of the factors that increase the risk of a person developing symptoms of PTSD, as well as other psychological conditions such as depression. (Cook & Mitchell 2013). The average length of service for a career firefighter is 30 years, and EMR call outs are increasing. MFB firefighters now attend more EMR calls than fires. Exposures over time and frequency of incidents are known PTSD risk factors.

Our members believe that out of all the emergency services, their exposure to trauma as first responders is perhaps the greatest. A firefighter is exposed to traumatic situations as soon as they are on station after their initial training. While their role until they have completed their certification is to observe, report and assist only, they are still exposed to the incident, and many of our younger members at the start of their careers have spoken of the initial shock they experienced when they first started attending EMR calls.

*“everyone we go to is either dead or dying – they are unconscious, not breathing, they have no pulse. As soon as the call comes in, your heart starts racing – will we get there in time, what happens if we can’t bring them back. That happens for every single call out and even when there is a good outcome, and we save more than we lose, the trauma of the situation is still there and can stick with you”*. Assistant Chief Fire Officer, 36 years of Service

There is a very strong perception amongst our members that many firefighters suffered from undiagnosed PTSD or depression, and that this impacted on work performance as well as having a detrimental effect on the individual’s health. In an occupation where teamwork is safety critical, the impact on the whole team of these sort of injuries is heightened.

The UFU has been a consistent and strong advocate on behalf of our members who have sustained psychological injuries at work to the fire services. As a result, there has been some significant refocusing on this issue in the services, and EAP and peer support systems put in place, as well as regular debriefings on station post incident. There is however, much more to be done, particularly as our knowledge of the contributing factors to PTSD related injuries continues to grow.

WorkSafe data for the five years between July 2002 and June 2007 shows that there were 907 claims from Victorian Firefighters, with the largest proportion of claims relating to physical injuries to the back (24%), knee, (19%), shoulder (11%) and leg (8%). (*WorkSafe Statistical Summary 2012, cited in Cook and Mitchell 2013*). Back injuries usually result in longer absences from work than other physical injuries, and our members tell us that EMR work – having to exert physical force to lift or move an unconscious or unresponsive patient so that care can be provided – does present constant manual handling risks.

Psychological injuries made up approximately 7% of claims. This rate was higher than the national rate of psychological claims for compensation lodged (5%). It is important to note that these figures do not include rejected claims, or where a worker is undiagnosed or attempts to deal with the injury without lodging a claim with their employer. This continues to be an issue, particularly with PTSD type injuries. We know that the recovery and rehabilitation process for a psychological injury is a longer process than for most physical injuries, and that the risk of reoccurrence is high.

As with any work-related injury, there are social and economic costs to the firefighter who has sustained the injury, their workmates and family, the fire service and the broader community. Recovering and returning to operational work can take many months and in some cases, has not been possible at all. Any reduction in the number of drug related EMR callouts attended by firefighters would contribute towards reducing these risks and costs.

## Conclusion

The UFU calls on the government to put its support behind the Bill. Medically Supervised Injecting Centres have been shown to save lives, and to free up emergency medical resources which are of benefit to the broader community, as well as to our firefighter members who provide these services. It is consistent with the harm minimisation approach adopted by the Government in other funded drug programs.

We respectfully request that the Legal and Social Affairs Committee supports this Bill and recommends to the Victorian Parliament that they support the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017.

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