PENINGTON INSTITUTE

Patrick O'Brien
The Secretary
Legal and Social Issues Committee (Legislative Council)
Parliament House
Spring St
Melbourne VIC 3002

Dear Mr O'Brien,

Thank you for inviting Penington Institute to make a submission to the Legal and Social Issues Committee's (the Committee) Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 (the Inquiry). Policymakers' renewed interest in this this issue is very welcome.

About Penington Institute

Our mission

Penington Institute actively supports the adoption of approaches to drug use which promote safety and human dignity. We address this complex issue with knowledge and compassion. Through our analysis, research, workforce education and public awareness activities, we help individuals and the wider community.

Our history

Launched in 2014, Penington Institute, a not for profit organisation, has grown out of the rich and vibrant work of one of its programs, Anex, and its 20 years' experience working with people and families directly affected by problematic drug use. Penington Institute is inspired by and named in honour of Emeritus Professor David Penington AC, one of Australia's leading public intellectuals and health experts.

Our vision

Our vision is for communities that are safe, healthy and empowered to manage drug use.

Our understanding

Drug use trends, drug development and markets historically move faster than research and policy

Chief Patron: Emeritus Professor Sir Gustav Nossal AC CBE

Patrons: Professor The Hon Dame Marie Bashir AD CVO, Professor Suzanne Cory AC, Emeritus Professor David de Kretser AC, Professor Peter Doherty AC, Professor Margaret Hamilton AO, Professor The Hon Barry Jones AC, The Hon Michael Kirby AC CMG, Emeritus Professor David Penington AC, Professor Fiona Stanley AC

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responses. With our outreach to the front line we are well-placed to know and understand the realities of how drugs are impacting communities – well before the published literature surfaces significant issues.

We combine our front-line knowledge and experience with our analysis of the evidence to help develop more practical research and policy, support services and public health campaigns. Our strong, diverse networks provide an excellent platform for building widespread support for effective initiatives.

Our activities:

We:

- Enhance awareness of the health, social and economic drivers of drug-related harm.
- Promote rational, integrated approaches to reduce the burden of death, disease and social problems related to problematic substance use.
- Build and share knowledge to empower individuals, families and the community to take charge of substance use issues.
- Better equip front-line workers to respond effectively to the needs of those with problematic drug use.

Our purpose is framed by our knowledge that we need to look at more effective, cost-efficient and compassionate ways to prevent and respond to problematic drug use in our community.

Summary of our submission

Providing settings for the supervised consumption of drugs is likely to generate significant benefits for the health, safety, economy and amenity of Victorians. Importantly, many of the benefits of supervised injecting facilities (SIFs) cannot be achieved through alternative interventions. There are also few, if any, tangible downsides to supervised consumption.

In this sense, the more challenging question is not whether Victoria should implement supervised consumption, but rather how and where to do it.

Given particularly elevated concern about drug harms in North Richmond and stakeholders' existing progress in generating local support for a SIF, implementation should occur there. However, the effectiveness of SIFs is so compelling that – provided they are properly designed, locally accepted and integrated in the broader service system – Victoria should not legislate to limit its trial to a single location. Similarly, the merits of client age and staff qualification requirements should be carefully tested and balanced at the local level – and should not lock the state in to a single arrangement that does not work in practice.

Penington Institute therefore supports the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill2017 (the Bill), with the following proposed changes. Full recommendations for each of these points are made in the relevant sections of the submission:

- an extension of the trial period to three years;
- an interim evaluation after 18 months;
- removal of the restriction on the number of SIF licences that can be issued (currently proposed to be capped at one licence) – or, alternatively, removal of the restriction on the number of premises that can be issued under a single licence;

- replacement of the age restriction with a youth-specific support strategy within SIFs; and
- maintaining medical oversight of SIFs without a requirement for every site to be directly overseen by a medical doctor.

We expand on each of these suggestions below, as well as addressing other, complementary measures that will enable the successful implementation of SIFs in Victoria.

Supervised drug consumption

Supervised drug consumption is a service offered within drug consumption rooms (DCRs), which are professionally supervised health care facilities where people can consume drugs in safe conditions.[1] Supervised injecting facilities (SIF) – a form of DCR designed for injecting drug use – are currently the subject of considerable debate in Victoria. We note the Bill proposes a 'medically supervised injecting centre', which would be a form of SIF. We use term 'SIF' throughout this submission because not all DCRs have a predominantly medical focus or staffing profile. We expand on various service models and design considerations for DCRs at pages 6-10.

In 2016 there were 90 drug consumption rooms operating worldwide in Australia (Sydney), Canada, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland.[2] Ireland and Scotland have plans to introduce SIFs during 2017.[3]

Ethics and outcomes

While supervised consumption's benefits have been well ventilated (and we have provided a summary below), it is worth directly addressing some of the commonly-cited concerns regarding its introduction.

The first is that SIFs will cause an increase in drug-related crimes in their immediate vicinity. This objection was more commonly cited in the early days of SIFs, but empirical data has not borne it out. Drug consumption rooms do not cause either an increase or decrease in thefts or robberies around the facility.[4] Concerns about increases in drug dealing also appear to be unfounded,[5] but these can be simultaneously addressed as part of service model design.

Other common concerns include that providing a legitimate setting for drug use condones an illicit behaviour, thus sending the wrong message about drugs and/or the rule of law. Opponents have also objected to supervised consumption on the basis that it signals surrender in the fight to eliminate drug use in the community.

These are primarily moral considerations. They cannot be answered by 'the evidence' alone. However, people who are concerned about compromising on principled grounds must ultimately weigh their

[1] Harm Reduction International (2016), *Global State of Harm Reduction Overview*, https://www.hri.global/files/2016/11/15/Global_Overview_2016.pdf, p. 18.

[2] Harm Reduction International (2016), p. 18.

[3] Ibid.

[4] EMCDDA (2016), *Drug consumption rooms: an overview of provision and evidence*, http://www.emcdda.europa.eu/system/files/publications/2734/Drug%20consumption%20rooms_update%202016.pdf.

[5] Potier et al (2014), "Supervised injection services: what has been demonstrated? A systematic literature review", *Drug and Alcohol Dependence*, 145:48-68.

conceptual concerns in light of the clear evidence that SIFs deliver better outcomes than both the status quo and more authoritarian measures.[6] This is, itself, an ethical calculation.

Almost all drug users recover – SIFs quicken the process

It is also important to think about drug use over the course of a life. The vast majority of people who use drugs do so for a fairly short period in their lives, experience relatively minimal harm, and then stop.[7]

For the small proportion of drug users who become dependent, most stop using or at least enter a phase of recovery where drug-related harm diminishes significantly.[8] As the evidence for effective, holistic drug treatment improves – and absent any significant external pressures which might increase the prevalence of drug harms – the success rate for treatment should only get better. The opportunity of supervised consumption is thus to keep people who are dependent on drugs alive and to support them to reach recovery earlier.

As we explore below, SIFs are able to attract the most marginalised drug users.[9] Given there is no evidence that SIFs increase drug use or delay clients' uptake of drug treatment,[10] the concern about sending a 'wrong message' appears to be unfounded. Indeed, if there is a message that should be sent to these people – and to the broader community – it should be that all human lives have value. As a community, we have a chance to avert the senseless waste of human life. We should take it.

Policing the drug market can continue

Ultimately, SIFs do not prevent law enforcement from pursuing their objective of shrinking the illicit drug market. Victoria Police have long acknowledged that they cannot arrest their way out of drug problems, and it is already their policy not to routinely dedicate resources to drug use and possession offences. Police can allow a SIF to operate while still enforcing drug market-related laws, such as trafficking, violence and property offences.

Fair access to health

We should also consider whether the denial of supervised consumption is a fair application of the community's standards for health care. Australia does not, for example, prevent people from accessing medical care merely because they have made choices – illicit drug use, alcohol consumption, tobacco smoking, unhealthy diet, physical inactivity – that may harm their health.

Nor can it be a question of drugs' status as 'illegal', given drug users are equally entitled to current health services. Australia does not deny care to other people who commit harmful, illegal acts that affect others – such as people who are admitted to hospital after perpetrating an act of violence.

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[6] Increasing criminal penalties would be likely to exacerbate drug harms, cyclical reoffending and prison overcrowding. In the face of persistent poor outcomes, the justice system is itself embracing alternatives to failed punitive responses, such as drug courts and diversion. However, these measures cannot replace the benefits available via supervised consumption.

[7] NSW Bar Association Criminal Law Committee (2014), "Drug Law Reform Discussion Paper", http://www.nswbar.asn.au/docs/webdocs/Drugs_DP_final1.pdf, accessed 12 December 2016.

[8] U.S. Department of Health and Human Services (2009), *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research?*, https://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Guiding_Principles_Whitepaper.pdf, p. 21.

[9] Potier et al (2014), "Supervised injection services: what has been demonstrated? A systematic literature review".

[10] EMCDDA (2016), *Drug consumption rooms: an overview of provision and evidence*.

It is therefore peculiar to extend acute care to these groups while opposing SIFs, which merely prevent later, costlier, and less effective interventions.

Human rights

There is a compelling case for establishing supervised consumption as part of the gradual realisation of the human rights to life and health, both of which are endorsed by Australia under relevant treaties. The right to life is part of Victoria's Charter of Human Rights and the International Covenant on Civil and Political Rights, to which Australia is party.[11] Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) requires Australia to recognise, and take steps to realise, "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,"[12] including to help prevent disease.[13]

Supervised consumption is clearly attainable in the Australian context, given its longstanding presence in NSW and our world-class health system. Indeed, for Victoria in 2017, and in light of the ever-growing body of evidence that DCRs work, a single-site SIF trial would be too modest a step toward realising these rights.

The benefits of supervised consumption

The effectiveness of drug consumption rooms in reducing deaths and disease and improving their clients' connections to services has been well-established. A review, last updated by the European Monitoring Centre for Drugs and Drug Addiction in 2016,[14] provides a recent summary of their impact.[15]

- **Engaging hard-to-reach people**

  DCRs reach, and stay in contact with, highly marginalised target populations. This contact results in immediate improvements in hygiene and safer use for clients, as well as wider health and public order benefits.[16]

- **Reduced injecting risks**

  SIF clients report reductions in injecting risk behaviour, such as the sharing of injecting equipment.[17]

- **Reduced deaths**

  Australia's only SIF, in Sydney, has managed over 6000 overdoses, without any fatalities,[18] and a study of the Sydney facility showed fewer ambulance call-outs during its operating hours.[19] There are no

[11] Malkin (2001), "Establishing Supervised Injecting Facilities: A Responsible Way to Help Minimise Harm'", *Melbourne University Law Review*, 25(3): 680.

The Victorian Parliament previously opted not to add economic, social and cultural rights to the state's Charter, but the right to health is part of the ICESCR, which is ratified at the national level.

[12] Commonwealth of Australia, Australian Human Rights Commission (2017), "International Covenant on Economic, Social and Cultural Rights - Human rights at your fingertips", https://www.humanrights.gov.au/international-covenant-economic-social-and-cultural-rights-human-rights-your-fingertips-human-rights, accessed 1 May 2017.

[13] Ibid. Article 12.

[14] EMCDDA (2016), *Drug consumption rooms: an overview of provision and evidence*, http://www.emcdda.europa.eu/system/files/publications/2734/Drug%20consumption%20rooms_update%202016.pdf.

[15] There are some uncertainties about the impact of DCRs on population-level measures of drug use and harm. This is because of difficulties in measuring and attributing causal effects in complex systems, and because the service coverage of DCRs may not be sufficiently scaled up to be observable in headline figures.

[16] Ibid, p. 4.

[17] Ibid.

[18] Uniting, "Uniting Medically Supervised Injecting Centre: Get to Know Our Story", https://uniting.org/__data/assets/pdf_file/0005/139370/Uniting-MSIC-Brochure-.pdf.

recorded deaths inside a SIF anywhere in the world. SIFs may not be sufficiently scaled up to have a detectable impact on population level measures; however, some studies have suggested drug consumption rooms may contribute to reducing drug-related deaths at city level.[20]

- **Increased uptake of treatment services**

  SIFs increase uptake both of detoxification and of drug dependence treatment, including opioid substitution.[21]

- **Improved public amenity and safety**

  DCRs are associated with a decrease in public injecting and a reduction in the number of syringes discarded in the vicinity.[22]

Lessons from other jurisdictions

Although all DCRs share the same conceptual underpinnings, they vary considerably in important respects. The history of DCRs' development often reflects the different priorities of the communities in which they are located. Some were set up to reduce drug harms, such as overdose and blood borne virus transmission, whereas others primarily sought to reduce public drug consumption and increase safety and amenity (and feelings/perceptions thereof).[23]

Service models

These varying priorities flow through to DCRs' practical operations, including service models, eligibility/admission criteria and capacity.

Much of the literature differentiates between three broad categories of DCR:

- **Integrated** DCRs are where supervised consumption is offered alongside other services, such as health, counselling and drop-in style facilities for people who are homeless or marginalised.
- **Specialised** DCRs have supervised consumption as their primary objective. While this may include some health promotion services (such as education about drugs and safer using), clients seeking other services would receive a referral.
- **Informal** DCRs are not formally sanctioned by government. They are usually illegal but may be tolerated by authorities. We have placed these out of scope for this submission.

Mobile DCRs, which are usually a specially converted bus or van, have limited space compared with fixed site services and would generally fall into the specialised category. Mobile services warrant consideration – especially as a complementary measure to address out-of-hours and spatial access problems. Mobile

[19] Salmon et al (2010), "The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia", *Addiction*, 105(4: 676-683.

[20] Strang et al (2015), "Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction", *British Journal of Psychiatry*, 207(1): 5-14.

[21] EMCDDA (2016), *Drug consumption rooms: an overview of provision and evidence*, p. 5.

[22] Ibid.

[23] Fitzgerald (2013), "Supervised injecting facilities: a case study of contrasting narratives in a contested health policy arena", *Critical Public Health*, 23(1): 77-94.

services work best when they connect and add value to fixed site services.[24] They may help reduce harm where problematic drug use:

- has high population prevalence, but is less geographically concentrated, such as in Victoria's suburbs and growth corridors;[25] or
- is highly concentrated in a particular locale, such as a public housing development, but overall numbers are small (thus not meeting the threshold for a fixed site service).

Establishing and trialling facilities

The experience in Australia and internationally is that, as SIFs commence operation and become established in the community, stakeholder acceptance increases and non-acceptance decreases[26] – including among police forces.[27] It is important to note that SIFs cannot operate effectively without formal, ongoing support from police (assuming drugs remain criminally prohibited). Having this support in place at the outset is essential.

As the benefits of SIFs have been demonstrated consistently in a range of settings, there is little reason to be limited to a single demonstration site. In 2017, the question for any jurisdiction considering supervised consumption is not whether it 'does or does not' work, but rather, how SIF models can best be tailored to the needs of communities affected by serious drug harms and open drug markets. A contemporary supervised consumption trial should involve multiple sites in priority areas, thereby demonstrating the benefits to the actual communities that need them. Naturally, a multi-site trial would still apply a best practice design, evaluation and improvement process both within and across each local setting.

For the Committee, perhaps the most essential point here is the need to set clear objectives within SIFs' enabling legislation, while avoiding 'designing in' restrictions on the number of SIFs and their service models. Being excessively prescriptive on (for example) eligibility or operational matters jeopardises a facility's ability to respond to the needs of stakeholders and remain fit-for-purpose. It may also inhibit a fair assessment of its effectiveness and efficiency.

The remainder of this section draws together some lessons from the literature that will facilitate a best practice SIF model in Victoria, and strongly supports the need to avoid an excessively prescriptive authorising framework.

Eligibility and 'house rules'

Overall, in establishing eligibility considerations, house rules and operation hours, consultation is essential to understand the real world application of these criteria. We should always ask, 'who might be excluded?' This is a very important consideration, because, while we know SIFs work well for people who do use them, there is an absence of information about people who would be considered a target audience for a SIF, but still do not attend. For example, a ban on injecting others may exclude people who are reliant on a partner to inject – particularly women – and would likely result in non-attendance by that person's partner, too. This compromise may or may not be considered worthwhile, but should be agreed at a local level.

[24] Dietze et al (2012), Mobile safe injecting facilities in Barcelona and Berlin, *International Journal of Drug Policy*, 23: 257-260.

[25] Victorian Government (2016), *Victoria's Mental Health Services Annual Report 2015-16*, p. 43.

[26] European Harm Reduction Network (2014), *Drug Consumption Rooms in Europe: Organisational overview*, http://www.eurohrn.eu/images/stories/pdf/publications/dcr_in_europe.pdf, p. 21.

[27] Ibid, p. 19.

Age limits

We note the Bill currently proposes that only people aged 18 and over should be eligible to access the SIF.

The community is understandably concerned by young people's drug use, and especially so where they have already progressed to injecting drugs. While population-level prevalence is very low, the small number of people aged under 18 who do inject drugs are the most likely to engage in the riskiest injecting practices – including public injection and needle sharing.[28] A young person publicly injecting may well already be dependent on drugs, so turning them away from a SIF would not reduce or discourage their drug use. Young people are also particularly vulnerable to violence and sexual exploitation on the street. In short, this group is in extreme need of assistance, and denying them access to supervised consumption will push them into an even direr situation.

We should also consider the situation in 'inverse'. Many adults who experience the most severe, chronic/relapsing drug dependence commenced using drugs as young people.[29] Their experiences across these formative years – including perhaps being subject to violence, abuse, homelessness and marginalisation – may well make future drug problems more complex and entrenched. We should therefore view any young person presenting to a SIF as an opportunity for early intervention.

On balance, there are serious risks and no clear benefits associated with imposing an age limit on SIFs. However, this does not mean we should treat them as adults.

There is evidence to suggest that adult SIF clients would themselves be concerned about the presence of children in a SIF, potentially discouraging overall uptake.[30] There may also be risks involved with allowing under-18 clients to mix with adults. If children are allowed to access supervised consumption in Victoria, a separate consumption room, and a tailored support set of support services, should be made available to them (remembering that overall numbers are likely to be low). This is the practice in Canada's long-running facility, InSite.[31]

Pregnant women

We note the Bill does not place any restriction on pregnant women. However, the issue may be raised by stakeholders.

There is no reason to conclude that health or safety outcomes are enhanced by turning pregnant women away. We affirm, for similar reasons to those set out for young people, that pregnant women seeking to access a SIF should be permitted to do so – but with differing support protocols to protect the health of both the mother and the child. The specific treatment advice would vary depending on the substance(s) involved (among other things).

[28] Horyniak et al (2013), "The relationship between age and risky injecting behaviours among a sample of Australian people who inject drugs", *Drug and Alcohol Dependence*, 132(3): 541-6.

[29] Lloyd (1998), "Risk Factors for Problem Drug Use: Identifying vulnerable groups", *Drugs: Education, Prevention and Policy*, 5(3): 217-232.

[30] Watson et al (2015), ""Drugs don't have age limits": The challenge of setting age restrictions for supervised injection facilities", *Drugs: Education, Prevention and Policy*, 22(4): 370-379.

[31] Rogan (2016), "State 'must' let pregnant drug users inject", *The Times*, 18 February 2016, https://www.thetimes.co.uk/article/state-must-let-pregnant-drug-users-inject-9ghgwh8l898.

This is consistent with the vast majority of international practice. Overseas facilities do not systematically limit pregnant women's access (with the exception of Luxembourg).[32] Sydney's MSIC varies from the norm in this regard, although its operators have long sought to change its eligibility criteria to include pregnant women.[33]

Place of residence

We note the Bill does not place any restriction on clients' place of residence. However, the issue may be raised by stakeholders.

While practice varies, some overseas facilities extend access only to people living within a nearby geographic area.[34] The merits of this decision should be weighed at the local level, based on a careful balancing of the objective of the facility and the needs and priorities of the local community. In drug market locales that already attract a high volume of external consumers (such as Richmond), it would not make sense to limit the facility to local residents only – risky, public injecting would persist in that area.

House rules

Most drug consumption rooms also implement a range of 'house rules', including an entry interview for new clients, an express requirement that drugs already be obtained before entry (that is, no dealing is allowed inside the facility) and a prohibition on clients' injecting other clients inside the SIF.[35]

Capacity and hours

The overseas experience suggests that the facilities' capacity and breadth of opening hours have an important impact on service uptake, as they both affect how long a prospective client may have to wait before using the facility. Givens SIFs seek to reduce public injecting, which is partly a product of drug users' need to consume drugs very quickly after obtaining them, these are important considerations. Longer opening hours and less waiting were cited as two out of three highest priorities in a 2005 survey of people attending Canada's InSite (along with a washroom).[36]

InSite now operates between 10:00am and 4:00am daily and, in August 2016, commenced 24-hour operation for three days per month in response to elevated demand and overdose rates in the days following the payment of welfare benefits.[37] Other Canadian supervised consumption services have recently followed suit.[38] Many European SIFs provide similarly extended hours, with rooms in the Netherlands open up to 15 hours per day[39] and rooms in Germany up to 12 hours per day.[40]

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[32] International Drug Policy Consortium (2012), *IDPC Briefing Paper: Drug consumption rooms: Evidence and practice*, http://www.drugsandalcohol.ie/17898/1/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf.

Some countries set eligibility on a site-by-site basis but the denial of service to pregnant women is not applied systematically.

[33] Robertson (2016), "Pregnant women: Sydney injecting room doctor hits back at Deputy Premier Troy Grant", *Sydney Morning Herald*, 11 August 2016, http://www.smh.com.au/nsw/sydney-injecting-room-doctor-hits-back-at-deputy-premier-troy-grant-20160811-gqq3fm.html.

[34] International Drug Policy Consortium (2012).

[35] European Harm Reduction Network (2014).

[36] Petrar et al (2007), "Injection drug users perceptions regarding use of a medically supervised safer injecting facility", *Addictive Behaviours*, 32: 1088-1093, p. 1088.

[37] Vancouver Coastal Health (2016), "Insite expands hours to combat overdose crisis", 19 August 2016, http://www.vch.ca/about-us/news/insite-expands-hours-to-combat-overdose-crisis.

[38] Lupick (2017), Overdose-prevention sites join Insite in extending hours during welfare-check weeks, *The Georgia Straight*, 24 April 2017, http://www.straight.com/news/899071/overdose-prevention-sites-join-insite-extending-hours-during-welfare-check-weeks.

[39] International Drug Policy Consortium (2012), p. 15.

Staffing considerations

The literature highlights the importance of an appropriate mix of staff within DCRs, depending on the nature and purpose of the services offered in a given location. Some DCRs may emphasise medical supervision, choosing to employ a mix of doctors and nurses, while others focus on social services and outreach.[41] There is, of course, a need to maintain some medical and emergency competence in any facility.

From an outcomes perspective, there is evidence that education on safer injecting practices can and does work if staff are trained to assist clients.[42]

Staff must also be involved in the development and refinement of house rules to ensure they feel safe and supported in their roles.[43]

Supervised consumption in Victoria

Our submission now considers what the published literature and experience from other jurisdictions might mean for Victoria – in the context of growing drug harms across the state and Coroner Hawkins' recommendation that a SIF be trialled in North Richmond.

Current drug harms in Victoria

The latest data on overdose deaths in Victoria is best captured in the Coroners Court of Victoria's submission to the Victorian Parliamentary Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform.[44] Overdose deaths in both metropolitan and regional areas have been growing for some time, but particularly since 2014.[45]

Although the current focus is on a trial in North Richmond, which is part of Yarra local government area (LGA) and has the highest Victorian overdose death rate (23.7 per 100,000), a number of metropolitan LGAs have serious overdose problems. These include the Melbourne, Brimbank, Darebin, Frankston, Greater Dandenong, Greater Geelong, Maribyrnong and Port Philip.[46]

These same areas also frequently have higher rates of hepatitis C virus (HCV) notifications than the state average[47] – and we know that the vast majority of new HCV cases are among injecting drugs users who share equipment.[48]

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[40] Ibid, p. 11.

[41] Ibid, p. 3.

[42] Fast et al (2008), "The perspectives of injection drug users regarding safer injecting education delivered through a supervised injecting facility", *Harm Reduction Journal*, 5(32).

[43] European Harm Reduction Network (2014), p. 20.

[44] Coroners Court of Victoria (2017), *Submission to the Inquiry into Drug Law Reform*, http://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs_/Submissions/178_2017.03.17_-_Coroners_Court_VIC_-_submission.pdf.

[45] Ibid, pp. 37-40.

[46] Ibid.

[47] Victorian Government, "Browse all surveillance reports", https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/search-infectious-diseases-data, accessed 18 May 2017.

See, for example, the latest infectious disease notification comparison tables for Yarra, Port Phillip and Maribyrnong.

[48] Commonwealth of Australia (2014), *Fourth National Hepatitis C Strategy 2014-2017*, http://www.health.gov.au/internet/main/publishing.nsf/content/A68444CDED77B3A9CA257BF0001CFD80/$File/Hep-C-Strategy2014-v3.pdf.

Providing settings for supervised consumption in at least some of these high priority locations would be an opportunity to address these harms, by reducing the frequency of risky injection practices and providing coordinated services and pathways into treatment.

The harms summarised above come in addition to the well-ventilated concerns by local residents, particularly in North Richmond and Abbotsford, about frequent public injecting, overdose and inappropriate disposal of injecting equipment.

Ensuring supervised consumption services meet community needs

Number and location of trial sites

Given particularly elevated concern about drug harms in North Richmond and stakeholders' existing progress in generating local support for a SIF, implementation should undoubtedly occur there. However, the clear need for, and effectiveness of, SIFs is so compelling that – while all of the high priority LGAs set out above would be worthy of consideration – we suggest that at least three locations should be included in an expanded trial.

At the very least, Victoria should not *legislate* to limit its trial to a single location, nor lock itself in to key details that may vary based on local need or changes over time. We consider the Objects and other provisions in the Bill are sufficient to ensure Victorian SIFs are governed safely, accountably and with a clear purpose. The Bill's restriction on the number of SIF licences and/or premises should be removed, or increased to at least three.

Ultimately, the precise number and location of sites for an expanded trial should be settled by the Victorian Government after undertaking a more detailed assessment of community needs, readiness, service infrastructure and cost. Should the trial be expanded to multiple sites, given North Richmond is in a more advanced state of readiness, the other sites may require more time to commence implementation. We therefore suggest that the Bill institute a two-stage evaluation process with an interim evaluation undertaken after 18 months and a final evaluation completed after three years.

Age restriction

As set out in the previous section, while acknowledging it is a fraught issue, there are serious risks and no benefits to placing an age restriction on SIF access. This should be removed from the Bill and replaced with a requirement that a separate consumption room and support stream be available for clients who are under 18.

As a non-preferred option, if a firm age limit is applied, it should not be 18 years, but rather as low as possible.[49]

Staff qualification requirements

We note the Bill requires that the director of any SIF be a registered medical practitioner. Although, of course, we do not object to the notion of doctors' involvement in SIF practice, making this a legislated requirement is not commensurate with need or risk.

While undoubtedly some medical expertise is essential to safely run a SIF, few facilities around the world require such a high level of medical supervision. Many are run by nurses or other harm reduction

[49] Watson et al (2015).

practitioners who have appropriate training. Although overdose events are common in DCRs around the world, no facility – whether run by a doctor or not – has ever seen a death.

A legislated requirement for any SIF to be directed by a doctor would appear to limit the service models available, reducing government's capacity to deliver supervised consumption that is both cost-effective and fit-for-purpose for a given community's drug market.

As an alternative, the Committee should consider linking oversight from a medical practitioner to each licence issued, but not necessarily to each location or premises. This would maintain a high level of medical oversight while allowing more flexible and affordable implementation.

Co-design and collaboration – with local communities, services and people who use drugs

The Victorian Government's needs assessment, and design of, supervised consumption services should be collaborative with the community. As part of this, there are stakeholders whose engagement and support will be crucial to a SIF's success. In particular, there is good reason to directly consult the prospective clients of a SIF in each locale to ensure that the facility has the best chance of attracting the intended cohorts and improving outcomes.[50]

We also note the Bill calls for Victoria Police to exercise discretion in the enforcement of drug laws in the vicinity of the proposed facility. We suggest that the Committee recommend a formal mechanism to ensure and monitor transparency in the operation of police discretion, and that this matter be specifically considered as part of the evaluation of the trial.

Recommendation 1: Given clear evidence of effectiveness and need within the Victorian community, the Committee should recommend passage of the Bill, with amendments in accordance with Recommendations 2, 3 and 4.

Recommendation 2: The Bill should provide for a trial of at least three SIF sites, selected by the Government based on local needs, community readiness, service infrastructure and cost. In keeping with the expanded trial, the evaluation schedule should be amended to enable an interim evaluation after 18 months, and a full evaluation after three years.

Recommendation 3: With regard to SIF access by people under 18 years of age:

a. the proposed age restriction should be removed from the Bill, as it presents serious risks, offers no empirical benefits and is not in keeping with international best practice; and

b. the Bill should add a requirement that a separate consumption room and tailored support stream be made available for children who present to a SIF; or

c. as a non-preferred option, if a firm age limit is applied, it should be as low as possible under 18 years. A separate consumption space and support for children should also be required under this arrangement.

Recommendation 4: The Bill should require that oversight from a medical practitioner be linked to each SIF licence, but not each SIF premises. Further requirements regarding the qualifications of SIF staff should be provided for at a policy or regulatory, rather than legislative, level.

[50] Watson et al (2012), "Design considerations for supervised consumption facilities (SCFs): Preferences for facilities where people can inject and smoke drugs", *International Journal of Drug Policy*, 24(2).

Concurrent reform opportunities

SIFs are generally not open 24 hours a day and, inevitably, they will not attract all at-risk drug users all the time. Governments therefore need to consider the overall sufficiency of their efforts to address drug harms. This will be influenced by the adequacy of measures such as needle and syringe programs, community overdose prevention, crisis accommodation and outreach and drug treatment services.

The Netherlands is one country that has integrated financial and administrative arrangements for their 'local addiction care', with a single organisation managing supervised consumption, prescribed heroin, methadone and other key services in each local area.[51] These arrangements aim to facilitate a smoother pathway to recovery.

Apart from her SIF recommendation, Coroner Hawkins made a range of recommendations to address accidental drug overdose in the City of Yarra, including expanded availability of naloxone and a range of state government services that support the health and wellbeing of people who inject drugs.[52] In her appearance before the Victorian parliamentary committee undertaking the drug law reform inquiry, State Coroner Judge Sara Hinchey commented particularly on Victoria's fragmented pharmacotherapy system.[53]

We note that the Victorian Government has made new funding announcements with regard to naloxone, outreach for overdose survivors and peer education. Penington Institute welcomes these initiatives, and considers them complementary to options for supervised consumption.

The cost of opioid replacement therapies

However, neither the Victorian nor Commonwealth Governments have addressed the single biggest factor standing in the way of a better-functioning pharmacotherapy system – the dispensing fees charged to clients.

Penington Institute addressed this issue at some length in our submission to the drug law reform inquiry.[54] We have not reproduced the full argument here. It is sufficient to say that dispensing fees represent a large and often prohibitive cost for many people with opioid dependence. The fees lead to inconsistent participation and dosing, creating barriers to the better management of addiction, generating churn in the system and producing variable drug tolerance in clients (placing them at greater overdose risk).

Despite a 2010 Victorian review acknowledging these problems and a robust analysis suggesting the cost of subsidising fees would be easily paid for by other health system savings, the problem remains ignored. We suggest the Committee raise this issue with their parliamentary colleagues as part of the concurrent drug law reform inquiry.

Recommendation 5: The Victorian Government should establish a funding model to subsidise pharmacotherapy dispensing fees in Victoria. This will increase service coverage, access and quality in the

[51] European Monitoring Centre for Drugs and Drug Addiction (2012), *The Netherlands Drug Situation: Report to the EMCDDA by the Reitox National Focal Point*, http://www.emcdda.europa.eu/system/files/publications/720/2012_Netherlands_National_report_full_443208.pdf, pp. 62-65.

[52] Coroners Court of Victoria (2017), "Finding – Inquest into the Death of Ms A", Melbourne, http://www.coronerscourt.vic.gov.au/resources/d48c9cdc-8db0-45b5-83c2-5ea6918e3ccd/ms+a_+241816.pdf, p. 24.

[53] The appearance was on 8 May 2017. The transcript is forthcoming.

[54] Penington Institute (2017), *Submission to the Inquiry into Drug Law Reform*, http://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs_/Submissions/209_2017.03.24_-_Penington_Institute_-_submission.pdf, pp. 43-46.

pharmacotherapy system and be an enabling factor for other reforms (such as improving service integration and workforce resilience). Victoria could work with the Commonwealth on a national approach, but given perennial inaction on this issue, should be open to establishing a state-based system.

Next steps

This Inquiry comes at a time of great opportunity to reduce drug harms in the Victorian community. I trust Penington Institute has provided some useful evidence to support the Committee's deliberations. I would welcome the chance to discuss these matters with the Committee.

Yours sincerely,

John Ryan
CEO