Executive Officer
Law Reform, Road and Community Safety Committee
Parliament House
Melbourne

To: Committee members

Please find attached a written submission Harm Reduction Victoria has developed for the Victorian Parliament Inquiry into Drug Law Reform.

HRVic would welcome the opportunity to elaborate on our written submission with an invitation to present verbally to Committee members, and we look forward to hearing from you further in this regard.

In addition, please follow the below link to the quarterly WHACK magazine Harm Reduction Victoria produces for and by Victorians who use drugs, for their families and friends, and for workers in the Victorian alcohol and other drug sector. This edition was developed specifically for the Victorian Parliamentary Inquiry late last year using the previously released Terms of Reference. As you will see, however, the changed Terms of Reference do not impact on the content of this Parliamentary Inquiry special edition. We hope you find the magazine interesting in terms of the well-researched, evidence based articles, contributions from drug users interstate and overseas participating in alcohol and other drug programs HRVic would like to see implemented in Victoria. If you would like hard copies of the magazine, please let us know.


Please do not hesitate to get in touch if I am able to assist Committee members further.

Kind regards

Tamara Speed
Policy and Communications Manager
HARM REDUCTION VICTORIA (formerly VIVAIDS Inc.)
www.hrvic.org.au

Harm Reduction Victoria acknowledge the traditional custodians of the land on which we work, the people of the Boon Wurrung, Woi Wurrung and Kulin Nation as a whole. We pay our respects to them, their culture and their Elders both past and present.

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Submission to the Law Reform, Road and Community Safety Committee
Parliament of Victoria

Inquiry into Drug Law Reform

March 2017
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HARM REDUCTION VICTORIA (HRVic)

Harm Reduction Victoria (HRVic) formerly VIVAIDS Inc. is the drug user organisation for the state of Victoria. 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. Through peer education, advocacy, workforce development and community development processes, HRV 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 scene 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 at all levels, 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 seven broad 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 Drug Law Reform. This submission advocates for a harm reduction approach in the response to illicit, synthetic and prescription 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\(^1\). Harm reduction focuses 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 HRVic submission is underpinned by these key areas for consideration:
- the return on investment in needle and syringe programs;
- addressing stigma and discrimination faced by people who use drugs;
- peer education, by and for people with current lived experience of illicit drug use, as a core element of harm reduction policy and practice.

The following Victorian laws hinder the effective rollout of harm reduction services:
- *Drugs, Poisons and Controlled Substances Act 1981*;
- *Misuse of Drugs Act 2001*;
- *Criminal Code*

As noted in the below quote, there is a correlation between laws and societal abhorrence of drug use which impacts the standards of care and barriers to access health care and support by people who use illicit drugs.

> "It is clear that poor attitudes towards people with a history of injecting drug use are creating very real barriers to access in relation to critical health and social services...[and] current drug laws directly contribute to the way in which illicit drug use is perceived as ‘immoral’ and effectively gives the ‘green light’ to poor treatment, social exclusion and discrimination against people who engage in this behavior."\(^2\)

Despite its overt failure, the ‘war on drugs’ and the ‘war on drug users’ prevails, with:
- many Australians experiencing discrimination in employment, housing and health care due to past or current experience of drug use;
- family members of drug users feeling shunned; and
- people who use drugs being denied access to appropriate health care.

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\(^2\) Australian Injecting and Illicit Drug Users League (AIVL) 2010. *Hepatitis C Models of Access and Service Delivery for People with a History of Injecting Drug Use*, AIVL Canberra
HARM MINIMISATION FRAMEWORK

In 1985, harm minimisation was adopted by the Australian Government and the State and Territory Governments as the framework in response to and addressing the range of issues related to the use of alcohol and other drugs. There are 3 pillars, or approaches, under which the strategies to manage the use of illicit drugs and the misuse of licit drugs take place, namely:

- Supply Reduction - to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.
- Demand Reduction - to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- Harm Reduction - to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

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<thead>
<tr>
<th>Pillar</th>
<th>Strategies</th>
<th>% of resources allocated to respond at national and local levels</th>
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<tr>
<td>Supply Reduction</td>
<td>Police, Courts, Prison, Legislation, Customs</td>
<td>66%</td>
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<tr>
<td>Demand Reduction</td>
<td>Drug Education eg schools, Opiate Replacement Therapies eg methadone, Residential rehabilitation Centres, Detox centres, Therapeutic Counselling</td>
<td>22%</td>
</tr>
<tr>
<td>Harm Reduction</td>
<td>Drug Consumption Centres, Needle and Syringe Programs, Peer Education, Drug User Organisations</td>
<td>2%</td>
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It is significant in its poignancy, the extremely low level of funding allocated to Harm Reduction responses. A comprehensive review of the breakdown in funding for alcohol and other drug use responses across supply, demand and harm reduction initiatives is required, along with more resources directed into peer-based initiatives, and acknowledgement that peers are the true experts in this area.

HRVic’s submission will focus exclusively on law, procedures and regulations relating to harm reduction policies and practices.

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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; and

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<tr>
<th>HARM REDUCTION INTERVENTIONS TO COUNTER DRUG RELATED HARMS</th>
<th>DRUG RELATED HARMS</th>
<th>BARRIERS TO HARM REDUCTION INTERVENTION</th>
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<tr>
<td>First Aid Training including peer education</td>
<td>Opiate Overdose</td>
<td>Funding not allocated in a whole-of-system response</td>
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<td>Distribution of Naloxone (trade name Narcan®)</td>
<td>Injury related to period of unconsciousness</td>
<td>Naloxone not generally stocked in pharmacies</td>
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<tr>
<td>Access to Naloxone</td>
<td></td>
<td>General Practitioner (GP) workforce and pharmacists appear unaware of change to scheduling</td>
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<td>Expensive as an over the counter medication</td>
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<td>People who inject drugs have experienced discrimination when seeking naloxone from a GP and/or pharmacist</td>
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<td></td>
<td></td>
<td>Family and friends of people at risk of opiate overdose are informed by GP or pharmacists they are not able to have a prescription for naloxone</td>
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<td>Family members, friends and people who inject opiates unaware of naloxone availability</td>
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<tr>
<td></td>
<td></td>
<td>Family members, friends and people who inject opiates confused by recent rescheduling thereby not increasing access and availability as intended</td>
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<td>HARM REDUCTION INTERVENTIONS TO COUNTER DRUG RELATED HARM</td>
<td>DRUG RELATED HARM</td>
<td>BARRIERS TO HARM REDUCTION INTERVENTION</td>
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<td>Needle and Syringe Program (NSP)</td>
<td>Transmission of Blood Borne Viruses (BBV) i.e. HIV/AIDS, hepatitis B and hepatitis C</td>
<td>Drugs, Poisons and Controlled Substances Act 1981</td>
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<td>Peer/Secondary Distribution of sterile injecting equipment</td>
<td>Overdose</td>
<td>The Victorian Needle and Syringe Program: Operating Policy and Guidelines</td>
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<td>Peer Education Resources</td>
<td>Vein damage</td>
<td>Police – informal agreement that police won’t monitor NSP</td>
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<td>Peer Educators working on NSP</td>
<td>Local infection</td>
<td>Poor NSP coverage – lack of NSP in specific geographical areas</td>
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<td></td>
<td>Endocarditis</td>
<td>No NSP in prison</td>
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<td>Attitudes of Emergency Department hospital staff toward people who inject drugs accessing NSP after hours</td>
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<td>Limited funding</td>
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<td>Stigma and discrimination towards people who inject drugs regarding employment</td>
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<td>Police checks – pre-employment</td>
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<td>Fear of identification and disclosure as a drug user</td>
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<td>No identified peer educator position/s with community NSP; with additional support/supervision as required</td>
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<td>HARM REDUCTION INTERVENTIONS TO COUNTER DRUG RELATED HARMS</td>
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<td></td>
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<td>State government veto pill testing</td>
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<td>Lack of uptake among GP</td>
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<td>Lack of alternative models of testing for people with difficult/damaged veins</td>
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<td>Lack of peer-based models of treatment and support</td>
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<td></td>
<td>Overdose</td>
<td>Policy for Maintenance Pharmacotherapy for Opioid Dependence DHHS</td>
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<td></td>
<td>Vein damage</td>
<td>High cost</td>
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<td></td>
<td>Local infection</td>
<td>Lack of prescribers and pharmacies</td>
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<td></td>
<td>Endocarditis</td>
<td>Reduction in weekly takeaway doses which impacts on employed people on ORT (if they are unable to get to the pharmacy within opening hours to be dosed outside of their working hours)</td>
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2.1 Needle and Syringe Programs (NSP) - Peer/Secondary Distribution

Background
NSP were established in Australia in the mid-1980’s in response to preventing the transmission of HIV among people who inject drugs (PWID). Since then, NSP have been expanded to include the prevention of viral hepatitis (hepatitis C and B), deliver health education, and act as a referral service to drug treatment centres. Until recently, it has been illegal in all Australian states and territories to pass sterile needles and syringes between community members, eg a parent providing their child with equipment to keep them safe from blood borne viruses (BBV), or a PWID collecting equipment from a NSP and giving some to their peers (people who inject drugs). However, within the last 2 years, the NT, ACT and Tasmanian governments have announced their intentions to change laws to allow members of the community to pass on (distribute, give out, share) sterile injecting equipment. In doing so, the legal systems of these jurisdictions have caught up with practices long since regarded as normal and made it possible to properly promote and support peer (or secondary) distribution⁴. Data from the 2009 Australian NSP Survey indicated that despite it being illegal, onward supply of needles and syringes was common and 37% of survey respondents reported onward peer distribution⁵. In addition to removing criminal sanctions and reducing the transmission of BBV and the harms associated with the use and reuse of used injecting equipment, the distribution and reach of sterile injecting equipment through NSP has expanded, further improving the cost-effectiveness of the NSP as an evidence-based public health intervention.

Victorian Approach
In Victoria, it is illegal for unauthorized individuals, including family members and PWID, to collect sterile injecting equipment from a government authorized NSP (including pharmacies) and pass this equipment on to PWID. The Victorian government is aware this illegal activity is taking place and NSP workers are required to ask clients, and record the data on the daily statistic sheets, responses to the question “How many people are you collecting for”?

“My friends and I always share clean equipment; one of us will score [the drugs], another will go to the exchange [NSP] and we’ll all use together. If I ever got busted because of this stupid aiding and abetting law, there goes my job....to be busted for keeping friends healthy, and the community safe, is mind-bogglingly ridiculous. Who am I harming? What purpose does this law serve?”.  
Joanne, 43, Community Services Manager

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⁴ C. Treloar (2016). Peer distribution of sterile injecting equipment: UNSW and Monash research supports recent change of laws in three Australian jurisdictions, CSHR UNSW.
⁵ Australian Injecting and Illicit Drug Users League (AIVL) 2010. Legislative and Policy Barriers to Needle and Syringe Programs and Injecting Equipment Access for People Who Inject Drugs, Canberra ACT.
Victorian NSP are authorized for operation by the Department of Health and Human Services (DHHS) and the Drugs, Poisons and Controlled Substances Act 1981 provides protection for a person selling or supplying a hypodermic needle or syringe if they are employed by an authorized pharmacy or organization, or they have been issued with a NSP Outreach Worker card. These cards are issued by the Victorian DHHS and an individual is required to be connected to an authorized NSP to apply for a card. The cards expire after 12 months which is problematic in nature, costly and resource intensive for the DHHS, potentially requiring follow up and the reissuing of (conservatively) approximately 1,500 authorized Victorian NSP cards annually.

HRVic supports peer distribution and trains groups of volunteers to distribute sterile equipment and brief interventions to discrete, hard-to-reach communities. The success of HRVic’s Peer Network Program (PNP) is that it educates and reaches people who do not usually attend NSP or generalist health centres due to experiences of social isolation and stigma. HRVic applies to the DHHS for NSP Outreach Worker cards for each volunteer, which provides them with legal protection to do this work. Feedback on what it means to be a volunteer peer networker includes:

“Being a role model to the community that I am a part of in terms of promoting healthier and safer ways of consuming drugs... Giving back and because I’m around so many people using and reviving people.......to try and save lives and educate people on clean fits. The fact you don’t have to go through bins and bleach fits.......”

**Interstate – Tasmanian and the Australian Capital Territory (ACT) Approach**

- In 2015, the Tasmanian Parliament passed the Public Health (Miscellaneous Amendments) Act 2015 which changed the legal status of secondary distribution of sterile inject equipment. This change made it legal for any person, including people who inject drugs, to collect sterile injecting equipment from a NSP and distribute it to a person who inject drugs.

- The Justice and Community Safety Legislation Amendment Bill 2016 was introduced to provide clarity as to whether a person who provided sterile injecting equipment to another person had committed an offence under ACT legislation. As such, the secondary distribution of sterile injecting equipment is no longer a criminal offence under ACT legislation.

**Recommendation 1:**
Amend the Drugs, Poisons and Controlled Substances Act 1981 to provide legal protection to people, not licensed under the Victorian NSP system, to distribute sterile injecting equipment to people who inject drugs.

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Recommendation 2:
On implementation of Recommendation 1, the requirement to provide legal protection to people distributing sterile equipment is no longer required. Hence, discontinue the time limited, person-specific DHHS NSP authorization card system whilst maintaining the authorization procedure for the operation of agency NSP.

Recommendation 3:
Enhance the funding of HRVic’s Peer Networker Program to enable staff to deliver ‘train the trainer’ style education to teams of peer volunteers across the State. The teams will be provided with ongoing support and be in a position to distribute sterile needles and syringes to isolated pockets of people who inject drugs.
2.2 Needle and Syringe Programs (NSP) — Expansion within Rural and Regional Areas

Background
NSP are supported by Victorian Drug Strategy as they continue to be the cornerstone of Australia’s approach to reducing the harms associated with injecting drug use. Between 2000 and 2009, the Australian Government invested $243 million in NSP which resulted in the prevention of an estimated 5,500 new HIV infections and 18,800 cases of hepatitis C in Victoria. In 2002, the Australian Government commissioned an independent evaluation of the return on investment by the NSP and it was identified that for every one dollar invested in NSP, $27 is returned in cost savings. Significant public health benefits can be attained with further expansion of sterile injecting equipment distribution. If NSPs were to decrease in size and number, then relatively large increases in both HIV and hepatitis C could be expected with associated losses of health and life and reduced returns on investment. Rural and remote areas are continuously highlighted in successive national and state policy documents as areas of need for improved NSP access.

Victorian Approach
The types of NSP available in Victoria include mobile services, outreach foot-patrols, fixed site, vending machines and disposal hotlines. Primary NSP are fully funded by the DHHS and secondary NSP operate within existing organizations and are supplementary to the primary service objectives of the ‘host’ organisation eg community health services.

Interstate – WA Approach
Since 2001, an Operational Directive issued by the Director General of the Department of Health WA, has required all Western Australian regional and rural hospitals with emergency after-hours services to provide after-hours access to needles and syringes for PWID. After-hours access is defined as the hours during which the local or nearest community pharmacy is closed. If the local pharmacy does not retail needles and syringes, or if there is no local pharmacy, local hospitals are required to provide 24-hour access to sterile needles and syringes, or in the event the hospital is not open 24 hours, then access must be provided for all the hours the hospital is open. The WA Operational Directive will become a Mandatory Policy in late 2017.

“Whether anyone will admit it or not, the fact is that areas around NSP are a target for police. Sometimes I’m forced to use drugs without all of the equipment I need to do so safely, because there’s a policing operation going on between me and the NSP. A criminal charge could mean being locked up, or ending up with a record that would greatly limit my options in life. I shouldn’t be forced to choose between my health and my freedom or future.”

Alice, 29 Social Work student

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7 Commonwealth Department of Health and Ageing (2002) Return on Investment in Needle and Syringe Programs in Australia Commonwealth of Australia, Canberra
Recommendation 4:
The Victorian Department of Health require all public health services in receipt of state funds and delivering health services to the community 24 hours a day, including rural and remote hospitals, to dispense sterile injecting equipment after hours. The definition of ‘after hours’ is to depend on the type of health service, the location of the nearest community pharmacy and the pharmacy’s hours of operation and retailing of needles and syringes, with the aim of maximizing 24-hour access to sterile injecting equipment to people who inject drugs and living in rural and remote areas of Victoria.

Recommendation 5:
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.
2.3 NEEDLE AND SYRINGE PROGRAMS (NSP) — IN PRISONS

Background
There is clear and unequivocal evidence to support the urgent need for Australian governments to act to address the increasing rates of blood borne viruses (BBV) in our prisons. Prisons are extremely high-risk environments for the transmission of BBV, including HIV and hepatitis C (HCV), due to the large numbers of people imprisoned for drug related offences, coupled with high rates of continued injecting drug use in prison and very poor access to sterile needles and syringes.9

Indeed, research shows that 45% of prison entrants report injecting drug use (IDU)10 rather than men (43%) more likely to report IDU in prison.11 Other practices such as unsafe tattooing and piercing and unprotected sexual encounters can also contribute to elevated rates of BBV transmission in prisons.12 Given the nexus between IDU and BBVs, rates of hepatitis C are extremely high within Australian prisons with an overall prevalence of 29%, and 57% among people who inject drugs.13 In 2011, the Victorian Ombudsman noted that 41% of prisoners tested positive for the HCV.14

Syringe sharing rates are also significantly higher in prisons than in the general community, with regular anecdotal reports of individual needles and syringes being used 100s of times by many prisoners. Indeed, the demand for access to any kind of needle and syringe in prisons is so high they often operate as a commodity (referred to by prisoners as “gold”), with used needles and syringes ‘rented out’ at rates that can exceed the cost of the drugs themselves. As needles & syringes are classified as contraband within the prison environment in Australia, they are often modified and ‘cut-down’ to prevent them being found and confiscated by the prison authorities including being hidden for “safe-keeping” on the body, in toilet bowls and other unsanitary places.15

The failure to provide access to essential BBV prevention measures to prisoners is contrary to Australia’s obligations under the Universal Declaration of Human Rights and other international instruments that deal with the rights of prisoners and prison health services which, in respect to the ‘right to health’, requires States to provide prisoners with access to preventative measures that are ‘equivalent’ to that

available in the community - without discrimination on the grounds of their legal situation. Failure to provide access to such standardised preventative measures is also contrary to domestic obligations in Australia in relation to protecting the health of prisoners.

In the Australia context, NSP which provide access to new injecting equipment to prevent the transmission of BBVs have been available in the general community since the mid-late 1980s. There are currently no NSP operating in any Australian prisons. In this context, there is an urgent need to address the ongoing discrepancy in basic access to what is a proven and effective health service, by acting to provide NSP in all Australian prisons.

**Interstate – ACT Approach**

“*It’s about actually encouraging safety. You’ve got to weigh it up and balance it, you know? They [officials] need to go into the gaol system and have a look. Come and speak to me and other inmates and we’ll tell them about what happens when there’s no sterile fits available and what happens, the craziness and the... it’s just insanity... I can’t stress this enough. It’s just a right, it’s a human right, whether you’re in gaol, or whether you are in the community, to have basic, basic rights as a human being.*”

Alison, 38 ex-prisoner

More than any other Australian jurisdiction, the ACT has, over the past 10 years, both proactively pursued and vigorously debated plans for the implementation of what would have been Australia’s first NSP in a correctional facility, in the ACT’s first and only adult prison – the Alexander Maconochie Centre (AMC). The ACT is one of only two Australian jurisdictions with a Charter of Human Rights (the other being Victoria).

Under the *ACT Human Rights Act 2004*, detainees have human rights to humane treatment while incarcerated and to have their lives protected by the public authority that detains them. Further, the 2007 *ACT Human Rights Audit of Adult Correctional Facilities* found that to deny prisoners ‘protection against the transmission of disease in such a high prevalence and closed population could be considered inhumane’. The Audit went on to recommend that ‘a pilot program for a needle and syringe exchange with provision for safe disposal of needles should be developed for the AMC’.

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16 Article 25 *Universal Declaration of Human Rights* and Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR). The obligation to respect the right to health requires States to, inter alia, refrain from denying or limiting equal access for all persons, including prisoners or detainees.


18 *ACT Human Rights Act 2004*, s.19(1).

The AMC, developed under the framework of the *ACT Human Rights Act 2004*, opened in 2009 amid debate from opposing and conflicting viewpoints that it would be both Australia’s first ‘drug-free prison’ and the site for Australia’s first trial of prison-based NSP. In July 2011, the Moore Report, *Balancing Access and Safety*, commissioned by the ACT Government, put forward a range of different models for a NSP in the AMC with the preferred model being an NSP operated by an external agency within the existing prison health centre with a safe injecting facility component.²⁰

In August 2012, following 18 months of operation and the introduction of a voluntary BBV testing and monitoring protocol at the AMC, then Chief Minister Katy Gallagher reported at a public health conference that 9 cases of hepatitis C infection were allegedly acquired while detainees were in the AMC. This prompted the ACT Government to release a *Draft Strategic Framework for the Management of BBVs in the AMC* which included an actionable priority that detainees in the AMC have regulated access to sterile injecting equipment from medical staff.

Across the life of this debate in the ACT, and despite overwhelming support among the ACT general community, prison officers in the AMC and their representative union the CPSU, have vehemently opposed all ACT Government efforts to implement a trial NSP in the AMC. Protracted opposition by prison staff and the CPSU resulted, in April 2015, in the ACT Government deferring a decision on an NSP for the AMC. A change of Chief Minister and Health Minister in the ACT also lead to the establishment of a new working group (well populated with prison officers and a handful of other stakeholders) to propose and consider a preferred model for an NSP in the AMC.

Despite the working group recommending a medically supervised injecting room as the preferred model for a NSP in the AMC in July 2016, an enterprise agreement between the ACT Government and AMC prison staff, gave AMC staff full veto over any decision to proceed with the implementation of a preferred model.²¹ In September 2016, AMC staff overwhelmingly rejected the preferred model proposed by the working group in an all-staff vote. The ACT Government subsequently abandoned the idea of a trial in the AMC just before the October 2016 ACT elections. No further progress has occurred on implementing an NSP in the AMC since that time despite calls as recently as January 2017 from the AMA and many other groups for the ACT to return to leading the national debate on this issue.²³

**Victorian Approach**

Unlike the experience in the ACT, public debate and Victorian Government engagement on the issue of implementing NSPs in Victorian prisons has been relatively scarce over the past decade. Most of the activity in this space has been at the strategic advocacy level with public health and harm reduction organisations and leading human rights advocates urging the Victorian Government to act to meet their

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obligations and avoid the potential for legal liability over prisoners being exposed to infectious diseases while in Victorian prisons.

Along with the ACT, Victoria is one of only two jurisdictions in Australia with a charter of human rights – the Victorian Charter of Human Rights & Responsibilities Act 2006. The report from the 2015 review of the Victorian Charter outlines that “for the Charter to be effective, the Victorian Government must prioritise work to build a stronger human rights culture, particularly in the Victorian public sector.” It states that having the law is not enough to achieve human rights protection, rather Victoria also needs a “culture that makes human rights real in people’s everyday interaction with government” and that the operation of the Charter needs to be proactive rather than reactive.24

In this context, HRVic continues to strenuously advocate for the Victorian Government to meet its legal duty to protect the health and human rights of those in its care, including in the prison system. In order to protect the fundamental rights to life and health for prisoners, a harm reduction approach, equivalent to that provided in the general Victorian community, should be provided to respond to the issue of injecting drug use and BBV prevention in Victorian prisons.

Overseas Approach

While Australia does not have an evidence base upon which to draw in relation to prison-based NSP, such programs have been operating in numerous other countries for over 20 years (in 2014 there were over 70 programs in 7 countries) with several of these programs having been evaluated.25 A variety of models have been adopted by programs operating in other countries with the 4 main models used including:

1. hand-to-hand by prison health staff, social worker, physician or nurse;
2. hand-to-hand by external personnel or NGOs who also provide other harm reduction services;
3. hand-to-hand by trained peers (ie prisoners) to ensure confidential contact with prisoners who use drugs and access at almost all times; and
4. automated dispensing machines.

The evidence reveals that sterile needles and syringes are readily accepted by PWID in prisons and contribute to a significant reduction of syringe sharing. The evidence also highlights that where they exist, prison-based NSP have been shown to be affordable and feasible in a range of different settings as well as effective in reducing BBV transmissions. Further, such programs have had no serious, unintended negative consequences, including no increases in the consumption or injection of drugs, are not associated with increased attacks against prison staff or other prisoners and can act to increase rather than decrease the overall health and safety of the environment. These evaluations provide an evidence based opportunity for the establishment of a prison NSP in Australia; utilising the available evidence to assist in program design and operation.

Conclusion

“The prison systems and governments can no longer avoid their responsibilities to provide for the health of prisoners by dismissing prison needle exchange programmes as something new or untested. They are neither.”

Lines in McDonald, 2005.1

The ongoing discussion concerning the implementation of NSPs into Victorian/Australian prisons needs to take account and balance the rights of both prison staff, in relation to a safe work environment, and prisoners, in relation to their right to protect their health. Harm Reduction Victoria believes it is possible to successfully accommodate the rights of both prison staff and prisoners in relation to the implementation of NSPs in prison and this is amply supported by the evidence from programs operating in other countries. In relation to initiatives to prevent the transmission of BBVs, prisoners in Victoria do not currently have access to an equivalent, or even broadly consistent, level of services as are available in the general Victorian community. This is a fundamental human rights issue and in the context of the Victorian Charter of Human Rights and Responsibilities Act (2006) one that should be of great concern to all Victorian parliamentarians.

Recommendation 6:
Establish prison-based NSP in all Victorian correction facilities as a matter of urgency.

Recommendation 7:
Develop a Strategic Framework to support the implementation of prison-based NSP in Victorian prisons that draws on best available international evidence, learnings from the ACT experience and consultation with prisoners and key stakeholders.
2.4 OPIATE OVERDOSE -NALOXONE

Background

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.

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) observed26. Doctors have generally been unwilling to prescribe naloxone to lay people, eg 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.

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.

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

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

<table>
<thead>
<tr>
<th>Ampoules/doses</th>
<th>Concession Card</th>
<th>Prescription</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Yes</td>
<td>Yes</td>
<td>$6.30</td>
</tr>
<tr>
<td>5</td>
<td>No</td>
<td>Yes</td>
<td>$38.80</td>
</tr>
<tr>
<td>1*</td>
<td>N/A</td>
<td>No – purchase over the counter</td>
<td>$25+</td>
</tr>
</tbody>
</table>

*Not all pharmacies stock naloxone and if they do, prices will vary, starting at $25 for a single ampoule.

"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

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.

"Regarding the rescheduling of naloxone for the purpose of ‘increasing its availability’ and ‘removing barriers for people’ I believe has failed miserably. I kept hearing stories of people being refused naloxone without a script even after informing the pharmacist of its recent shift to dual listing status. I thought people were exaggerating but after personally visiting 6 different pharmacies and being turned away from each one I now see the desperate need for the development of an education campaign targeting pharmacists and pharmacy staff to raise their awareness to the issue."

Susan, 35, Peer Educator

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 overdose.


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 control 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.

**Recommendation 8:**
The Victorian Government lobby the Australian Government for naloxone as an over the counter medication on the Pharmaceutical Benefits Scheme.

**Recommendation 9:**
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 10:**
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 11:**
Trial distribution of naloxone on release to prisoners with a history of opioid use.

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29 Anex (2012). Australian Drug Policy: Lifesavers - access to naloxone to reduce opioid overdose-related deaths and morbidity. Anex Melbourne, Australia
2.5 **HEROIN MAINTENANCE TREATMENT PROGRAM**

"Without such a [heroin maintenance] trial...its efficacy or otherwise will never be known. Until attempted, it is very difficult to move forward or to consider alternative strategies."

Justice Wood, Royal Commission into the NSW Police Service, 1997

**Background**

Over the years, there has been a major Commonwealth, State or Territory enquiry into illicit drugs held every year, many of which have recommended a heroin maintenance trial in Australia. Despite years of debate, progress has been painfully slow. Morag McArthur\(^\text{31}\) has suggested that strident media campaigns and lack of political will have negatively influenced the outcomes of heroin response strategies, including the establishment of heroin maintenance therapy. Key inquiries include:

- **In 1981** the NSW Government asked the question as to whether heroin should be used as a form of maintenance therapy. The then Premier appointed Jim Rankin to chair the *NSW Committee of Inquiry into the Legal Provision of Heroin and Other Possible Methods of Diminishing Crime Associated with the Supply and Use of Heroin*. The Committee recommended a trial of heroin assisted treatment. The recommendation was never taken up.

- **During the 1990’s** the ACT Legislative Assembly appointed a *Select Committee on HIV, Illegal Drugs and Prostitution*. The Committee considered and accepted a recommendation to undertake a trial of heroin assisted treatment. The ACT Legislative Assembly also accepted the recommendation and after 6 years of extensive research into the feasibility of a trial, a report was presented to the ACT Chief Minister in 1995 recommending 3 pilot studies to assess the usefulness of heroin as a maintenance treatment for dependent heroin users. The ACT Chief Minister then commissioned a Task Force headed by NSW Coroner Kevin Waller to examine community attitudes to a heroin trial. In 1996 the Task Force recommended that the ACT Government proceed to a clinical trial to test the efficacy of heroin prescription as an additional maintenance treatment option. The Federal Minister for Justice believed the findings of the *Heroin Pilot Task Force Report* were important from a law enforcement perspective. In July 1997, the *Australian Ministerial Council on Drug Strategy approved a heroin trial*. However, with the change of Government in August 1997, the newly appointed Liberal Prime Minister John Howard announced the decision to withdraw Commonwealth support for the planned scientific trial in the ACT which would have provided heroin to 40 intractable opioid users. Howard argued the trial sent the ‘wrong message’ and that his decision reflected the community’s opposition to the trial - despite the findings of Kevin Waller’s Task Force research and report on community attitudes.

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In 1995 Victorian Premier Jeff Kennett established the Premier’s Drug Advisory Council headed by Professor Pennington to inquire into illicit drugs and how to tackle the illicit drug trade. Impetus for the Inquiry was linked to a reported increase in heroin trafficking across the State and a substantial increase in heroin related overdoses in Victoria from 59 in 1993, 84 in 1994 to 140 in 1995. The Council’s 1996 report unanimously recommended the Victorian Government encourage the Commonwealth to support the ACT heroin pilot study and, if appropriate, the subsequent clinical trial of heroin prescription in Victoria. The Council took the view that it was important to look afresh at strategies that might curb demand and reduce harm. The Victorian Government rejected the Inquiry’s response, a clinical heroin trial in Victoria.

Simplistically, opponents to heroin maintenance therapy argue:
- efforts and resources should be put into ‘curing addicts’, improving education programs to discourage uptake of drug use, increasing the number of drug rehabilitation programs and strengthening law enforcement and customs activities; and
- providing and thereby condoning the supply of heroin would encourage more people to use the drug, as it would be cheaper, more readily available, and the risks (health, social and legal) fewer.

However, Australia’s current prohibition policies continue to report:
- an increase in drug availability;
- an increase in the number of Australians who use drugs; and
- an increase in the number of Australians dependent on drugs.

**Victorian Approach**
For decades, Victoria has been adversely affected by heroin use, demonstrated by the number of heroin related overdoses, heroin related treatment admissions, and/or HIV and viral hepatitis transmissions related to heroin injecting. Notwithstanding the increased expenditure on law enforcement and the expansion of drug treatment regimens (including detox centres, rehab beds and pharmacotherapy programs), heroin related harms continue. The benefits to the Victorian community from the implementation of a heroin treatment program would far outweigh the costs inherent in the current situation and the lack of forward thinking or forward movement with a program which has been discussed in Australia for over 30 years. The fact that heroin maintenance programs have been successfully implemented in many countries overseas seems to have made little difference in Victoria.

“Methadone and buprenorphine do not suit everybody – we need more treatment options for opioid dependent people, what about an injectable opioid – heroin (ideally) or even injectable methadone (I do not mean a depo buprenorphine either!”

Jen, 43, AOD Treatment Worker
Notwithstanding the considerable efforts put into ORT including methadone, there are increasing numbers of long term dependent users in Victoria. The heroin maintenance programs operating in overseas countries are a supplement to methadone programs and do not seek to replace existing pharmacotherapy programs. As with methadone maintenance programs, heroin therapy is considered a long-term maintenance program and, when withdrawn, benefits for the clients and society as a whole disappear.

**Overseas Approach**

Since the 1990’s, 6 countries (including Switzerland, The Netherlands, Germany, Canada, Spain and the UK) have carried out randomised controlled trials of heroin assisted treatment. In each of the 6 trials, heroin treatment was designed for and provided to 5% of heroin users who were older and severely dependent, who had previously tried multiple other treatments, often multiple times, and after many years of treatment, rehabilitation and prison, little benefit had been achieved (Wodak). Reuter notes the “patient population [in Switzerland] is aging and, mostly, very troubled. They have long-standing problems in all aspects of their personal lives and little prospect of being able to improve their conditions”.

Each of the international trials have had consistently impressive results, with participants allocated heroin treatment doing much better than those allocated to the control group, who are provided with high quality methadone. The trials highlight that the participants provided with heroin demonstrate substantial improvements in “physical and mental health, substantially reduced illicit drug use, improved social functioning and substantially reduced crime” (Wodak). Further reported improvements and results from international heroin maintenance therapy trials include:

- access to heroin in controlled clinical settings;
- reduction in heroin related harms eg overdose and virus transmission;
- substantial reduction in use of street heroin;
- substantial reduction and/or cessation in (property) crime;
- higher treatment retention rate;
- reduced need to sell to other users to support habit;
- improvements in health and social functioning;
- no indication heroin has leaked from the facilities onto the black market; and
- treatment has not led to an increase in the number of persons experimenting with heroin.

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“I have been a client of the methadone program in Utrecht, a city in the Netherlands, for 10 years now with small ‘breaks’ in between. Two years ago, I started the heroin program where I am provided free heroin. I receive 45mg methadone and half a gram of heroin per day*, which is enough for me most of the time. Since I have been on the heroin program I...worry a lot less about getting sick [withdrawal] because I haven’t used].

Another big gain for me is that I don’t have to ‘hunt’ for heroin and I am not dependent on dealers anymore. Without this program to provide my heroin, I would have to commit criminal activities such as stealing, selling stolen goods or dealing to support my habit. Because I have never studied or had a good job, I couldn’t pay for it. But even with a good job, the cost of heroin would still be unaffordable.

I have tried to stop using heroin but it was hard for me to persist. I still find heroin very pleasant and that’s why it is hard to find the right motivation to quit.

The heroin scene in my city has become a lot worse and meaner over time. Because of the heroin program I can function without having to mingle with the scene anymore”.

*Ben is required to use the heroin daily on the premises (in the drug consumption/safe injecting room) and may take his methadone home.

Ben, 39 years of age

Recommendation 12:
Undertake negotiations with the Australian Government for the importation of diamorphine (Heroin) under federal law.

Recommendation 13:
Roll out the prescription of injectable diamorphine (heroin) to people suffering from problematic opiate use to help Victorians who have historically failed to respond to conventional treatments such as ORT.

Recommendation 14:
Commission an independent evaluation of the heroin treatment program.
2.6 **OPIOID REPLACEMENT THERAPIES (ORT)**

**Background**

First used in Australia in 1969, opioid replacement therapies (ORT) ie buprenorphine/naloxone and methadone have consistently shown to be an effective harm reduction measure, reducing illicit drug use, retaining people in treatment and reducing the incidence and consequences of risky drug use, ie BBV transmission, drug-related overdose and acquisitive crime.\(^{34}\) ORT has been found to improve quality of life both for the consumer and their families in relation to housing, employment, general wellbeing, etc.\(^{35}\) Most people on ORT in Australia have their pharmacotherapy dispensed through a community pharmacy, with an estimated 75% of consumers dosed at a community pharmacy on a snapshot day in 2015.\(^{36}\) As community pharmacies are commercial entities, they typically charge consumers a ‘dosing fee’ to recoup costs associated with providing the ORT dispensing service to consumers.

For most PBS (S85) prescription medications, the Commonwealth provides a set dispensing/recording fee (and as relevant, a dangerous drug fee) to the pharmacist, and most consumers usually pay a maximum patient co-payment contribution per dispensed prescription (rather than per dose of medication as it is for ORT). In contrast, ORT medications fall under S100 Opioid Dependence of the *National Health Act 1953* and different government funding arrangements apply. Although the ORT medications are supplied at no cost to providers by the Federal Government, dispensing costs for pharmacists are not covered under these arrangements and there are no safety net provisions for consumers as there are with other PBS prescription medications. This results in a wide variety of dispensing arrangements and dosing fees across jurisdictions, with people charged varying amounts from one pharmacy to another.\(^{37}\)

Research shows that ORT consumers dosing at community pharmacies currently pay between $1.50 and $12.00 per day/per dose with a median methadone price of $4.65 and $5.00 for buprenorphine preparations, which equates to between $1800-$3650 p/a a consumer.\(^{38}\) This represents a significant proportion of weekly income for most ORT consumers living on government benefits, who on average spend 10-15% of their weekly income on ORT dispensing fees. In comparison, other Australians on a


A concessional health card for a chronic condition would pay $6.20 per monthly prescription to a maximum total of $372.00 annually under the Safety Net provisions. Research has also shown that successful ORT outcomes are strongly linked to the length of time an individual is retained in treatment.\textsuperscript{39} Other studies, including a 2008 Pharmacy Guild of Australia study found that affordability of treatment has a significant impact on the ability of clients to stay on ORT.\textsuperscript{40} Further, Victorian research into the cost of ORT in 2008 showed that dispensing fees were one of the primary reasons for involuntary discontinuation of treatment and the single biggest barrier to retention in treatment.\textsuperscript{41}

Non-payment of dosing fees is frequently a reason for refusal of dose and ORT consumers can find themselves unable to be dosed or even remain on the program, as they can neither pay their current pharmacy nor transfer to a new pharmacy, as the previous pharmacist would disclose the existing debt.\textsuperscript{42} Some pharmacies offer discounts to consumers for paying for dosing in advance, generally in the range of 1 free dose p/w. As noted above however, fee paying arrangements vary considerably between pharmacies and jurisdictions, with no overarching state/national agreement. Pharmacists ultimately have discretion to refuse to dose for ‘payment related’ reasons.\textsuperscript{43}

\begin{quote}
\textit{The WHO has declared pharmacotherapy drugs as “essential medicine”, as a consumer dependent on this ‘treatment’ (yes, the most successful treatment for opioid dependence), I have to pay more for this type of medicine than for anything else I have ever been prescribed, yet this is the one medicine that I need simply to be able to physically function on a daily basis. There are clear benefits to the whole community when pharmacotherapy treatment is available, (reduced rates of crime and imprisonment, hospital admissions, drug related overdose, ambulance attendance, BBV transmission etc) – in fact research (NEPOD 2003) indicates that for every $1 spent on ORT the community benefits in a saving of $5 to $8 – yet I have to pay approximately 11\% of my total Centrelink income on the one medication, leaving me with little money for food and absolutely no entertainment budget ever.

I genuinely believe more people would take up this treatment option (or perhaps more to the point) remain on these programs for longer (research indicates the longer a person stays on a program the greater their chance is of achieving eventual abstinence) if this treatment was provided to opioid dependent people free of cost for the duration of time each person requires.”

Trish, 56 mother
\end{quote}


In line with the *Victorian Charter of Human Rights & Responsibilities Act (2006)*, HRVic believes cost and availability of ORT program places for the most vulnerable clients should be addressed as a priority.

**Victorian Approach**

Victoria’s ORT program is designed as a community-based program with all ORT consumers prescribed by GP or nurse practitioners (known as ‘prescribers’) in the community and dispensed through community pharmacies. The system operates on an ‘opt-in’ approach, whereby both prescribers and pharmacists elect to participate in the program. A growing problem for the ORT program in Victoria is the decreasing number of new prescribers entering the program, particularly as some of Victoria’s most established and experienced GP prescribers, many with very large client loads, reach retirement age and leave the system.

While encouraging new community pharmacies into the Victorian ORT program is an ongoing challenge, the shortage of ORT prescribers is placing significant pressure on an already under-resourced program, particularly in regional and rural Victoria. When someone seeks access to the ORT program, typically they are in a state of ‘personal crisis’ and require access to the program immediately, not in several weeks or months. This problem is further highlighted by recent data from the *Pharmacotherapy Advocacy, Mediation and Support (PAMS)* Service (operated by HRVic – see below), which shows that difficulty finding a prescriber is one of the main issues of concern for people contacting the PAMS Service.44

It is possible for GPs to prescribe buprenorphine/naloxone to 5 people without undergoing formal training to become a registered prescriber.45 While this potentially provides an as-yet under-explored mechanism to bring new prescribers into the State ORT program, the small numbers, and the restriction on buprenorphine prescribing only, will mean the overall impact on the statewide prescriber shortage will be limited. This limited impact however, should not be viewed a reason not to provide greater information and support to GPs willing to prescribe buprenorphine to small number of people. Targeted education and support will help to allay concerns that GPs new to the program may have about taking on ORT patients and can assist them with the policies and protocols associated with ORT prescribing. By providing appropriate support and a positive initial experience, some GPs may be willing to undertake the further training needed to become a fully registered prescriber. Along with training for GPs, priority should also be placed on providing funding for training aimed at improving attitudes towards and reducing stigma and discrimination against people with opioid dependence issues among other practice staff.

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45 Currently *General Practice Victoria* is the sole organisation authorised to provide ORT registered prescriber training to GPs seeking to prescribe ORT to more than 5 people in Victoria.
In 2012, the DHHS developed a new region-based statewide framework for ORT with the establishment of the 5 ‘Pharmacotherapy Area Based Networks’ (PABN). The PABN were funded to improve the overall health and wellbeing of ORT clients, enhance service integration, coordination and referral pathways and reduce the overall vulnerability of the Victorian community based ORT service system. Reporting by these newly established PABN indicates that this new framework may already be delivering a positive results with a reported increase in new ORT prescribers statewide in 2015/16 through the implementation of innovative, incentive-based initiatives for prescribers and pharmacists, the introduction of mentoring programs and enlist the assistance of GP prescriber ‘champions’.

One of the most unique programs associated with the Victorian ORT Program is HRVic’s Pharmacotherapy Advocacy, Mediation and Support (PAMS) Service. PAMS is a state-wide, telephone service which addresses any Victorian ORT related issue or concern. Over the last 16 years, PAMS has grown from a complaints-resolution service into its current form, which focuses on increasing access to and retaining current consumers in ORT treatment. PAMS also supports service providers to continue prescribing and dispensing ORT, especially with complex clients or when complex client related problems arise. The results achieved by PAMS’ intervention constitute win/win outcomes which benefit all parties.

Despite its unique and vital role, PAMS is extremely under-resourced with only 1.5 funded workers. Currently, the service is funded to manage a client case-load of 35 cases per month. In the 2015/16 financial year, PAMS managed a total of 964 cases at an average of 81.3 cases per month. To date, in 2016/17, PAMS has already managed a total of 663 cases at an average of 55.2 cases per month. The need for greater resourcing for PAMS is urgent and will not only improve the responsiveness of PAMS itself, but will also encourage GPs and pharmacies to the participate in the program due to the assistance it provides in managing complex client issues.

**Interstate – NSW & ACT Approaches**

As a way of addressing affordability and costs issues, some jurisdictions operate public ORT clinics that provide dosing at no cost to the consumer. The obvious benefit of the service is that it is provided ‘cost free for the consumer’. One of the main jurisdictions providing this type of service is NSW. These public clinics sometimes offer temporary ‘fee relief’ places for a limited amount of time under certain circumstances, but this is rare and not all states have public ORT clinics – Victoria is a case in point.

One of the criticisms of Victoria not having public ORT clinics is that there are no options available for consumers to continue their ORT if they are removed from their community pharmacy for non-payment of dosing fees or other problems. Currently in Victoria there is very limited emergency fee relief for ORT.

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46 Source: DHHS Discussion Paper on PABNs.
consumers, and where it does exist, it is only through the PAMS service. Consumers can find themselves unable to continue their program for financial reasons. HRVic believes consideration should be given to establishing either public clinic-type dosing arrangements in Victoria and/or funding for additional incentives, in the form of payments, for community pharmacists willing to take on people with debt management issues.

Other than the public clinic model, the only notable exception to the type of dosing fee arrangements available in Victoria is that of the ACT. The ACT Government provides a subsidy of $20 per week, paid directly to the ORT community pharmacies, and ORT consumers make an additional weekly co-payment to the pharmacist of $15 per week, per ORT consumer, regardless of income level. This allows community pharmacies to receive remuneration of $35 per week per ORT consumer. It has been argued that the ACT Government is able to offer such an arrangement due to the relatively small numbers of ORT consumers. Whether such a subsidised approach could work in a much larger jurisdiction such as Victoria with approximately 14,000 ORT consumers remains open to debate.

**Recommendation 15:**
The Victorian Government should work with the Australian Government to address the cost of ORT to Victorian consumers through a review of the regulatory arrangements for funding of ORT medications.

**Recommendation 16:**
The Victorian Government provide funding to support greater incentive payments to both ORT prescribers and community pharmacists to support their continued and increased participation in the Victorian ORT program.

**Recommendation 17:**
Fund and implement training for GPs, other prescribers and practice staff to improve attitudes towards and reduce stigma and discrimination against people seeking and/or currently on ORT programs. Training to include people currently on ORT programs providing a lived experience perspective.

**Recommendation 18:**
Increased funding for the Pharmacotherapy Advocacy, Mediation and Support (PAMS) Service to expand the delivery of support and advocacy services for people on and seeking access to ORT in Victoria.

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47 Currently PAMS is funded only $14,000 per annum to assist with emergency dosing fee relief which effectively equates to $1/annum per ORT consumer in Victoria.
2.7 **Pill Testing (also known as ‘Drug Checking’)***

**Background**

Pill testing involves the use of sophisticated chemical analytical instruments to determine the content and purity of illicit drugs in powder, press pill, or other forms (e.g., cocaine, MDMA/’ecstasy’, GHB, or LSD etc), that are currently being consumed in recreational settings without discretion or the opportunity for such a health promotion/harm reduction intervention. There are successful examples of pill testing service models in the EU, North and Central America, among others, that have been operating at varied scales since the 1990s (the EU collective includes: Austria, France, Luxembourg, the Netherlands, Portugal, Spain, Switzerland, and the UK). In such participatory jurisdictions, pill testing services are integrated with other health, wellbeing, and peer education services that enable individual drug users to have their drugs (e.g., analysed, as well as receiving education, counselling and advice, and, if necessary, access to appropriate referral pathways. Pill testing services assist in reducing harms caused by drugs containing unknown substances or drugs of an unknown purity, provide drug users with the opportunity to discard drugs that produce unexpected results, and proactively connect with health and wellbeing services.

There have been many well-publicised, but also other discreetly-managed, cases of drug-related deaths at nightclubs, music events and festivals, and at private parties in Australia as a result of the global illicit drug market’s ongoing expansion and adulteration. An emerging concern is the presence of new psychoactive substances (or NPS). More than 750 new drugs have been recorded by the EU Early Warning System in the past year. The presence of NPS as adulterants and substitutes for MDMA in ecstasy pills is documented as causing an increase in drug-related hospitalisations, among other harms.

Pill testing results obtained in a range of settings can be triangulated with the results from police drug seizures to form useful intelligence about the fast-evolving drug market. Pill testing provides an ideal opportunity to monitor trends in drug markets and note new and emerging drugs of concern. Pill testing acts as an early detection tool enabling swift implementation of harm reduction strategies and responsive treatment of substance use problems.

The establishment of pill testing facilities at music events and festivals—but also at fixed locations, like in the Primary Healthcare Networks—is therefore a lifesaving harm reduction measure to incentivise safer drug use within the community through:


1. providing opportunity for people to be informed and consider a range of issues before determining whether to consume an illicit drug;
2. reducing the number of people potentially attending hospitals, police holding cells and courts as a result of consuming unknown drugs - which in turn provides a range of individual, family and community based positive outcomes; and
3. obtaining a range of street samples for detailed testing that allows for both community health warnings on new compounds and assists law enforcement intelligence on drug importations.

**Victorian Approach - Pill testing in Practice**
There are many pill testing models proposed within the harm reduction literature. Most pill testing models focus on the use of services at nightlife events and festivals, as these venues are strongly associated with substance use and are an ideal avenue for harm reduction interventions. HR-Vic supports the use of mobile pill testing services that provide individual advice directly to substance users. Such onsite pill testing would utilise various forensic chemical testing techniques. Some of the equipment utilised overseas include high-performance liquid chromatography (HPLC), liquid chromatography–mass spectrometry (LCMS), gas chromatography–mass spectrometry (GCMS), thin-layer chromatography (TLC), fourier transform infrared spectroscopy (FTIR) and quadrupole time-of-flight mass spectrometry (Q-TOF). These techniques can produce results onsite in under an hour and are highly sophisticated analytical techniques capable of identifying adulterants in substances as well as the purity of drugs and have considerable advantages over ‘reagent tests’ used by consumers presently.

A typical drug checking facility is set up in a van, shipping container, or a tent onsite at an event, with partygoers lining up to have their drugs tested by forensic chemists. Testing can take from 20 to 40 minutes and provides an ideal opportunity to provide harm reduction education to the consumer by peers and other trained professionals.

Based on the data produced in jurisdictions that have pill testing, we expect the following key outcomes:
- decreased number of overdoses and adverse reactions to drugs;
- decreased consumption of drugs by those patrons electing to have their substances tested;
- decreased consumption of drugs by those within a service-user’s social circle of influence;
- decrease poly drug use by those electing to have their substances tested
- increased safety and amenity for patrons and their families
- reduced numbers at emergency departments and hospitals as a result of adverse drug reactions at the music festival;
- increased the level of knowledge and awareness of drug issues amongst music festival patrons;
- Greater engagement of people using drugs with health professionals;
- reduced emergency department costs;
- reduced emergency transport costs;
- reduced policing and criminal justice system costs;

increased data and intelligence on the drugs in circulation in the ACT;
potential use of information to establish a real-time early warning system for health officials and general public;
greater opportunity to improve the lives of young vulnerable people; and
riloting of a project to immediately distribute information to patrons of the event regarding any dangerous products identified.

Drug-checking facilities are ideally suited to tackling the issue of new psychoactive substances (NPS) in ecstasy pills. In particular, drug checking may assist in:54
- identifying the NPS and other contents of the pills or powders;
- monitoring NPS availability and use trends to enable an effective public health response;
- identifying emerging hazards from specific NPS and the formulations available;
- improving the knowledge base for effective clinical management of acute and chronic presentations;
- providing an opportunity for users to seek help, obtain health information to reduce potential harms and to offer options for individual drug taking behaviour change; and
- providing intelligence that could influence supply reduction dynamics.

Pill testing facilities also provide an ideal venue to provide peer-based harm reduction educations. It is the experience of HRVic, through the administration of the DanceWize program,55 that harm reduction education programs that are delivered by peers within a festival environment are the most effective in reducing problematic drug taking behaviours. This is supported by evaluations of drug prevention programs, particularly for adolescents, which indicate peer-based initiatives as the most effective.56 This is also well supported by research on overseas drug-checking programs, which note the programs’ ability to target to at-risk, dependent individuals.57

Drug checking facilities are ideal suited to ecstasy (or MDMA) users who are largely without dependency issues and commonly cease drug use on their own accord. A paper by Peters et al notes that because motivations for behaviour change in relation to ecstasy users are largely self-initiated, health promotion resources are better spent on harm reduction programs rather than trying to induce cessation of use.58

55 DanceWize utilizes a peer-education model to performs specialised harm reduction education, alcohol and other drug welfare, and crowd care outreach at music events and festivals across Victoria.
particular, research has shown that consumers would discard a pill if they were told it did not contain 
MDMA but instead contained ‘suspicious’ substances.  

For drug checking facilities to work effectively, Victoria Police would need to exercise its discretion to 
ensure both tester and consumer are immune from arrest and charge. This requires clear, public support 
for these programs by law enforcement so both operators and consumers feel protected. 

**Overseas Approach - European Drug Checking Facilities**
Drug checking facilities are available in many European cities for over a decade. In Zurich, the ‘Saferparty’ program developed in conjunction with the University of Bern placed forensic chemists and drug testing facilities at dance festivals. In the UK, ‘The Loop’ charity provides high-tech drug checking facilities to festivals throughout the country.

The Europeans the Nightlife Empowerment & Well-Being Implementation Project (NEWIP) has developed an extensive set of best practice standards for the operation of drug-checking facilities and could be used to assist in drug checking services operating in Australia.

> “When I went to Boom Festival in Portugal last year it was the first time I had access to onsite, lab-quality pill testing services. I wanted to check out ‘CheckIt’ because of the ‘novelty-factor’. I wasn’t concerned about the contents of my own drugs, but when I got the test results back and learned my drugs were cut with things I didn’t expect, not necessarily dangerous stuff, but random stuff, it made me reconsider what I was putting in my body and the absence of quality-control in the large and murky illicit drug market.”

**Rose, 27 Registered Nurse**

**Other Considerations**

**Is there a “Honeypot” effect?**

International research and evaluations of pill testing focus on this procedure’s ability to reduce harm. However, in understanding this innovative approach to reduce the harms associated with the consumption of illicit drugs, especially at festivals, it is important to understand that the notion of a “honeypot” effect is not validated by the data.

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While on occasion the notion of the ‘honeypot effect’ is referred to in political discourse and media, there is no evidence to suggest it to be a consequence of pill testing when reviewing the scientific or legal literature.

Much of the international literature frames the pill testing into two tactical responses.
1. Reducing the harm and potential death of those who choose to use illicit substances and who also frequent music festivals; and
2. An early intervention service for a “hard-to-reach” cohort of drug users as this group does not use traditional drug related services.

The literature also notes that the pill testing program is a unique and robust method of monitoring the illicit drug market. It is also important to note that this cohort is clearly defined in the literature as being mostly aged 20-40 years and with a significant portion having tertiary qualifications.

**Major concerns regarding pill testing**

Most of the international literature in relation to the concerns regarding pill testing/drug checking fall into two categories:

1. **Reagent kits** - there are limitations to having reagent kits be the sole source of information by this cohort of drug users and their families. While this a band-aid solution and better than no safeguard at all, this approach lacks an aspect of early intervention.
2. **Encouraging drug use** - international evidence unanimously shows that pill testing/drug checking does not encourage drug use and that indeed, a significant proportion of those have their drugs tested will discard their drugs if they have been given adequate information of the dangers.

   Indeed, there is international evidence that on-site pill testing allows people to avoid specific pills or otherwise modify their drug use based on test results (Benschop et al., 2002; van de Wijngaart et al., 1999).

**An Ethical Responsibility**

As Johnston et. al point out:

> “…it has been suggested that the provision of pill testing is an ethical responsibility, whereby the right to know and the opportunity to decide on potential health risks associated with illicit substance use should be rated higher than legal or ideological concerns”

(Davidson, 2005b; EMCDDA, 2001).

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62 BURKHART, G. KRIENER, H. “Análisis de pastillas como prevención selectiva” ADICCIONES (2003), VOL. 15, SUPL. 2
64 A.M. Camilleri, D. Caldicott / Forensic Science International 151 (2005) 53–58
Johnston and others argue that not only does pill testing offer the ability to communicate to a group previously difficult to reach out to, it also offers the opportunity to disseminate information about the legal risks associated with illicit drug consumption, safe sex safer driving.

**Recommendation 19:**
Immediately cease passive alert detection operations (sniffer dogs) at all Victorian music festivals and events and other public spaces such as nightclub districts as this supply reduction strategy has no evidence base supporting its use as a deterrent measure, and it has been linked to increased high risk drug taking behaviour causing death and other harm.68

**Recommendation 20:**
Fund laboratory quality pill testing services at a range of fixed and mobile settings, including nightclubs and at music events and festivals across Victoria.

**Recommendation 21:**
Ensure pill testing services are integrated to include the employment of peer educators to deliver a range of harm reduction education and strategies.

**Recommendation 22:**
Release pill testing results to enable the development of services responsive to evolving drug markets, such as the EU’s Early Warning System.

**Recommendation 23:**
Indemnify all those accessing and working at pill testing services against legal ramifications.

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2.8 **Drug Consumption Room / Safe Injecting Room**

**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, a service type which provides 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 is 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 viral hepatitis treatment specialists.

**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 injecting rooms 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 drug ‘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 he made not to establish a drug consumption room in the state.

On Wednesday 15 March 2017 HRVic did a snapshot survey of street-based heroin injectors along North Richmond’s Victoria Street. Below are responses to the question “Would you use a safe injecting room?”:

<table>
<thead>
<tr>
<th>Response</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I’d use one because everyone knows where you are, there’s less danger if you drop. It’d be good.”</td>
<td>Tom</td>
</tr>
<tr>
<td>“...of course, for safety and not having to use in public. Not being interrupted.”</td>
<td>John</td>
</tr>
<tr>
<td>“...much safer if you OD. And it’s a cleaner environment [than the street]”</td>
<td>Sam</td>
</tr>
</tbody>
</table>

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Today’s Melbourne drug market is a shifting landscape. For example, Springvale’s street market of the late 1990’s has moved behind Dandenong’s train station and Footscray’s market has moved out a little toward St Albans. The establishment of a mobile SIF would suit Melbourne’s changing drug market and areas of consumption.

**Interstate – 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%.

**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\(^70\) 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\(^71\). The advantages of a mobile SIF is that governments are able to respond to changes in drug

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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 24:**
Establish a mobile safe injecting facility in Melbourne to move across changing locations and areas of need, guided by an expert advisory committee including representation of people who inject drugs.
2.9 DRUG DECRIMINALISATION: THE PORTUGAL MODEL

Background
Given the shortcomings of the current criminalisation approach to drug-related harms, harm reduction advocates have looked promisingly toward developments in Portugal as an example of an alternative approach.

Portugal is a country with a population of just over 10 million and spends around 9.5% of GDP on health, a level comparable to Australia. In the 1990s, Portugal experienced a dramatic increase in heroin related harms, including rising rates of viral hepatitis as well as HIV transmission. By 1999, Portugal had the highest rate of drug-related AIDS in the European Union and the second highest prevalence of HIV amongst injecting drug users. Drug-related deaths had increased in Portugal to a peak of 369 in 1999 (an increase of 57 per cent since 1997).

Portugal has a particularly difficult task in reducing drug supply into the country, given its geographic location and ties to drug producing or transiting regions such as South America and, West and North Africa. In 1998, the government appointed the Commission for the National Strategy to Fight against Drugs, with the mandate to produce a report with guidelines for the ‘fight against drugs and drug addiction’. The resulting report made comprehensive recommendations, which would be adopted by the Portuguese Government as part of the 1999 National Strategy for the Fight Against Drugs, the essential blueprint for what eventually became known as ‘The Portugal Model’.

Overview of The Portugal Model
Beginning in 2001, The Portugal Model consisted a set of legal and policy changes designed to shift the focus of laws regarding drug use away from criminal law enforcement toward a public health approach.

The foundation of this shift were two major legal changes:

1. The passage of Law 183/2001 provided a new legal basis for harm reduction and treatment interventions in Portugal. This strategy had a clear focus on drop-in centres, outreach services, substitution therapy and social re-integration programs.
2. The passage of Law 30/2000 repealed criminal offences for the possession of illicit substances, at a quantity consistent with personal supply, and established an administrative penalties regime designed to reduce problematic drug use in the community.

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74 Instituto Português da Droga e da Toxicodependência, Report to the EMCDDA—Portugal: Drug Situation 2000, 2000 Lisbon IPDT
The Portugal model is often described as a process of ‘decriminalisation’ to distinguish it from the ‘depenalisation’ approaches in other parts of Europe, which retain criminal offences for possession and use but divert offenders from imprisonment. Nevertheless, the possession and use of illicit substances is still illegal in Portugal and criminal offences still apply to supply, trafficking and importation of illicit drugs.

What makes Portugal unique is the coupling of decriminalisation with an increased emphasis on harm reduction and treatment. Each step in the Portugal process is designed to reduce stigma surrounding drug use and addiction in order to promote primary prevention and pathways to health and treatment programs.76

Model in Practice

Under the Portugal Model, when a police officer suspects a person is using or possessing an illicit substance for personal use,77 a summons is issued. This summons requires the offender to attend one of the 18 Commission for the Dissuasion of Drug Abuse panels or “CDTs” across districts in Portugal. A CDT consists of a three-person interdisciplinary team: a lawyer, a health professional and a social worker. The CDT meets with the alleged offender to perform a case assessment and provide a ruling on what is in the individual’s best interest and that of the community. Article 10 of Law 30/2000 states that a CDT must:

> “gather the information needed in order to reach a judgment as to whether he or she is an addict or not, what substances were consumed, the circumstances in which he was consuming drugs when summoned, the place of consumption and his economic situation”.

Several possible orders/rulings are available to the CDT, including:78

- provisional suspension of the process for those not requiring targeted intervention or for drug addicted/drug-dependent persons to seek treatment;
- issuing a warning;
- banning the offender from attending certain areas;
- banning the offender from associating with particular persons;
- requiring the offender to attend regular visits to particular places (including treatment services);
- removal of professional licenses;
- removal of firearms licenses; and
- issuing a fine (for non-addicted persons).

The CDT provides a number of advantages, including early intervention for drug users by a specialist panel of experts; the provision of a broader range of responses; increased emphasis on prevention for

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77 Personal use is defined as no more than 10 daily doses of drugs, the weight of which is prescribed by regulations. The officer must also have no suspicions that the drugs were being possessed for supply.
78 Article 15-17, Law 30/2000.
occasional users; and increased provision of treatment and harm-reduction services for experienced and dependent users.\textsuperscript{79}

**Benefits of the Portugal Model**

The key benefit of the Portugal approach is that it lowers barriers to harm reduction interventions and provides an ideal process for problematic drug users to gain access to treatment.

Following the implementation of decriminalisation laws, the prevalence rate of heroin use in Portugal has reduced from 2.5 to 1.8 per cent.\textsuperscript{80} There has also been a significant reduction in drug-related deaths.\textsuperscript{81, 82}

A 2006 report found that the number of individuals accessing substitution treatment for opioid dependence increased 147\% following decriminalisation.\textsuperscript{83} The overall numbers of drug users in treatment expanded in Portugal from 23,654 to 38,532 between 1998 and 2008.\textsuperscript{84} Moreover, the number of newly reported cases of HIV and AIDS has been declining substantially since decriminalisation.\textsuperscript{85}

The laws have also lowered burdens on Portugal’s criminal justice system, with the prison density (prisoners per 100 prison places) of Portuguese prisons falling from 119 in 2001 to 101.5 in 2005.\textsuperscript{86} The approach also assists in better relations between drug users and police. A 2007 paper noted that: \textsuperscript{87}

> "The law enforcement sector was seen as supportive of the reform, particularly because they perceived decriminalization and referral to education and treatment as offering a better response to drug users than under the previous legislative approach. Key informants asserted law enforcement have embraced the more preventative role for drug users."

Concerns that decriminalisation would lead to a dramatic increase in drug use in the Portugal have not been borne out by evidence. Since the enactment of the decriminalisation laws, illicit drug usage rates

\textsuperscript{79} Caitlin Elizabeth Hughes, Alex Stevens; ‘What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?’ *Br J Criminol* 2010; 50 (6): 999-1022. doi: 10.1093/bjc/azq038


\textsuperscript{82} Hughes and Stevens, above at n8.


\textsuperscript{84} Instituto Nacional de Administração, above at n10.


\textsuperscript{87} Hughes and Stevens, above at n8, 6.
among the critical 15-19 age group have decreased.\textsuperscript{88, 89} For older age groups there has been a mild increase in drug usage, although there is dispute as to whether this increase is a consequence of decriminalisation or in keeping with increased usage rates across Europe.\textsuperscript{90}

**Recommendation 25:**
Repeal of criminal offences applicable to possession and use of illicit drugs for personal use, to be replaced with an administrative penalty system designed to increase offender access to health services and treatment.

\textsuperscript{90} Hughes and Stevens, above at n8.
The current laws and policies applying to illicit drugs users in Victoria raise serious concerns regarding the respect for and preservation of human rights in our State. In particular, current practices appear to infringe the following rights under the Victorian Charter of Human Rights and Responsibilities:

- **The Right to Life:** as existing laws hinder life-saving harm reduction interventions, particularly in regard to the spread of blood-borne virus transmission and risk of overdose. As barriers to these practices increase risk of preventable death, existing practices arguably violate the right to life under s 9 of the Charter of Human Rights and Responsibilities Act 2006 (Vic).

- **The Right to Privacy:** as existing laws interfere deeply with the personal lives of drug users and their families, particularly individuals suffering from drug dependency or addiction, it is arguable such laws interfere with an individual’s right to privacy under s 13 of the Charter of Human Rights and Responsibilities Act 2006 (Vic).

- **The Right to Humane Treatment when Deprived of Liberty:** as existing policies prevent adequate harm reduction interventions, in particular NSP, for incarcerated individuals. Given the particular vulnerability of prison populations to addiction and risk of blood borne viruses, it is arguable current practice interferes with an individual’s right to humane treatment when deprived of liberty under s 22 of the Charter of Human Rights and Responsibilities Act 2006 (Vic).

In light of the considerations outlined above, reform of existing laws would be wholly consistent with the aims of the Charter and would greatly assist in the preservation and respect of human rights in Victoria.

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93 Ibid.
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. Amend the *Drugs, Poisons and Controlled Substances Act 1981* to provide legal protection to people, not licensed under the Victorian NSP system, to distribute sterile injecting equipment to people who inject drugs.

2. On implementation of Recommendation 1, the requirement to provide legal protection to people distributing sterile equipment is no longer required. Hence, discontinue the time limited, person-specific DHHS NSP authorization card system whilst maintaining the authorization procedure for the operation of agency NSP.

3. Enhance the funding of HRVic’s Peer Networker Program to enable staff to deliver ‘train the trainer’ style education to teams of peer volunteers across the State. The teams will be provided with ongoing support and be in a position to distribute sterile needles and syringes to isolated pockets of people who inject drugs.

4. The Victorian Department of Health require all public health services in receipt of state funds and delivering health services to the community 24 hours a day, including rural and remote hospitals, to dispense sterile injecting equipment after hours. The definition of ‘after hours’ is to depend on the type of health service, the location of the nearest community pharmacy and the pharmacy’s hours of operation and retailing of needles and syringes, with the aim of maximizing 24-hour access to sterile injecting equipment to people who inject drugs and living in rural and remote areas of Victoria.

5. 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.

6. Establish prison-based NSP in all Victorian correction facilities as a matter of urgency.
7. Develop a Strategic Framework to support the implementation of prison-based NSP in Victorian prisons that draws on best available international evidence, learnings from the ACT experience and consultation with prisoners and key stakeholders.

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

9. 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.

10. 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.

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

12. Undertake negotiations with the Australian Government for the importation of diamorphine (Heroin) under federal law.

13. Roll out the prescription of injectable diamorphine (heroin) to people suffering from problematic opiate use to help Victorians who have historically failed to respond to conventional treatments such as ORT.


15. The Victorian Government should work with the Australian Government to address the cost of ORT to Victorian consumers through a review of the regulatory arrangements for funding of ORT medications.

16. The Victorian Government provide funding to support greater incentive payments to both ORT prescribers and community pharmacists to support their continued and increased participation in the Victorian ORT program.

17. Fund and implement training for GPs, other prescribers and practice staff to improve attitudes towards and reduce stigma and discrimination against people seeking and/or currently on ORT programs. Training to include people currently on ORT programs providing a lived experience perspective.
18. Increased funding for the Pharmacotherapy Advocacy, Mediation and Support (PAMS) Service to expand the delivery of support and advocacy services for people on and seeking access to ORT in Victoria.

19. Immediately cease passive alert detection operations (sniffer dogs) at all Victorian music festivals and events and other public spaces such as nightclub districts.

20. Fund laboratory quality pill testing services at a range of fixed and mobile settings, including nightclubs and at music events and festivals across Victoria.

21. Ensure pill testing services are integrated to include the employment of peer educators to deliver a range of harm reduction education and strategies.

22. Release pill testing results to enable the development of services responsive to evolving drug markets, such as the EU's Early Warning System.

23. Indemnify all those accessing and working at pill testing services against legal ramifications.

24. Establish a mobile safe injecting facility in Melbourne to move across changing locations and areas of need, guided by an expert advisory committee including representation of people who inject drugs.

25. Repeal of criminal offences applicable to possession and use of illicit drugs for personal use, to be replaced with an administrative penalty system designed to increase offender access to health services and treatment.