Submission to the Legal and Social Issues Committee
Parliament of Victoria

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

April 2017
# Table of Contents

<table>
<thead>
<tr>
<th>Title</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm Reduction Victoria: Vision and Mission</td>
<td>3</td>
</tr>
<tr>
<td>Guiding Principles</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Terms of Reference</td>
<td>5</td>
</tr>
<tr>
<td>Drug Consumption Room/Safe Injecting Room</td>
<td>6</td>
</tr>
<tr>
<td>Naloxone</td>
<td>11</td>
</tr>
<tr>
<td>Services Review and Improvement for People who Inject Drugs</td>
<td>16</td>
</tr>
<tr>
<td>Recommendations</td>
<td>17</td>
</tr>
</tbody>
</table>

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HARM REDUCTION VICTORIA (HRVic)

Harm Reduction Victoria Inc. (HRVic) formerly VIVAIDS Inc. is Victoria’s drug user organisation. Incorporated in 1987 (as VIVAIDS), HRVic is a membership driven, not-for-profit organisation. HRVic played a key role in mobilising the IDU (injecting drug user) community in response to the threat of HIV/AIDS. Since the heyday of the HIV/AIDS epidemic, HRVic has taken on a wider brief of drug user health issues. Using peer education, advocacy, workforce development and community development processes, HRVic addresses issues such as hepatitis C, heroin overdose, amphetamine-type stimulant related harms, the drug treatment needs of Victorians, drug-related harms in the dance-music arena etc.

HRVic is the only organisation in Victoria with a mission to represent the needs and perspectives of people who currently use illicit drugs. HRVic provides advice and input on drug-use issues to the community, strategic policy advice to government, and to agencies and service providers whose work impacts upon the health and rights of people who use, or have used, illicit drugs.

HRVic employs people with current lived experiences of illicit drug use and/or drug treatment services, including pharmacotherapy programs. HRVic acknowledges these community members are uniquely placed with a high level of expertise and knowledge of the minutiae of drug use and therefore the specific harms associated with illicit, synthetic and prescription drug taking. Alongside formal training, this ideally positions HRVic employees to discuss and encourage harm reduction practices with their drug taking peers. HRVic is an active member of the national network of peer-based drug user health organisations, headed by the Australian Injecting and Illicit Drug Users League (AIVL). AIVL is the national peak body representing all state and territory drug user organisations across Australia.

OUR VISION

A world where all people are treated the same and have the same opportunities regardless of their drug of choice.

OUR MISSION

Harm Reduction Victoria works to advance the health, dignity and social justice of people who use drugs in Victoria.
GUIDING PRINCIPLES

Harm Reduction Victoria (HRVic) is committed to the following 7 Guiding Principles:

- **COMMUNITY OWNERSHIP AND ACCOUNTABILITY**
  HRVic is of and for our community. Through active engagement with our membership and constituent communities, HRVic aims to identify and serve the needs of Victorian drug users. We encourage a broad-based sense of ownership and involvement in all aspects of HRVic’s operations.

- **INCLUSION**
  HRVic respects and represents all people who use drugs in Victoria, regardless of gender, sexuality, age, disability, faith, cultural or ethnic group. We prioritise those at greatest risk of drug related harm particularly people who inject drugs, due to the risk of blood borne virus transmission.

- **“NOTHING ABOUT US WITHOUT US”**
  HRVic asserts the right of people who use drugs to have a voice in decisions which directly affect their lives and to be involved in the response to drug use and associated harms including drug related policies and programs [http://www.opensocietyfoundations.org/reports/nothing-about-us-without-us](http://www.opensocietyfoundations.org/reports/nothing-about-us-without-us).

- **HUMAN RIGHTS**
  HRVic rejects all forms of arbitrary discrimination against people who use drugs. We believe that the stigma associated with drug use undermines human dignity and self-efficacy, and creates barriers to participation in the social, cultural and economic life of the community. We work towards the elimination of these destructive attitudes.

- **PARTNERSHIPS AND COLLABORATION**
  In order to respond more effectively to the needs of people who use drugs, HRVic is committed to pursuing partnerships and strategic alliances with other community sector organisations built on shared goals and trust.

- **HEALTH PROMOTION**
  HRVic is a health promotion organisation. We are guided by a belief that drug related harm should be treated as a health issue and not a criminal issue. Our aim is to advance the health and wellbeing of people who use drugs by creating an environment in which individuals are empowered to realise their aspirations, meet their needs and participate fully in society.

- **EXCELLENCE**
  HRVic strives to be a model employer, to be accountable to our members and constituent communities for all of our actions, and to achieve optimal outcomes at all times.
INTRODUCTION

Harm Reduction Victoria (HRVic) welcomes the opportunity to respond to the Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017. This submission advocates for a harm reduction approach in the response to drug use in Victoria. Harm reduction commonly refers to policies and programs that primarily seek to decrease detrimental effects associated with substance use, rather than to decrease substance use overall. Harm reduction focusses on the safety of the individual, the family and the community, and in so doing, provides agency to the individual, to families and the community to protect the health and wellbeing of all Victorians.

The elimination of drugs within society, and of drug use at an individual or community level, is quite frankly unachievable. In consideration of this, it is important harm reduction strategies are put in place which are effective, achievable and will be adopted to prevent the harms associated with drug use. To ensure this is the case, drug users must be engaged in the conversations and play a role in the development and ongoing review of harm reduction services.

The Victorian Drugs, Poisons and Controlled Substances Act 1981 hinders the effective rollout of harm reduction services, impacts standards of care, and is an access barrier to health care and support services for people who use illicit drugs. A ‘safe injecting facility’ or a ‘drug consumption space’ is an evidence based successful harm reduction strategy aimed at reducing the adverse health, social and economic consequences of the use of drugs. This submission responds to the following Terms of Reference:

1 RECOMMENDATIONS IN CORONER HAWKINS’ FINDING – INQUEST INTO THE DEATH OF MS A, DELIVERED ON 20 FEBRUARY 2017 AND OTHER RELEVANT REPORTS;
   • That Martin Foley MP, as minister for mental health, take the necessary steps to establish a safe injecting facility trial in North Richmond.
   • That Kym Peake, Secretary DHHS, 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.
   • That Kym Peake, Secretary DHHS, review current DHHS funded services that support the health and wellbeing of injecting drug users in the City of Yarra, and consult with relevant service providers and other stakeholders, to identify opportunities to improve injecting drug user’s access and engagement with these life-saving services.

2 NATURE AND EXTENT OF CURRENT, RELEVANT REGULATIONS; AND

3 AND NATURE AND EXTENT OF ASSOCIATED, RELEVANT POLICING POLICY.

DRUG CONSUMPTION ROOM / SAFE INJECTING ROOM

That Martin Foley MP, as minister for mental health, take the necessary steps to establish a safe injecting facility trial in North Richmond.

Background
Supervised injecting facilities (SIF) are places people who inject drugs go to self-administer illicit drugs such as heroin. They are also known as drug consumption rooms, which is a service type providing the facilities for drugs to be used in different ways, eg smoking methamphetamines. SIF are a harm reduction response to the health and safety of individual drug users and the broader community. They provide sterile injecting equipment and an emergency medical response on site to prevent fatal overdoses. A team of registered nurses, counsellors and peer health education officers supervise episodes of drug taking and help to bring about changes to harmful injecting practices. The facilities provide a range of services which may include access to health care, counselling and referrals to drug and blood borne virus treatment specialists including hepatitis C.

Victorian Approach
Melbourne discussions on SIF began in the 1990s with a trial proposed for Springvale. Labor Premier Steve Bracks’ Drug Policy Expert Committee advised on the feasibility of a multi-suburb’s injecting room trial. The ALP injecting room policy was dropped in October 2002, in favour of the establishment of 5 primary health centres for people who inject drugs across the ‘hotspots’ of Melbourne: eg Footscray and St Kilda.

The number of heroin deaths in Victoria rose by almost 20% in 2015 and it has been noted by the Coroners Prevention Unit that 20 of these 172 fatal heroin overdoses occurred in the City of Yarra. The Coroners Court data revealed overdose deaths have reached a seven-year high, and a steep rise in heroin overdoses largely accounts for the spike. In February 2016, the Victorian Coroner recommended Mental Health Minister Martin Foley take steps to establish a safe injecting facility trial in North Richmond, saying there was strong stigma towards drug users in Richmond, and staff at a safe injecting room could efficiently engage with them. The leader of the Australian Sex Party introduced legislation for a medically supervised drug-injection centre in North Richmond last year, and has called on the Victorian parliament to allow a conscience vote on a proposed supervised drug-injecting facility. However, Victorian Premier Daniel Andrews stands by an election promise made, not to establish a drug consumption room in the state.

On Wednesday 15 March 2017, HRVic staff undertook a snapshot survey of 11 street-based heroin injectors along North Richmond’s Victoria Street. Demographics being: 6 men and 5 women, within the age grouping of 35-55 years of age, with the average age of 37 years old.

Responses to questions asked are:

- Do you score in Richmond? Yes - 11
- Do you use in Richmond? Yes - 11
- Would you use a safe injecting room? Yes – 10; No - 1 (prefer to use in own home).

**Would you use a safe injecting room?**

“I’d use one because everyone knows where you are, there’s less danger if you drop. It’d be good.”

“...of course, for safety and not having to use in public. Not being interrupted.”

“...much safer if you OD. And it’s a cleaner environment [than the street]”

“Safer than street”

As a street based injecting drug user, it was important for this respondent that the

“Police not allowed in, can’t be interrupted ....”

“People drop, room would help them in general people would use it”

“There should be childcare there”

“Great to have somewhere safe to use”

“Safer than public – overdose”

“I reckon most people who just roll in to Victoria Street to score would use it”

“Should open at 7am”

“It would be busier in the day”

Today, the drug market in Melbourne and suburbs is a shifting landscape, eg Springvale’s late 1990’s street market has moved behind Dandenong’s train station and Footscray’s market has moved out a little toward St Albans. This is important in considering a location for, and type of, SIF for the State. Those locations suggested by the Bracks’ Government review are not now as they once were. The establishment of a mobile SIF would suit Melbourne’s changing drug market and areas of consumption, and would be responsive to the following quote from a potential client of a Melbourne SIF:

“People wouldn’t come to MSIC in Richmond if the market shifts”
NSW Approach
Following on from a NSW Drug Summit in 1999, Australia opened its first MSIC in Sydney in 2001. The Kings Cross service remains the only one of its kind in the southern hemisphere. Since opening, it has:
- supervised more than 965,000 injections;
- managed 6,089 overdoses without a single death;
- made more than 12,000 referrals connecting people to health, drug treatment and social welfare services;
- been well accepted: 70% of local businesses and 78% of local residents support the centre;
- noted the number of publicly discarded needles and syringes in Kings Cross almost halved when the centre opened;
- taken the pressure off emergency services with an early study showing the number of ambulance callouts to Kings Cross dropping by 80%.

Given Melbourne’s shifting drug markets and the different drug cultures in NSW and Victoria, the Melbourne SIF should not be a carbon copy of the Sydney MSIC. The Melbourne SIF should benefit from known client access barriers and challenges faced by the Sydney MSIC model as follows:

Challenges with the NSW MSIC
1. **The Kings Cross MSIC does not allow the following ‘groups’ to use the service:**
   - parents, guardians, carers with a young person (under the age of 18) in their company;
   - women who disclose they are pregnant or they are noticeably showing; or
   - young people under the age of 18.

   **Response:** Currently Australian needle and syringe programs (NSP) do not turn away or deny young people from accessing sterile injecting equipment. The Victorian NSP data collection sheet records clients in the age grouping ‘under 15’. Given community awareness that young people are injecting drugs, it would seem an ideal opportunity to have a ‘hard-to-reach’ population access a SIF and engage with them on safer drug use practices and treatment opportunities. The Vancouver “insite” SIF permits young people to use their facility and records clients accessing their service within the age grouping 14-26 years of age. It is not uncommon for local NSP to have a child’s play area attached to the service where children undertake activities such as drawing whilst their parents/guardians/carers collect and drop-off injecting equipment. A set-up of this nature could be attached to the Melbourne SIF. Women who are pregnant use drugs, and by allowing them access to a SIF, the potential exists for them to receive ante-natal care which they may not otherwise be getting.

2. **Peer workers can’t disclose their current or past drug use history to clients.**

   **Response:** It is important peer workers (current injecting drug users) are employed in a health promotion/education/counselling role in the Melbourne SIF, and that they are able to be ‘out’ about their status. Far from compromising the worker-client relationship, by allowing peer workers to disclose their drug use to clients of a SIF, it allows for the establishment of a credible rapport, based on trust and respect to be built up, which leads to improved health outcomes.
3. **No more than 2 clients can split a drug mix/packet**

**Response:** It is important the booth space and facility rules allow for the sharing of drug mixes and/or drug packets in a safe and sterile manner. Drug packets quite often are purchased jointly eg a couple sharing a deal or its cheaper to purchase a greater weight in the first instance.

4. **Banning of clients with 0.05 and above blood alcohol reading**

**Response:** It is important to acknowledge this ruling is a vital risk reduction strategy, however there are options in the management of a client with a high blood alcohol reading. For example, in most cases the client will inject their drugs regardless, and this could take place in a rushed and less than sterile environment and alone, which places them a risk of a fatal overdose. The client on the other hand could be monitored at the SIF and/or convinced to delay having their drugs. It is also important to remember there will be clients using the SIF who will have had an alcoholic beverage prior to injecting their drugs, and have slipped through undetected by the monitoring system, resulting in enhanced risk taking behavior. Also, in addition to alcohol use prior to injecting opiates, there will be clients who have taken benzodiazepines prior to injecting opiates and at risk of fatal overdose.

5. **Sydney MSIC License System is prescriptive and problematic; it limits, constricts and controls operations eg the NSW Police Commissioner is a signatory on the license for the MSIC and in effect are able to pull their support and close the door at any time**

**Response:** The licensing system should not be used. Regulations which apply in the operations of generalist health and medical services should apply with the Melbourne SIF. The service should have accreditation thereby ensuring systems are credible and safe, the service is accessible financially, across gender and culture and for clients with a disability, the workforce be skilled, qualified and supported, and clients of the service are involved in continuous improvement activities. None of this is enshrined within a licensing system. The SIF should be framed within a public health model, treated no differently to a holistic community medical health service.

   a. **There is no requirement for the MSIC to have a peer steering committee, or any structural accountability to the drug using community. There is no method for drug users to give feedback or influence changes to the service system.**

   **Response:** Quality improvement processes must be in place to ensure the SIF is established and operates within best practice framework.

   b. **There is the potential for the MSIC to close if the Police are in opposition to operating systems**

   **Response:** this is problematic that one party/community service has the ‘power’ to close a service.

   c. **The licence model doesn’t permit any changes**

   **Response:** The ability to change service systems is in line with evolving service and client needs and research, best practice evidence.
Overseas Approach
The world’s first medically supervised injecting centre (MSIC) was opened in Switzerland in the 1980s. There are now approximately 100 MSICs worldwide, the majority are in European countries, including Germany, Spain, the Netherlands, Norway, Luxembourg and Denmark. Canada has 2 facilities and an evaluation of Vancouver’s MSIC (in operation since 2003), demonstrated the centre had led to:

- a 30% increase in the use of detox services and an increase in people getting addiction treatment;
- a 35% reduction in fatal overdoses in nearby areas; and
- observable changes in public order including a reduction in public drug use and public syringe disposal.

Barcelona and Berlin are major European cities with established drug markets that have run since the 1970s. Neither city has one large public drug scene, rather smaller scenes in a number of locations across the city have become established in which dealing and in some cases consumption takes place. To cater for this, both cities have especially fitted out mobile SIF vans and are physically located in close proximity to established drug markets and drug injecting precincts. Each van is fitted with 3 injection booths and they provide a sanctioned space for the injection of drugs. The Berlin mobile SIF travels between 2 sites on a publicised weekly timetable, and the Barcelona SIF is stationed at one site permanently. These ‘enabling environments’ have been shown to have a range of public health benefits, from improvements in the management and response to acute drug overdose, through to successful referral to other services. The advantages of a mobile SIF is that governments are able to respond to changes in drug market locations occurring as a result of police operations or other market and consumption variables. Mobile SIF can be ‘parked’ next to primary health centres as a further client referral and support point.

In asking the North Richmond ‘crew’ their opinion on SIF, one member commented positively on the idea of a mobile SIF as follows:

> "Great to have somewhere safe to use. Could be in a shipping container like pop-up shops."

Shane

**Recommendation 1:**
Establish a mobile safe injecting facility in Melbourne to move across changing drug market locations and areas of need, guided by an expert advisory committee including membership of Harm Reduction Victoria to represent the interests of Victorians who inject drugs.

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Naloxone

That Kym Peake, Secretary DHHS, 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.

Naloxone hydrochloride (trade name Narcan®) is used to reverse opioid overdose. It works by blocking opioid drugs (eg heroin, methadone, oxycodone and fentanyl) from attaching to opioid receptors in the brain. Naloxone can be administered intravenously or intramuscularly and has traditionally been used by paramedics responding to ambulance callouts. In 2015, naloxone was rescheduled from a Schedule 4 (S4) drug to a dual listing (S4 and 3) making it available on prescription or available to purchase over the counter. The latter is more expensive as naloxone is not covered by the Pharmaceutical Benefits Scheme. It is important to acknowledge those more often than not, in a position to intervene and reverse an opiate overdose are people who inject drugs and many do not have the financial resources to purchase naloxone without both a prescription and a concession card.

The purchase of naloxone with a script over the counter is much cheaper than without a script.

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<th>Concession Card</th>
<th>Prescription</th>
<th>Cost</th>
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<tr>
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<td>Yes</td>
<td>$6.30</td>
</tr>
<tr>
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<td>No</td>
<td>Yes</td>
<td>$38.80</td>
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<tr>
<td>1*</td>
<td>N/A</td>
<td>No – purchase over the counter</td>
<td>$25+</td>
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*Not all pharmacies stock naloxone and if they do, prices will vary, starting at $25 for a single ampoule.

Groups at risk of opiate overdose include:
- people who inject heroin;
- people buying over the counter codeine;
- poly-drug users eg opiates and benzodiazapines.
- people on prescription opiates living with chronic pain;
- inmates exiting prison following a period of incarceration;
- clients of a drug treatment program who relapse following a period of abstinence; and
- a person in the early weeks of induction onto methadone, for the purposes of maintenance.

Effective harm reduction strategies can be developed and implemented to counter the risk, including overdose prevention and recognition training, and the provision of naloxone to drug users, their families and other potential overdose witnesses. The prison system should provide this to inmates on release, treatment programs to patients at a relevant point in their treatment, and doctors and pharmacists involved in opiate replacement therapy (ORT) should educate patients and make naloxone available to them from treatment commencement. Naloxone available in the home is also crucial prevention in the case of accidental ingestion by a non-tolerant individual, eg children. There is great potential for witnesses
to an overdose to administer naloxone and thousands of overdose reversals have been performed by lay
people, including drug users themselves, in nonmedical settings, with virtually no adverse events
(including no severe opiate withdrawal) observed. Doctors have generally been unwilling to prescribe
naloxone to lay people, e.g. a person who is at risk of opioid overdose or the parents of a person at risk.
This is usually out of concern that they may face liability if the eventual recipient of naloxone did not
recover or acquired a brain injury. This concern is overly-cautious. Research indicates if those present
intervene and administer life support, outcomes for the victim are significantly improved.

A local NSP may be the only health service that people who inject opiates access on a regular basis, and
they are usually the only health service that injectors trust. As such, NSP provide an opportunity to
effectively deliver opiate overdose harm reduction strategies, including the free distribution of naloxone
and access to HRVic’s Drug Overdose Peer Education (DOPE) program.

**Victorian Approach**

HRVic is funded by the DHHS to coordinate the Drug Overdose Peer Education (DOPE) program. The DOPE
program’s opiate overdose peer education training delivered directly to people who inject heroin includes
the identification of overdose risks, myth busting, ‘hands on’ resuscitation techniques and a discussion
about naloxone administration and how to access the drug. Unfortunately, the DHHS funding does not
cover the cost of purchasing naloxone for distribution to participants as part of the training. Over the last
couple of years, the DOPE program has been asked to deliver overdose training to clients of local health
centres. With a doctor on site at the time of training, the GPs have written the participants a script and
the centre has covered the cost of filling the scripts. This has been a successful partnership however it is
not sustainable and health centres have not been able to donate the funds required to provide naloxone
to all training participants. HRVic does not have the funds to purchase naloxone for PWID who have come
into contact with HRVic through other means, such as peer contacts. In addition, the funding does not
provide the capacity for the DOPE program to be delivered Statewide.

Another issue for consideration is not all pharmacies stock and/or sell naloxone as is evidenced by the
following:

> “Out of concern for a friend, I recently went to a pharmacy to buy naloxone
over the counter. The pharmacist refused to sell it to me! She wasn’t aware
that it had been added to the over-the-counter schedule and said, “We don’t
stock that sort of thing anyway.”

Kate, 23, mother

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Anex (2012), Australian Drug Policy: Lifesavers - access to naloxone to reduce opioid overdose-related deaths and morbidity.
Anex Melbourne, Australia
Interstate – ACT and WA Approach

Australia’s first take-home naloxone (THN) program was established in the ACT in early 2012. The program involves comprehensive opioid overdose management training and the prescription and supply of THN to eligible participants who are not health professionals. The program is coordinated and delivered by the ACT’s drug user organisation Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), with prescriptions provided by local physicians. This collaborative approach is funded by ACT Health. During April 2012-December 2014, over 200 participants were trained in overdose prevention and naloxone administration, and the majority of these received a prescription for naloxone. 18 inmates at Canberra’s prison (which holds both sentenced prisoners and those on remand) were also trained and some of these received prescription naloxone after release. Fifty-seven overdose reversals using program-issued naloxone were documented during the evaluation period. All reversals were successful and no serious adverse events were reported. The evaluation identified a range of issues for consideration including modifying the workshop content and delivery by shortening the length of the workshop, reinforcing the need to call an ambulance in overdose situations and offering refresher workshops to reinforce knowledge and practice.

In late 2012, the WA Government funded the WA Substance Users Association (WASUA), the state’s drug user organisation to deliver the WA Peer Naloxone Project. Between January 2013-May 2015, 153 program participants were trained, completed pre- and post-training assessments and received a prescription for naloxone. Participants reported 32 overdose reversals following training, in which naloxone was administered by a peer; 29 of these instances were overdoses witnessed by program participants and 3 instances were personal overdoses of participants. Participants’ increased knowledge regarding opioid overdose following training suggests the program contributed to successful overdose reversals. Results indicate that the training had large to very large positive impacts on participant knowledge regarding how to recognise and appropriately respond to an overdose. No unintended negative consequences were reported, however an unintended positive consequence was that several participants reported a sense of empowerment and confidence resulting from the training.

Both the WA and ACT governments funded their state drug user organisations to develop and deliver a comprehensive opiate overdose training program, which included the distribution of naloxone to community members. Both programs used a workshop model to deliver the training and independent external evaluations were conducted by national research bodies. In line with the evaluation of the ACT model, a Victorian model would work best based on the Washington Heights Corner Project, which is a one-on-one model educating users in an informal manner in a setting right for the ‘person’, eg in the local park or café, taking the training to the person rather than expecting the person to come to the trainer.

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Overseas Approach
Increasingly, naloxone has been made available to those who can be termed “potential overdose witnesses”. Early pilot studies in the mid-1990s in the Emilia-Romagna region of Italy made naloxone available to heroin users, so their family or peers could reverse overdose quickly while waiting for emergency medical care to arrive. By 2000, reports were emerging from Germany that drug users themselves, when trained to administer naloxone, could successfully reverse other peoples’ opiate overdoses. Despite legal uncertainties, the first United States program to prescribe injectable naloxone was established in Chicago in 2001, and by 2010 had distributed naloxone to more than 15,000 potential overdose witnesses, and received reports of more than 1500 successful overdose reversals. The United States now has more than 50 programs under which naloxone is provided to potential overdose witnesses who are now credited with saving thousands of lives. In the US naloxone distribution has occurred for more than 10 years without any legal threat. In Boston City, regulations have been passed under which the city’s Board of Health assumes liability for the work of medical and nonmedical personnel involved in the program.

In the United Kingdom, a randomised controlled trial is assessing the effectiveness of giving naloxone on release to prisoners with a history of opioid use to prevent fatal overdoses. These programs show promise to save lives and the consequences of broader implementation need to be carefully assessed. A research paper found that an Ontario inmate’s chance of dying by an overdose spikes to 56 times the national average in the 2 weeks after release. In light of this, the Ontario Health Minister ordered the immediate distribution of naloxone to newly released inmates.

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8 Anex (2012). Australian Drug Policy: Lifesavers - access to naloxone to reduce opioid overdose-related deaths and morbidity. Anex Melbourne, Australia
Recommendation 2:
The Victorian Government lobby the Australian Government for naloxone as an over the counter medication on the Pharmaceutical Benefits Scheme.

Recommendation 3:
The Victorian Government fund the expansion of HRVic’s DOPE program to build a comprehensive State-wide peer overdose response team responsible for the delivery of overdose prevention training, distribution of free naloxone and work in partnership with pharmacists and the general practice workforce to enhance accessibility of the drug.

Recommendation 4:
The State Government fund the relevant Victorian pharmaceutical peak body to develop an awareness raising campaign to inform their membership that naloxone has a dual scheduling and is available as an over the counter medication. The campaign would also provide pharmacists with training in the administration of the drug.

Recommendation 5:
Trial distribution of naloxone on release to prisoners with a history of opioid use.
That Kym Peake, Secretary DHHS, review current DHHS funded services that support the health and wellbeing of injecting drug users in the City of Yarra, and consult with relevant service providers and other stakeholders, to identify opportunities to improve injecting drug user’s access and engagement with these life-saving services.

In Victoria, people who use drugs are consistently excluded from committees, networks and working groups that are influential in establishing services and policy responses to drug use. This is despite the Victorian Government having in-situ, and funding, one of Australia’s leading peer based drug user organisations run by and for Victorians who inject drugs. Harm Reduction Victoria has consistently demonstrated effectiveness in delivering peer education and harm reduction services across the State for over 3 decades.

Unfortunately for Victorians who use and/or inject drugs, lived experiences of stigma and discrimination prove to be the largest barrier to accessing services and hence their engagement in what could be life saving strategies and services. HRVic is keen to break these barriers down and believes one proactive way is through the education of the primary care workforce and affiliated industry workers.

The establishment of a Melbourne SIF provides an opportunity for inclusivity of people who inject drugs and to recognise their invaluable contribution in service system development, implementation, management and evaluation. HRVic recommends that consultation with the organisation, as a membership based service, representing the interests of Victorians who use illicit drugs, including Victorians who inject drugs, be prioritised in the establishment of the SIF, the implementation of the service and evaluation of the trial.

**Recommendation 6:**
Fund HRVic to deliver their *Apply Pressure Here: A new peer-spective on stigma and drug use* training which was developed in response to the education and information needs of Victoria’s health care sector. The package provides practical strategies for healthcare professionals to challenge and combat stigma and discrimination and to expand access and remove barriers to holistic wellness for people who inject drugs.
HRVic would be pleased to elaborate on this written submission and provide a verbal presentation to inquiry committee members.

RECOMMENDATIONS

Harm Reduction Victoria calls on the Victorian Government to:

1. Establish a mobile safe injecting facility in Melbourne to move across changing drug market locations and areas of need, guided by an expert advisory committee including membership of Harm Reduction Victoria to represent the interests of Victorians who inject drugs.

2. The Victorian Government lobby the Australian Government for naloxone as an over the counter medication on the Pharmaceutical Benefits Scheme.

3. The Victorian Government fund the expansion of Harm Reduction Victoria’s DOPE program to build a comprehensive State-wide peer overdose response team responsible for the delivery of overdose prevention training, distribution of free naloxone and work in partnership with pharmacists and the general practice workforce to enhance accessibility of the drug.

4. The State Government fund the relevant Victorian pharmaceutical peak body to develop an awareness raising campaign to inform their membership that naloxone has a dual scheduling and is available as an over the counter medication. The campaign would also provide pharmacists with training in the administration of the drug.

5. Trial distribution of naloxone on release to prisoners with a history of opioid use.

6. Fund Harm Reduction Victoria to deliver their Apply Pressure Here: A new peer-spective on stigma and drug use training which was developed in response to the education and information needs of Victoria’s health care sector. The package provides practical strategies for healthcare professionals to challenge and combat stigma and discrimination and to expand access and remove barriers to holistic wellness for people who inject drugs.