LRRCSC - INQUIRY INTO DRUG LAW REFORM
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VICTORIAN ALCOHOL & DRUG ASSOCIATION

VAADA submission

Parliamentary Inquiry into Drug Law Reform

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

Contact Person: Sam Biondo

Victorian Alcohol and Drug Association
211 Victoria Parade, Collingwood 3066
p. 03 9412 5600 f. 03 9416 2085
vaada@vaada.org.au
www.vaada.org.au
ABN 19 039 293 679

About VAADA

VAADA is a non-government peak organisation representing publicly funded Victorian AOD services. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. VAADA's purpose is to ensure that the issues for people experiencing harms associated with substance use and the organisations who support them are well represented in policy, program development and public discussion.

VAADA's membership comprises agencies working in the AOD field, as well as those individuals who are involved in, or have a specific interest in, prevention, treatment, rehabilitation or research that minimises the harms caused by AOD.

What does VAADA do?

As a peak organisation, VAADA's purpose is to ensure that the issues for people experiencing the harms associated with AOD use and the organisations that support them are well represented in policy and program development and public discussion.

VAADA seeks to achieve this through:

- Engaging in policy development;
- Advocating for systemic change;
- Representing issues our member's identify;
- Providing leadership on priority issues to pursue;
- Creating a space for collaboration within the AOD sector;
- Keeping our members and stakeholders informed about issues relevant to the sector; and
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drug services (and related services).

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to contribute to this inquiry. Alcohol and other drug harms are prolific through Australia and indeed globally. *The current system of dealing with severely affected individuals with drug and alcohol issues is failing. It's failing because of a lack of investment, a lack of appropriate policy implementation and the growing demands being placed on an overstretched and overburdened system.*

We hope that this necessary review will provide the clarity to drive sensible, evidence informed drug policy going forward as well as the impetus for enacting policy which prioritises harm reduction rather than policy which creates harm. There is a broad range of misconceptions and views which are not coherent with best practice or evidence on many alcohol and other drug (AOD) issues which are perpetuated throughout a number of forums and regrettably inform policy decisions (or policy inaction). Dr Fraser Todd, Psychiatrist, indicated at his keynote presentation at the VAADA 2017 conference that, in reference to AOD systems and policy, 'for every complex problem there is an answer that is clear, simple and wrong'.

Within Australia, governments spend $1.7 billion per year on AOD related activity in 2009/10 (Ritter et al 2013). Illicit drug use contributes to 1.8 percent to the total burden of injury and disease in Australia (Australian Institute of Health and Welfare 2016) with an early study indicating that illicit substances cost the Australian economy $8.2 billion per annum (Collins and Lapsley 2008). Those costs are associated with a broad range of harms, including justice, health and social costs. The harms and costs are borne out and exacerbated due to the overburdening of the AOD treatment system, which has experienced chronic underfunding for decades.

This submission will detail the various AOD related harms within Victoria and reflect on the effectiveness in which Victoria is responding to these harms. We will also reflect on some prominent and novel international innovations which have achieved some success in reducing harm.

We note that this inquiry does not provide an opportunity to canvass issues related to alcohol; alcohol is a significant contributor to harm and in many cases, alcohol related harms are intrinsically interlinked with illicit and pharmaceutical related harms. For example, more than half of all AOD treatment presentations involve alcohol as either a principal or secondary substance of concern; alcohol is a common co-contributing substance in fatal overdoses, with 18 percent of all overdose deaths involving alcohol and other substances (either illicit substances or pharmaceuticals or both) (Jamieson 2014). In developing sensible policy to reduce substance related harm, alcohol should be considered.

We also note that the views of consumers and people who use drugs (PWUD) should be strongly considered within the context of this inquiry and going forward in progressing associated AOD policy.

AOD treatment is cost effective

AOD treatment provides a strong return on investment with evidence indicating that over a 12 month period, treatment provides a cost benefit ratio of $8 being saved for every $1 spent (Coyne, White & Alvarez 2015).

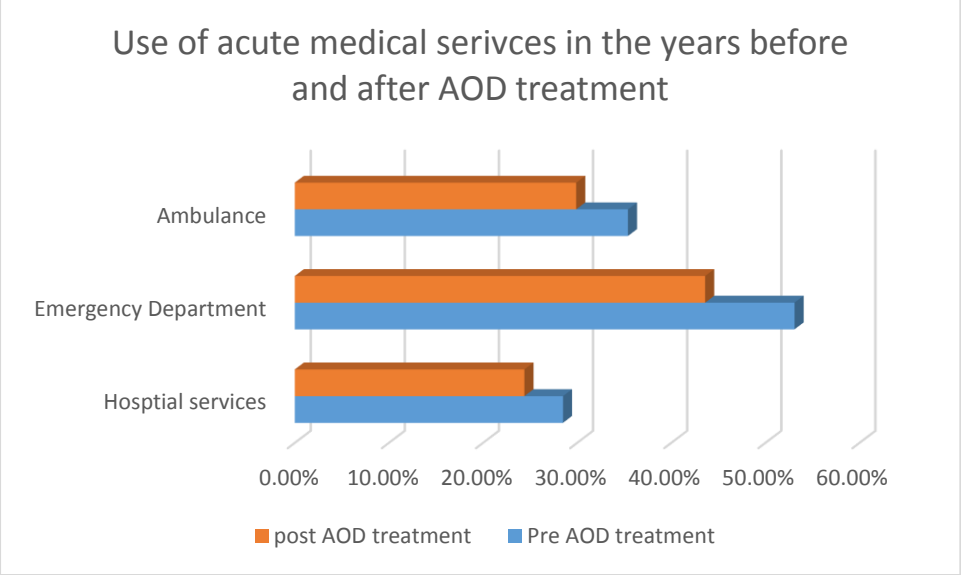
There is a growing body of evidence which indicates that engagement in AOD treatment services reduces demand for acute health services. *The Patient Pathway's Project* (Lubman et al 2014), which follows AOD service users both prior to and post treatment, noted that service users who have

accessed AOD treatment utilized less acute health services in the year after the treatment in comparison to the year leading up to the treatment:

- Demand for hospital services among those with AOD dependence issues decreased from 28.5 to 24.4 percent for those who have, in the past year, attended AOD treatment;
- For the same population, ambulance attendances decreased from 35.4 to 29.9 percent; and
- Hospital emergency admissions decrease from 53.1 to 43.6 percent

Figure 1 reveals the positive impact of AOD treatment on acute health service demand.

Figure 1: Impact of AOD treatment on acute health service demand



Lubman et al (2014) highlight the positive impact of AOD treatment on acute health service demand, noting that overall there was a 16 percent reduction in research participants requiring ambulance, ED or hospital admissions in the year post treatment. Further, they assert that this is 'likely to reflect a substantial reduction in health care costs'.

Needle and syringe programs provide a significant return on investment, with a national study indicating that between 2000 and 2009 these programs have, nation-wide, averted 32,050 HIV infections and 96,667 hepatitis C infections and achieved a net cost saving of over $1 Billion. Over a ten year period, the return on investment amounts to $4 for every $1 spent (DOHA 2009).

Recent evidence indicates that AOD residential rehabilitation is more cost effective than prisons. The NIDAC study (ANCD 2012) found that, when compared with prison, the diversion of Aboriginal people to rehabilitation programs achieved savings of $111,458 per prisoner with additional health related savings associated with lower mortality and better health outcomes of $92,759. Savings to the justice system also occur through the use of the Drug Court, with a cost benefit ratio of 1:5.81 (VAADA 2013); a more recent review of the Victorian Drug Court (KPMG 2014) found that over two years it accrued $1.2M in savings through reducing the prison population (these savings do not account for the range of other benefits including reduced recidivism and improved health and social circumstances. In light of this, the pending additional Drug Court capacity is most welcome.

International evidence indicates a return on investment for AOD treatment in the USA of $4 in health care and $7 for justice related expenses for each dollar spent (Office of National Drug Control Policy 2012); evidence from the UK indicates a £2.50 saving for each pound spent (National Treatment Agency for Substance Abuse 2012).

Despite the breadth of evidence indicating the health, financial and social benefits of AOD treatment, research indicates that, across Australia, the sector would need to provide for 200,000 to 500,000 individuals who are in need of treatment meet national demand (Ritter et al 2014). Many of these people will be falling through the cracks, ending up in our justice systems, our acute health systems or our morgues. In light of this, the Australian Institute of Health and Welfare (2016a) notes that, nationally, there were 38,636 overnight hospitalizations for AOD, totaling a daunting 299,829 bed days nationally throughout 2013/14.

The obvious benefits of AOD treatment are greatly diminished by the limited resourcing and capacity afforded to the sector, including harm reduction measures. Accounting for this, VAADA's submission will reflect broadly on the terms of reference set out below and detail recommendations which are cost effective and accord with contemporary evidence.

TOR 1: The effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs and the misuse of prescription medication in minimising drug-related health, social and economic harm

Current laws create a perverse incentive to enhance an unregulated market where profit is the paramount driver with little incentive to induce due diligence in the production of illicit substances to reduce the harms. The various legislative attempts to address the issues associated with synthetic substances, which often exist in a legal 'grey area', sold under the guise of products such as incense or plant fertiliser, appear to have limited success, with these products remaining available through a range of retailers (VAADA 2016). Further, recent research identifies the growth of an expansive online drugs market, with Australia having 'more online drug vendors per capita than any other nation accept the Netherlands' (Martin 2017). Despite extensive policing in drug use 'hot spots' the harms continue to rise with reports indicating that, for methamphetamine for example, procurement is persistently easy[1] (Truong et al 2016).

It is apparent that the various drug markets can rapidly adapt to account for policing and legislative practices related to supply reduction, often with far more agility than the mechanisms at hand for government. Many of the policing efforts simply generate a danger tariff, effectively increasing the prices and profits of drug traffickers and manufacturers and ensuring that at risk cohorts dig deeper into their meagre resources.

There have been a number of endeavours aiming to address the issues pertaining to methamphetamine which have consistently failed to engender a reduction in use and harms. These include media campaigns, punitive legislative reforms for trafficking methamphetamine, increased police resourcing as well as a small amount of additional funding to treatment services. There has also been a specific ice hotline developed as well as some education endeavours and front line

[1] 94% of people who use drugs (PWUD) surveyed indicated that methamphetamine was either easy or very easy to procure.

worker capacity building, most of which has been associated with Victoria's Ice Action Plan (Victorian Government 2015). Although a number of these initiatives have merit, the limited resourcing afforded does not provide the capacity to actively address the issue.

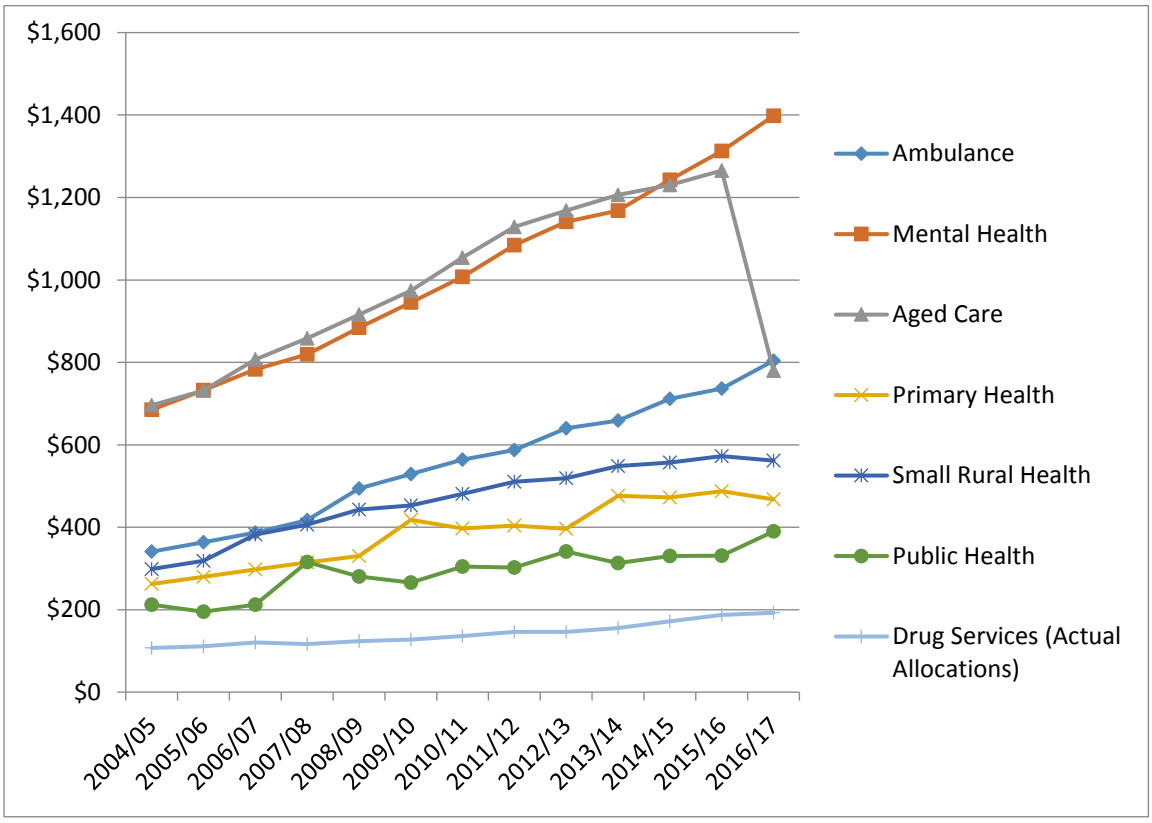
The various policing efforts appear to have done little to stem the supply of illicit substances such as methamphetamine despite massive seizures detailed year on year, with 2014/15 recording the highest number of amphetamine related border detections on record (ACIC 2016). These substances are still easy to procure, and the number of people experiencing harm, including fatal overdose, continues to increase, year on year from 342 fatal overdoses in 2010 to 453 in 2015 (Coroners Court 2016). Over the same period, illicit drug contributions to overdose has increased by more than 50 percent from 149 to 227. Despite the burgeoning contribution from illicit substances, pharmaceuticals continue to contribute to eight in 10 fatal overdoses.

The rate, per 100,000 head of population within Victoria of ambulance attendances involving illicit substances has also increased by more than 50% from 2011/12 (97.1:100,000) to 2014/15 (154.7:100,000) (Turning Point 2017).

Service gaps and adverse outcomes

The AOD treatment system: The Victorian AOD treatment sector has been grossly underfunded for decades which has perpetuated extensive waiting lists and the growth of an unregulated for profit residential industry. Figure 2 below detailed the annual state funding allocations to health sectors, revealing a fairly flat level of growth for alcohol and drug services over the past decade and beyond.

Figure 2: Output funding (health) 2004/05 – 2016/17 (in $millions)



There are significant gaps in the provision of service types, such as care, recovery and coordination; VAADA's 2017/18 state budget submission (VAADA 2017a) highlights the need for an additional 3194 courses of care and recovery coordination treatment to meet the additional estimates of demand provided by the Department prior to the recommissioning.

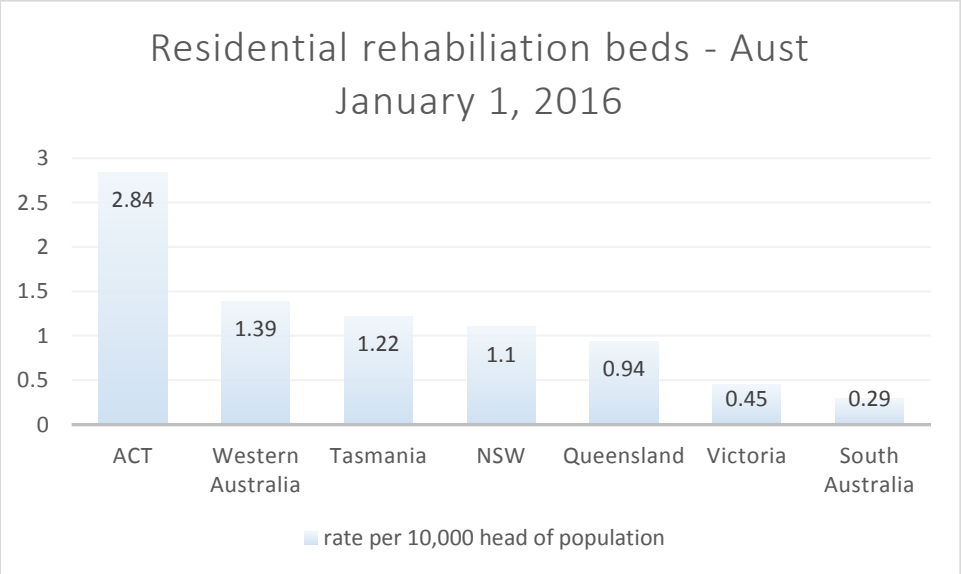
VAADA's membership indicates that wait times for certain types of treatment can exceed six months and accessing services can be unduly complex, particularly in rural and regional areas. Regarding growth corridors, it is becoming evident that population growth and subsequent service demand in those regions is outstripping resourcing, with some of those regions expanding at more than twice the rate of metropolitan Melbourne.

The extensive wait times for 'voluntary' treatment service users have been further strained in part due to the increasing expectations of the sector to address additional complexities and broader sector challenges. The AOD sector is having to prioritise burgeoning forensic demand, service expectations related to vulnerable children and family violence as well as the entrenched challenges in providing for service users experiencing co-occurring AOD and mental health concerns. These expectations are levelled at the sector without the benefit of additional resourcing to contend with the increasing demand. Individuals seeking to access service types such as residential rehabilitation, which already have lengthy waiting times, are having to wait for even longer periods of time.

Despite the welcome commitment form the Victorian Government to resource an additional 18 – 20 residential beds in the Grampians region, individuals residing in rural and regional areas of Victoria who require residential rehabilitation services will still face issues accessing this service locally and will often need to travel to metropolitan areas. There is a need to ensure that the various Catchment Plans are referred to in the allocation of additional beds.

Victoria currently has the second lowest ratio of residential rehabilitation beds per head of population nationally, as evident from Figure 3 below:

Figure 3: Number of residential rehabilitation beds per 10,000 head of population by state/territory



Besides South Australia, every other state/territory has over double the number of residential beds per head of population in comparison to Victoria. This has contributed to a disjuncture between community demand and sector capacity, and resulted in a number of adverse circumstances. Part of the unmet demand for this treatment type is currently being met through an unregulated expanding private sector, while some unmet demand is engaging the justice system and some would be facing acute health issues in light of untreated dependence, resulting in preventable mortality.

To address this capacity deficit, there is a need for Government to develop a plan to increase the capacity of residential rehabilitation across the state. This significant commitment, which will need to be adequately resourced, will necessitate the development of a plan which will account for gaps in service, demand by region and opportunities evident through partnerships and existing capacity. It should account for the complexities apparent in providing these services, and further consultations should be given to the composition of, and expertise availed to running, these facilities. The plan should involve content on addressing the needs of specific cohorts, including CALD communities, older people and acute co-occurring mental health and AOD presentations. The plan should identify specific opportunities which can minimise establishment expenses.

This plan should provide for the staged increase in residential rehabilitation capacity over a five year period with a view to increase the capacity of the Victorian funded residential rehabilitation system to 1: 10,000 head of population, necessitating approximately 300 extra beds. Such an endeavour, which would provide for an additional 1200 service users annually, would result in Victoria having the third lowest number of residential rehabilitation beds per capita but well within the range of other jurisdictions in Australia.

There is a pressing need to increase the capacity of Victoria's funded residential rehabilitation services and increase the regulation on for profit treatment providers.

Hospitals: In light of the increasing harms, it is evident that there are significant resources directed towards preventable acute health responses which often effectively remedies the immediate harms but does little to address the over-riding cause. The hospital system is not currently geared to effectively refer individuals who frequently attend emergency departments into the treatment system. This missed opportunity for intervention increases the likelihood of return visits and the increasing harms associated with multiple overdoses. Effort has been expended in bolstering the skills of first responders to deal with people who are experiencing severe intoxication due to ice but this does not entail referral to various necessary supports, nor address AOD system capacity issues. Hospitals experiencing AOD related emergency attendances should be geared to offer opportunities for immediate withdrawal and necessary and timely referral to AOD treatment services. The hospital based treatment program would in some cases, amount to a seven day stay with step up/ step down responses in line with the needs of the service user. This concept aligns with the maxim of taking the services to those in need.

The justice system: Victoria's prison population has increased by almost 50 percent from 2010 to 2016 (Corrections 2017), with much of that increase driven by a 145 percent increase in un-sentenced (remanded) prisoners. The unprecedented growth is likely the result of various sentencing reforms, including bail and parole and has necessitated a significant prison build resulting

in the recurrent prison budget surpassing $1 billion in 2015/16 well up from $640 million in 2010/11. This additional resourcing will only provide temporary relief to the overcrowded prison system with the Victorian system at peak capacity by 2019 (Victorian Ombudsman 2015), despite the new 1000 bed prison (Ravenhall) becoming operational in late 2017 (GEO Group 2017). Invariably, it will do little to improve community outcomes or address the myriad issues contributing to offending behaviour.

The Victorian Ombudsman (2015), referring to a number of sources, highlights the correlation between overcrowding, scarce resources and the negative impact on the safety of prisoners. The Victorian Auditor General (2012) similarly found that prison-based incidents (such as self-harm, attempted suicide and assault) have doubled over the six years leading to 2012 and that the provision and resourcing of treatment and rehabilitation programs have not kept pace with prison population growth. The Victorian prison population has expanded significantly since 2012 so it is not surprising that a number of prisons have failed to meet the benchmark for prisoner assaults in 2014 (Victorian Ombudsman 2015) in light of the challenges associated with overcrowding. Former Police Commissioner Kieran Walshe who was appointed to review the 2015 riots at the Melbourne Remand Centre also attributed overcrowding as a causal factor to the riots (Hall 2017).

The prison system plays a large part in incarcerating a significant portion of people who have otherwise been unable to access the AOD sector, with AOD related issues being highly prevalent within the Victorian prison system. The Victorian Ombudsman (2015) highlights the prevalence of AOD issues within the prison system, noting that over three quarters of all prisoners have reported prior AOD use. An Australian Institute of Criminology study (Payne and Gaffney 2012) notes that up to 52 percent of incarcerated persons attributed AOD as a factor in their offending.

It is evident that prisons represent an enclosed environment where a high portion of PWUD who are also experiencing a range of additional morbidities are detained with an absence of evidence informed harm reduction measures. The mass incarceration of individuals with AOD issues is indicative of policy failure at a government level, where the priorities, resourcing and direction have funnelled vulnerable individuals into the justice system, bypassing opportunities for early intervention. This has facilitated system failures across the breadth of supporting services. The prevalence of hepatitis C within the prison system and the absence of evidence informed harm reduction measures is an example of this failure.

A survey of PWUD within Australian prisons noted that 46 percent had injected while in prison (Fetherston et al 2013) which is accompanied by the epidemic of hepatitis C within the prison environment with estimates indicating that between 25 to 40 percent of prisoners live with hepatitis C (Victorian government 2016; Victorian Ombudsman 2011). These disturbing figures are not surprising in that 70.7 percent of all hepatitis C infections result from intravenous substance use (Boston Consulting Group 2012). Yet, despite the high prevalence of people who inject drugs residing in prison, with almost half of this population reporting on having injected drugs in prison before, and the high prevalence of hepatitis C within this cohort, successive governments have issued blunt refusals on implementing a prison based NSP. Within the community, NSP provides a significant return on investment which would likely be greater still if applied to a prison environment. There is no record of syringes being used in assaults on prison personnel within any jurisdictions where prison based NSP currently operates.

All Victorian prisons should provide sterile injecting equipment.

We note and commend government on recent initiatives to rollout hepatitis C treatment throughout the prison system, however the benefits of this are partly stymied in the absence of sterile injecting equipment being provided.

Prison based drug policy current penalises prisoners who receive a positive urine test through a reduction in visitation as well as possible transfers to other locations. There is a vast amount of resources employed in attempting to curtail the supply of drugs at the front gate accompanied by cell searches, strip searches and urine testing. Corrections data indicates that, despite these interventions, well over 1000 prisoners are deemed to have a positive urine result each year (Corrections, Prisons & Parole 2017); these prisoners endure a loss of external support through a diminution of their visiting rights and are often transferred to other locations, disrupting education and rehabilitative efforts. This results in a population which is already experiencing a range of challenges with pending community integrative needs enduring additional barriers to the necessary community supports and programmatic aid. The war on drugs in the prison system has been hopelessly lost for many years and now contributes to greater harms through knowingly increasing blood borne transmission and reducing prisoner reintegration.

Culturally and linguistically diverse communities (CALD): CALD communities are underrepresented in AOD treatment. Data shows that only 13 percent of closed treatment episodes for Australians in 2014-15 applied to clients born overseas (Australian Institute of Health and Welfare 2016b). Within the general population, 28% of people living in Australia were born overseas. It is evident that a disproportionately small number of CALD individuals attend AOD treatment services.

While the available research indicates that AOD use is generally lower in CALD communities compared to the general population (Donato-Hunt, Munot and Copeland 2012), it is also clear that that the low admission rates of CALD clients into AOD treatment is also due to an under-utilisation of services rather than just a lower need.

It is evident that further endeavour in engaging at risk CALD communities may reduce CALD community demand for acute health service and justice related demand in light of the evidence indicating that AOD treatment reduces demand for these services.

There is a need to enhance community engagement endeavour with at risk community groups and build AOD sector cultural competence and capacity to ensure that all services are best placed to address AOD issues within CALD communities.

Responding to illicit substances - harm reduction

Supervised injecting: The various measures of harm are generally indicating that there has been an increase in illicit substance related harms occurring within Victoria. Recently, there has been significant reporting on heroin related fatal overdoses and the associated challenges (White et al 2017; Preiss and Lucas 2017), as well as a Private Members Bill in the Legislative Council following a coronial finding and recommendation for the implementation of a supervised injecting centre (Hawkins 2017).

There is a disproportionate rate of fatalities occurring within certain areas within metropolitan Melbourne, with a small area in North Richmond and Abbotsford remaining as the enduring epicentre of fatal drug overdoses.

- The Coroners Court of Victoria (2016) has indicated that the fatal overdoses increased from 387 in 2014 to 453 in 2015 – **a 17% increase in one year**
- The Coroners Court of Victoria (2016) has indicated that illicit drug contributions to fatal overdose increased from 164 in 2014 to 227 in 2015 – **a 38% increase in one year with heroin and methamphetamine being the main drivers**

Figure 1: fatal drug overdoses*

	2014	**2015**	**% change**
State wide total – all drugs	387	453	**17% ↑**
State wide total – illicit substances	164	227	**38% ↑**
State wide heroin related total	137	173	**26% ↑**
State wide methamphetamine related total	53	72	**36% ↑**

*Coroners Court 2016

The longevity and persistently high overdose rate within the City of Yarra demonstrates that the current means of reducing heroin related fatal overdose have not been able to address the specific issues in this area

- The Coroners Court of Victoria has indicated that **Yarra has the highest rate of fatal overdose in the state at 23 per 100,000 head of population**
- The Coroners Court of Victoria (2016a) has indicated that in 2015 over **20% of all fatal overdoses involving heroin are directly link to a small area in North Richmond and Abbottsford – this amounts to approximately 34 deaths over a 12 month period**
- Ambulance data (2011/12 – 2014/15) indicates that **the per capita rate of heroin related ambulance callouts in Yarra is more than 10 times higher than the Victorian average (see figure 2) [Turning Point 2017]**

There is consensus among the experts on the marked achievements of SIF's in reducing harms among highly vulnerable cohorts. In 2001, the Medically Supervised Injecting Centre (MSIC) in Sydney opened; evaluations of the Sydney MSIC have found that up to May 2015 it had (Uniting 2016):

- Successfully managed more than 6,089 drug overdoses without a single fatality
- Reduced the number of publicly discarded needles and syringes in the Kings Cross area by approximately half
- Decreased the number of ambulance call outs to Kings Cross by 80%
- Generated more than 12,000 referrals to health and social welfare services[2]

There are various regions in Victoria, including but not limited to North Richmond, which would benefit greatly from the provision of supervised injecting.

[2] Elements from this section on supervised injecting centres has been adopted from a paper produced by VAADA in February 2017.

Drug data bases and pill testing: There is an increasing number of fatal and non-fatal overdoses occurring within various hotspots and festivals associated with what many users assume is MDMA. In some cases, police have indicated that they are aware of potentially highly hazardous pills within the community and have opted not to provide the public with this information. Disturbingly, reflecting on a spate of overdoses in Prahran in January 2017, PWUD opting to consume pills are relying on the social media pages of various notorious nightspots for public health information (Lillebuen 2017). Studies indicate that 84 percent of ecstasy users would attempt to ascertain the content and purity of ecstasy and 63 percent expressed an interest in pill testing should it become available (Johnston et al 2006). Clearly we need an effective early warning system for bad batches, as is the case for a range of health and safety concerns, such as warnings issued by the Chief Medical Officer on disease outbreaks.

There are various international examples of online data systems which provide information on drug markets and hazardous batches which should be considered in light of developing an online information system in Australia, such as the Drug Information and Monitoring System (DIMS) which has been operating in the Netherlands for decades and the Trans European Drug Information (TEDI) project which is a collaborative endeavour between a number of jurisdictions.

Victorian police forensic drug data should be rapidly analysed with a view to informing the online content of an online drug data system.

The accuracy and timeliness of this data would further be enhanced through the availability of pill testing in venues and events where there are pre-existing high levels of substance use. In many cases, those individuals seeking to purchase MDMA (ecstasy) will unknowingly be purchasing a different, more dangerous product. Pill testing services would ensure that they are aware of what they are purchasing; international research indicates that 50 percent of those who had their drugs tested would modify their substance use consumption based on the results of the test (Ritter 2014). Ritter (2014) also cites research asserting that 82 percent of 16 – 25 year old Australians would support pill testing.

We won't know whether the availability of pill testing would have impacted upon the choices made by those individuals who overdosed in January at a popular Prahran venue; however, in light of the above, it is likely that approximately half may not have consumed the hazardous substance.

Naloxone: The availability of naloxone creates the real possibility of every opioid related fatal overdose being preventable. Naloxone reverses fatal opioid overdose and should be made available to all at risk cohorts and their peers and family. We would advocate for naloxone being made available at no cost to any individual who is receiving takeaway methadone through the pharmacotherapy program – this would necessitate ensuring that adequate training is available to family and peers. We would also recommend, in light of the high mortality rate following release from prison, that naloxone be availed in the same manner to any individual released from prison who is on the pharmacotherapy program. More broadly, current supply issues should be addressed to ensure maximum availability of this life saving substance.

New psychoactive substances/legal highs: the legislative responses to these substances, often sold in various adult shops, has resulted in these substances being slightly modified to evade the bans. These modifications inflict new, unknown substances onto the market at greater risk the community. This is an example of iatrogenic legislation, where greater harms are caused the attempts to curtail supply of these substances. The Victorian Government has committed to implementing a blanket ban on these substances, as has occurred in other states (Premier of Victoria

2017). It is too early to tell whether these laws will have the desired effect – in other international regions where similar laws have been enacted, there appears to be a high prevalence of use of some of the banned substances. It is quite possible that the online market will fill any void if the street retailers cease stocking these products. The implementation and enforcement of this legislation should be carefully scrutinised with a view to identifying any perverse outcomes which may emerge through changes in substance consumption patterns and harms. Other jurisdiction, both within Australia and beyond, which have implemented similar legislation should be examined.

We note with some concern the significant presence and harms occurring relating to new psychoactive substances throughout parts of Europe, both in the community and prison systems. We need to ensure that these trends are not replicated in Victoria.

Addressing pharmaceutical related harm

Pharmaceuticals contribute to approximately 80 percent of all fatal overdoses in Victoria, with benzodiazepines contributing to over half of all fatal overdoses. Benzodiazepines also generate significant demand for ambulance services.

Commendably, following strong advocacy from a range of agencies and passionate families, the Victorian Government has committed to establishing a real time prescription monitoring (RTPM) system in Victoria by 2018. Currently, there is limited information regarding the form and specifics of this system, with details on the specific substances including and various supports accompanying this system still outstanding.

In light of the contribution of benzodiazepines to fatal overdose and other harms, they should be included in the RTPM system. There needs to be an appreciation that, in crafting this system, increased oversight of one set of substances may result in an unpredictable shift in the market. An example is the rescheduling of Alprazolam to S.8 which coincided with a reduction in alprazolam contributions to fatal overdose; however, other benzodiazepine contributions increased over the same time (Lloyd et al 2016), highlighting the possibility that drug use patterns have adapted to the rescheduling. This risk will become apparent if known high risk substances are not included in the RTPM system with the worst case scenario being a shift in the types of pharmaceuticals consumed by at risk cohorts but minimal change in the harms. In light of this, it is our belief that this system should cover all high risk pharmaceuticals.

Additionally, there is a need to adequately resourcing to the AOD sector to accommodate the influx of demand resulting from this system. General practitioners and pharmacists are likely to receive training to assist patients who are engaged in at risk pharmaceutical use. It is likely that many patients will be referred to AOD treatment, including pharmacotherapy – these sectors will require the requisite capacity to meet new demand otherwise there runs the risk that this intervention may result in a missed opportunity with the patient transitioning onto more harmful, and possibly illicit substances.

TOR 2: The practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law

There is a range of international endeavours to reflect on in light of positive drug law reform.

Various jurisdictions are engaging in forms of drug law reform including the regulation of cannabis, the application of justice reinvestment and the promotion of a range of initiatives which are coherent with therapeutic jurisprudence. The results from these initiatives vary and in some cases require further time to undertake a proper evaluation. Conversely, there are a number of regions where there has been some drastically dangerous drug law reform as well as pre-existing highly punitive practices; a number of countries still retain the death sentence for certain drug offences as well as the highly disturbing developments occurring in Malaysia.

There is a need to pair back the entrenched moral views regarding regulation of currently illicit substances and examine the issues under an evidence informed lens, reflecting on the positive and adverse outcomes which have occurred in other regions which have embarked on various forms of drug law reform. Ascertaining changes in the prevalence of harms, including dependency and associated illness, overall consumption rates and additional resourcing through taxation are also important.

There are certain measures which can assist in deriving resources for the necessary yet often underfunded health and welfare sector. One such measure is the practice of justice reinvestment, which is currently being practised in some regions in the USA. Justice reinvestment denotes a process whereby services within high risk regions experiencing significant harms which feed into the justice system receive additional capacity to better address the various challenges evident within the local community. This has a subsequent impact on justice system demand, including prisons, which allows for the diversion of resources into corrections towards the various services, including AOD treatment, which reduce offending. Research has indicated that four percent of all postcodes account for 28 percent of the most disadvantage indicators (Jesuit Social Services 2017); a number of these regions would be appropriate for trialling justice reinvestment practices reflecting on that occurring in NSW and overseas.

Supervised Injectable Heroin: Strang et al (2015) note in a review of six studies, that the provision of supervised injectable heroin is an effective treatment for 'particularly difficult-to-treat' cohorts of individuals experiencing heroin dependency. The studies in this review also identified that the provision of supervised injectable heroin engender better results than standard pharmacotherapy programs. It should be noted that this program is generally administered under fairly intense supervision to minimise the various risks such as diversion. This option should be explored in light of the increasing heroin related mortality in certain regions of Victoria.

Portugal – an example of decriminalisation:

The comprehensive reforms to Portugal's drug laws in 2001, which effectively decriminalised small quantities of illicit substances for possession and use, has resulted in significant changes in the composition and quantity of AOD related harms throughout that country.

These changes, having occurred over the last 15 years, provide a solid evidence base from which data can be reviewed with regard to long term outcomes. During that time, there has been no major

increase in substance use; overall, small increases and fluctuations have occurred, possibly in line with increased experimentation, but problematic and adolescent substance use has declined during this time (Drug Policy Alliance 2015).

Portugal has experienced a 60 percent reduction in arrests for drug related offences with the number of people referred to 'administrative processes' in light of substance use or possession has also remained fairly stable (Drug Policy Alliance 2015, p 2). There has been a significant increase in the uptake of voluntary treatment (60 percent increase over 13 years) and a reduction in HIV. Importantly, there has been an 80 percent reduction in annual overdose with just 16 overdoses in 2012 (Drug Policy Alliance 2015; Transform 2014). The estimated population in Portugal in 2012 was 10.5 million and with 16 overdoses that year, one individual fatally overdoses per 656, 875 head of population. Victoria, regrettably, has a far higher overdose rate - the population of Victoria in 2013 (5,791,000) and the number of fatal overdoses that year (380) (Coroners Court 2016) indicates that there was one fatal overdose per 15,239 head of population.

People living in Victoria are 43 times more likely to fatally overdose than those living in Portugal.

Although there may be other factors contributing to the overdose rate, the stark difference in risk of fatal overdose clearly indicates that serious consideration of Portuguese drug policy should be undertaken.

We hope that this inquiry engenders constructive consideration of a range of innovative means to reduce AOD related harms and leads to a broader public discussion on the preventable harms currently occurring within our communities. We hope also that this and other submissions will generate the necessary good will and understanding to enable risk averse governments to undertake the bold policy directions necessary to reduce AOD related harms.

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