

TRANSCRIPT

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 8 May 2017

Members

Mr Geoff Howard — Chair

Mr Bill Tilley — Deputy Chair

Mr Martin Dixon

Mr Khalil Eideh

Ms Fiona Patten

Ms Natalie Suleyman

Mr Murray Thompson

Witnesses

Judge Sara Hinchey, State Coroner of Victoria, and

Mr Jeremy Dwyer, case investigation officer, Coroners Court of Victoria.

**Necessary corrections to be notified to
executive officer of committee**

The CHAIR — We are next going to hear from the State Coroner, Judge Hinchey. Welcome this morning.

Judge HINCHEY — Thank you.

The CHAIR — Jeremy Dwyer is also assisting her. As you are aware, today is the first day of public hearings in regard to our inquiry on drug reform following opening submissions, of which we had over 220 written submissions. As you are aware Hansard is going to be recording what is said this morning, and in a couple of weeks you will get a transcript to look at and adjust factual or typographical errors. As you are aware the committee is held in public. If there was anything you wanted to share privately, we have the opportunity to discuss that and we can go into a confidential session if that is necessary.

I note that you have provided us with a submission, and we appreciate that. I have already advised observers, but for the few additional observers, I hope you have got your mobile phones turned to silent. I think that has covered the official part that I needed to cover. Thank you, Judge Hinchey and Jeremy, for coming along today. We certainly appreciate the submission that you have provided us with. In the next 20 minutes or so if you are able to share an overview of the submission — the key points, tease those out — and then we will be able to follow up with some questions.

Judge HINCHEY — Yes, certainly. Thank you, Mr Chair. Before I start could I just make it clear that Mr Dwyer is here to assist me in case there are areas of particular detail that the committee wishes to ask about, but he will not be answering any questions; he will just be feeding me information if it comes to that, as long as that is suitable to the committee. I have supplied this morning an overview statement which I intend now to make to you, which is supplementary to the written submission that has already been supplied and really highlights some of the key areas within that submission that the Coroners Court of Victoria sees as recurring and important themes for the committee to consider. So in summary, what I would like to do is offer some context and commentary regarding the written submission, which has already been provided, and after of course I will be pleased to answer all of your questions.

If I could start by explaining the role of the coroner, the Coroners Court of Victoria conducts investigations into a range of deaths, including any deaths that are unexpected, unnatural or violent, so of course drug overdose deaths fall within that category. A coroner is required to establish certain facts as a result of their investigation, including the identity of the deceased and the cause of death. In addition, the role of a coroner, under the Coroners Act 2008, extends to a consideration of how preventable deaths in the state of Victoria can be reduced. In fulfilling this role a coroner may seek evidence, engage the assistance of experts, hold public hearings so as to understand the circumstances surrounding a death and also how to reduce the risk which led to that death.

At the conclusion of an investigation a coroner may make recommendations or comments aimed at preventing similar deaths in the future. A coroner's power to make recommendations is limited to matters connected with the death and necessarily to the evidence before the coroner in that particular case. That is a very important point, because there might be times today when I tell you that we have not got any evidence about that issue. So to the extent that the Coroners Court has been prepared to comment in relation to your inquiry, all of those comments will be inexorably linked to evidence which the court has received in the past, including expert evidence. This hopefully will assist you to understand the difference between the coronial approach to drug harm and the approach being taken by your committee in relation to drug law reform.

A coroner's consideration of harm and any other issue is always linked to the circumstances of the death under investigation, whereas this inquiry of course is only constrained by your terms of reference, which are expansive. The consequence of this is that I can only address certain elements of the broader and more complex system of drug regulation which you are considering, but this is not to downplay the contribution which the Coroners Court can make to your inquiry. Coroners are exposed every day to overdose deaths, motor vehicle collisions, drownings and other fatal consequences of drug use. Drug dependence is certainly a contributing factor in many deaths investigated by Victorian coroners, such as suicides and also family violence homicides.

The Victorian coroner's appreciation of the harm which drugs do in the Victorian community is acute. Consequently the court, through its research arm, the Coroners Prevention Unit, which is where Dr Dwyer works, has dedicated a great deal of effort to the question of how this harm can be reduced. As an overview of the material within my submission, the effort put in by the Coroners Prevention Unit, on behalf of the court, is reflected in the 128 recommendations across 49 findings that Victorian coroners have made so far under the 2008 act, and they address issues related to drug harm reduction.

The text of these recommendations is found in attachment 1 to my submission, and it is the actual text of the particular recommendations made by each of those coroners in chronological order and gathered by theme. What happened was the Coroners Prevention Unit, under my instruction, gathered together all of the recommendations which it considered might be of relevance to your committee without being prescriptive in any way. So it may well be that there are recommendations there which you do not find useful, but we have decided to err on the side of supplying more information rather than less, but grouped into themes so that you can easily decide where to put your focus.

The effort put in by the Coroners Prevention Unit is also reflected in the range of data which the court has gathered so that it might better understand the prevalence of different types of drug harm amongst the deaths which the court investigates. Attachment 2 to my submission provides an overview of patterns and trends in Victorian overdose deaths across the period 2009 to 2016. I might say, and I am obviously happy to discuss this in further detail, some of the patterns and trends which you will see are quite surprising and probably would be quite surprising to members of the community but not people who work in the sector. And that, for instance, includes the prevalence of benzodiazepines and other pharmaceutical drugs in overdose deaths. People think immediately that overdose deaths arise, for instance, from heroin or methamphetamine or other illegal drugs, but an alarming number of overdose deaths see pharmaceutical or prescription drugs involved and, principally, benzodiazepines.

Attachment 3 describes the prevalence of drug dependence and its intersection with mental illness, which of course Mr Ryan also touched on, and that occurs across overdose deaths, suicide and family violence homicide.

Looking at the key themes in my submission, I acknowledge that the material which has been provided to the committee is extensive and very, very detailed. Please do not be put off; I am happy to discuss it further with you today. For the purposes of assisting the committee to understand the key areas of focus, I will now summarise the key issues raised in that submission to this inquiry and the five most important themes in my view.

The first is real-time prescription monitoring. Table 1 in attachment 2 — and feel free to turn to this, but you do not need to — shows that around 70 per cent of Victorian overdose deaths each year involve multiple drugs not just a single drug. Table 2 shows that the most frequent contributing drugs are pharmaceutical drugs not illegal drugs or alcohol. Pharmaceutical drugs contribute to around 80 per cent of overdose deaths each year — 80 per cent of overdose deaths! A study of 838 overdose deaths involving pharmaceutical drugs found that the vast majority of these drugs were prescribed to the deceased rather than diverted or purchased over the counter or imported via the internet; that is, most of these drugs were obtained legitimately through the existing health system by the person who died from their toxic effects.

From the perspective of Victorian coroners, the most pressing issue is to identify any opportunity to support safe, clinical, appropriate prescribing and dispensing of pharmaceutical drugs. As is evident from attachment 1 to my submission, coroners have identified that the best way to achieve this is through the implementation of a real-time prescription monitoring system. I want to make two points concerning these recommendations.

Firstly, real-time description monitoring systems are usually promoted as a way of tackling the issue of so-called doctor shopping, where a patient attends multiple doctors to obtain excessive amounts of addictive drugs without telling each doctor about the others. Indeed the early coronial recommendations in support of real-time description monitoring emerged from investigations of doctor shopping-related overdose deaths. But over the past two years it has become increasingly clear that doctor shopping is only part of the larger issue — namely, poor coordination of care between medical practitioners. Some doctors are unable to coordinate their care because they do not know about one another, and that is the classic doctor shopping scenario. But in other instances the doctors know that their patient is seeing one or more other doctors but do not know what those other practitioners are prescribing or why. This can lead to fatal outcomes. The use of the term ‘doctor shopping’ tends to blame the patient for their actions. The term ‘coordination of care’ helps to focus our attention on much-needed improvement in the health system, which is where the prevention focus should be.

Secondly, there is a perception that with the Victorian government having announced that it will implement a real-time prescription monitoring system next financial year the issue has been dealt with, but in fact it has not. Still outstanding is the question of what drugs will be monitored, and that is an extremely important question. When the system commences its operation, that must be resolved. The consistent position of Victorian coroners

is that all prescribed drugs must be captured by the system, because as shown in attachment 2, a huge range of drugs can be involved in fatal harm not just those drugs which are presently on schedule 8.

Theme number two, as I have mentioned earlier, is the role of benzodiazepines. While examining the topic of pharmaceutical drug-related harm it is important to draw particular attention to the risk of harm posed by benzodiazepines. At present benzodiazepines are the most frequent contributing pharmaceutical drug group in Victorian overdose deaths.

As shown in table 4b they are seldom fatally toxic by themselves, but they are highly addictive and they potentiate the effects of every other drug which depresses central nervous system function — so opioids and other benzodiazepines — often with fatal results. Of course that will include potentiating the effect of heroine, methamphetamine and other illegal street drugs.

The third issue is safe injecting facilities. On 20 February 2017 Coroner Hawkins handed down her findings into the death of Ms A, a young mother who fatally overdosed on heroin in a restaurant toilet in the City of Yarra. Coroner Hawkins made her findings following an exhaustive investigation that included a visit to the North Richmond area and receiving submissions from local alcohol and drug services, Victoria Police, the Department of Health and Human Services, Ambulance Victoria, local residents, traders and the City of Yarra. Coroner Hawkins also obtained expert evidence from three eminent experts in the field of drug harm reduction: Dr Alex Wodak, Professor Paul Dietze and Dr Marianne Jauncey. As was widely reported, Coroner Hawkins recommended that the Victorian Minister for Mental Health take steps to establish a safe injecting facility trial in the City of Yarra. The recommendation subsequently was incorporated into the terms of reference for another parliamentary inquiry, which is currently underway.

Less widely reported, though, was that Coroner Hawkins noted that a safe injecting facility by itself would not provide the whole solution to heroine-related harm seen in the City of Yarra. Coroner Hawkins also recommended an expansion in availability of Naloxone in the area together with a review of health services that support the area's injecting drug users. Pleasingly the court was notified last week that the Department of Health and Human Services has accepted both of these recommendations. Coroner Hawkins's finding reflected the fact that addressing drug harm in the Victorian community will require a range of strategies to be implemented at different levels. A single strategy or several uncoordinated strategies in isolation will not make a significant difference.

The fourth theme is the intersection between mental ill health and drug dependence. The complexities of the issues raised by the inquiry's terms of reference are brought into sharp relief by the coronial data on the intersection between mental ill health and drug dependence across fatal overdose, suicide and family violence homicide. The experience of Victorian coroners is that drug dependence and mental ill health often occur as dual diagnoses. Problems occur when, for example, one doctor provides opioid replacement therapy to a patient but refers the patient to other doctors for treatment of anxiety and depression. In this common scenario if any doctor changes a drug or dose provided to the patient but does not alert the other doctors involved in the patient's care, there is a potential for adverse drug interaction and overdose to occur. I would add to that observation something which was raised by the previous witness, and that is of course the area where patients are effectively shuttled between services — so they go for a drug or addiction treatment and are told, 'No, you have a mental health problem', and they attend for mental health intervention and are told, 'You need to get your drug addiction under control before we can help you'. So it is the coordination of care that is a theme that we see and that needs to be addressed as part of any solutions that are implemented.

The fifth theme is takeaway dosing and methadone maintenance therapy. A large number and range of coroners recommendations, which you will see in attachment 1 concerning methadone, particularly unsupervised or takeaway methadone dosing, might give the committee the impression that Victorian coroners are opposed to or do not support methadone maintenance therapy for treating opioid dependence, but nothing could be further from the truth. As Victorian coroners have repeatedly emphasised in their roles, methadone maintenance therapy plays a vital role in assisting opioid-dependent people to come to grips with their dependence in order to reduce their addiction and move on with their lives. But methadone is a very dangerous drug and coroners see many overdose deaths involving misuse of takeaway methadone. Tragically since 2010 these have included the deaths of seven children aged under 18, who overdosed on methadone that was not prescribed to them. The question which Victorian coroners have therefore been grappling with for the past decade is: how can the benefits of methadone maintenance therapy be maximised while its risks are minimised?

The Department of Health and Human Services has been very responsive to coroners' recommendations in this area, and last year it changed its policy on takeaway dosing to lower the number of takeaway doses which a patient could obtain from five doses to four doses per week. It is still too early to tell whether this measure will have a substantial impact on the number of methadone overdose deaths which occur annually, but through the Coroners Prevention Unit the court will continue to monitor the annual statistics concerning methadone overdose deaths in Victoria effectively to assess whether or not that change has made a significant impact.

In conclusion I would like to make an observation about the way in which the committee's inquiry ought to be approached in the view of the Coroners Court. Drug addiction is a public health issue. People who use drugs involved in the large number of overdose deaths which the Coroners Court sees every year face a daily battle against their compulsion to use those drugs and are at continued risk of death from their use. They include people from all walks of life, many of whom suffer from other issues, such as physical or mental ill health, unemployment and homelessness. Some come into contact with the criminal justice system as a result of their addiction. It is only when we as a society accept that addiction is a health issue that we are able to see more clearly what can and must be done to support drug users to reduce their risk of harm, and in the worst cases, their risk of death.

Thank you again for inviting me to address the public hearing. I will now be pleased to answer any questions that you might have.

The CHAIR — Thank you very much. Again, a lot of information was provided in your submission in regard to various coroners hearings and so on. The issue I want to tease out a little bit more — although you have covered a lot — is in terms of opioid replacement therapy and the problems associated with that. Could you just lead us through what might be the best practice as to the way forward in terms of opioid replacement.

Judge HINCHEY — Just to give the committee a brief overview of the development of the opioid replacement therapy policy — I will not go into all of the detail but give a summary of that — opioid replacement therapy, I might say, is universally accepted as being an appropriate treatment. When it was first introduced there was a limited number of takeaway doses that were available to patients who were accepted into the opioid replacement therapy program. The philosophy that underpinned the program was that it was supervised replacement therapy — supervised dosing — which was the appropriate measure. Recitation of that fact has been a theme in some of the coroners' recommendations, which you might have read.

What has developed is an acceptance of an entitlement by patients on opioid replacement therapy to have takeaway dosing if they gain the trust of their prescribing practitioner and effectively demonstrate that they can comply with the regime. Unfortunately takeaway dosing is what the Coroners Court sees as — not just sees as in perceives — and the evidence indicates is the source of the majority of methadone overdose deaths, whether the overdose death of the person to whom it was prescribed, or, really sadly, someone who gets hold of it, such as a child or other people. There is a secondary market where methadone takeaway doses are diverted for money, as gifts or for whatever reason. It is people who use methadone infrequently who often do overdose on it because they are not tolerant of the dose that is given to them.

What happened was when takeaway dosing was introduced, it was for a limited number of takeaway doses per week — initially two — and there were, by definition, restrictions, because there were only two doses allowed per week, on the number of consecutive doses that could be taken away. So the person on the methadone program still had to attend at a pharmacy and be supervised to a degree. Then there was in 2006 an increase in the number of takeaway doses that were legally allowed to be prescribed to a patient; that was increased to five, and there was no restriction on consecutive doses being given. At that point in time the overdose data for methadone overdose deaths had been steady at about 25 to 27 a year up until 2006. From the introduction of five takeaway doses per year in 2006 there was a steady increase in methadone overdose deaths — up to 75 deaths per year by 2012. It was in that context that coroners then began to make recommendations about the need to have another look at takeaway dosing, and that has in fact been done. It is the most recent change, which has reduced the number of takeaway doses from five down to four, but it is still too early to tell whether or not that will make a significant impact.

So this is the issue which needs to be balanced, because we understand why it is that people wish to have takeaway methadone. They wish to retain autonomy, they wish for their methadone participation not to interfere with employment opportunities and clearly to have as normal a life as possible, including not mixing with others who are drug addicts at the collection point for methadone. However, it does seem to Victorian coroners

who have made recommendations on this issue, and based on the evidence in the cases before them, that perhaps that regime of takeaway dosing is now being seen as an ‘as of right’ privilege for methadone users or people who are prescribed methadone, rather than being something that is a privilege that is extended to them because they have a need for the normalisation of their life. So perhaps what needs to occur is that the emphasis is more on whether or not they need the takeaway dosing, rather than that it just becomes something that happens as of right after a certain period of time. But again a recent measure has been taken. We do not have sufficient evidence at this point in time to say whether or not that has worked. Obviously we are hopeful that it will, but what we fear is that four doses, especially when it can still be consecutive and therefore stockpiling can be allowed — dose splitting, dose diversion — that that is a big issue.

The second issue in relation to takeaway dosing is secure storage, and at the moment that is a matter that is still to be addressed adequately in the view of Victorian coroners, because it is children getting hold of methadone, say, in the fridge which has led to some of the deaths.

Mr DIXON — Thanks, Judge. Your submission was really very meaty. It was just fantastic, so thanks for the amount of work that you and your staff have put into this. The real-time prescription monitoring system, can you just elaborate a little bit more on that, especially in terms of if you have a really coordinated system, does it not mean that it has to be national and that we are all sort of logged as individual citizens — our health records are out there, I suppose, in a way, in its purest form, or do we have to go that far? Can it still be effective without going that far?

Judge HINCHEY — I think what I need to do is of course to clarify the role the Coroners Court has. We can see through other examples of real-time prescription monitoring — for instance in Tasmania — the benefits that it brings to areas where it has been introduced. Even though clearly it is desirable — and there is a consensus amongst the sector who have given evidence about this measure and its success, its usefulness — that of course a national system would be desirable. But the situation is this: if it cannot be implemented nationally, in Victoria we can see the benefits that would be achieved by its introduction as a standalone system, as it was in Tasmania. There is much to be learned from Tasmania, and clearly the systems can be improved on. Every time a system is introduced, when you see it in operation you can always think of ways to make it function better. We do not tell lawmakers how to implement the recommendations that are made, but what we do is give them what we have gathered as the evidence for the efficacy of such measures, and it is then of course for the lawmakers to look at the myriad complex problems which attend the introduction of such a program.

Of course that is what is being evaluated now, and it is very pleasing that the commitment has been made to the introduction of real-time prescription monitoring. But of course the complexities of privacy and other issues that will emerge, such as the identification of a previously unknown population of people who are addicted to prescription drugs — with no doubt, all of those things will become issues, and it is in fact well recognised that it is a more complex thing than just saying, ‘Let’s have a computerised database’.

This goes back to my coordination of patient care point — it is far beyond just doctor shopping. This is about allowing doctors to prescribe to a patient knowing their full medical history, and that is what they are missing at the moment. Even in cases where we have had doctors who are clearly prescribing in a way which everybody agrees — and, I might add, even them by the time it gets to giving evidence — that was unacceptable, the fact is that they would have been better informed had they known. In one case I was looking at there were six other doctors prescribing. This was all benzodiazepines. Six other doctors were prescribing benzodiazepines on top of this one doctor who was an outlier. He was prescribing 50 or 100 tablets of diazepam a week to this patient, but there were six other doctors also prescribing various other benzodiazepines. Now, not one of them knew about any of the others.

So that is the first thing — coordinated patient care. Secondly there is the ability for pharmacists to know — even if the doctors know, there is the stopgap of the pharmacies also knowing that there are problems with prescribing or issues with prescribing and that they can see what other dispensing has gone on and from what other pharmacies.

The third thing is it may pick up mistakes. So if a pharmacist misreads a prescription it gives an opportunity to look back and see: what is the other prescriber, or if they cannot read the prescription and they can say, ‘Okay, well, I can see the history is that it’s actually this dose’. But it also allows the department an opportunity to identify statistically doctors who are prescribing outside the norms and allows them a chance to engage in early intervention and education, and Victorian coroners can see the benefits in all four of those measures.

Ms SULEYMAN — Thank you very much for your submission. It is just fascinating. My question is: you have spoken about the prescribed medication and illicit drugs. Is there in your opinion an issue with unprescribed medication that is purchased over the counter?

Judge HINCHEY — If I could just have a moment. Dr Dwyer has just very helpfully been able to tell me — he is a font of information, by the way — that apparently over-the-counter drugs are contributing factors in about 8 per cent of overdose deaths, so it is quite low by comparison. Having said that, of course taking into account that 70 per cent of overdose deaths involve multi-drug toxicity, in that 8 per cent of tests that drug — say, paracetamol — will be one of the drugs that is found in the toxicological analysis, and again other pharmaceutical drugs that are prescribed are likely to be found in about 70 per cent of those cases. So, say, 8 per cent of deaths, 70 per cent of that — so 6 per cent or something along those lines — will involve interaction or potentiation with legally prescribed pharmaceuticals, and 51 per cent of those deaths involve benzodiazepines, which is why I keep harping on about that.

Ms SULEYMAN — Yes, indeed. Thank you very much.

Mr TILLEY — Thanks, Your Honour. We certainly appreciate it. Coming from a career copper's background, it is pretty refreshing. Going on with the issues of toxicology and breaking down the statistical data and those types of things, is it identified where the deceased has alcohol, pharmaceutical and illicit drugs and is on methadone program, for example — through toxicology are we identifying significant further abuses when you have got that intervention through participating in an intervention program and then still continuing on with — —

Judge HINCHEY — Such as methadone?

Mr TILLEY — Yes.

Judge HINCHEY — Yes, that is true. Methadone is a contributing factor in numerous overdose deaths, and in most of those cases the source of the methadone has been identified as being through the opioid replacement therapy. But you are quite right. The statistic in attachment 2 — I will just find the right table. Once you understand how to read these tables they are actually very, very informative.

Ms PATTEN — They are wonderful.

Mr TILLEY — They are, yes.

Judge HINCHEY — We are looking at page 8 of 15. The total number of opioid deaths. It is the second part of that table. The total number of opioid-related deaths, I should say, is the figure in bold. Methadone is the second drug down. We have only got the figures from 2009, but if you were to look at them from the early 2000s, you would see a steady increase from 2006. You can see 50, 55, 72, 75, and then it stabilised about there. Have we got the table where we look at single drug versus multidrug for methadone?

Dr DWYER — That is table 5b.

Judge HINCHEY — Table 5b on page 9 sets out for each of the major drugs that have been found to be causally involved in an overdose death, whether or not they were the single drug or what percentage they were as part of the multidrug toxicity. You will see for methadone in the total sample 2009–2016 there were 526 overdose deaths of which methadone was a part. In only 9 per cent of cases was it the only drug, but in 90 per cent of cases it was part of a cocktail of drugs, if I could put it that way. This is the table by which you can work out what drugs are the drugs that are contributing to the multidrug deaths. Table 5b is continued over the page, and you will see there is only one drug which has a very high proportion of just being the only drug involved, and that is pentobarbitone, which of course is involved in people wishing to take their lives because of a fatal illness that they might be suffering, or at least that is anecdotally what we believe. Most other drugs are represented at quite low levels as just the single-drug contributor but at very high levels as part of a cocktail of drugs that might be taken.

Mr TILLEY — Your Honour, would you be aware of the replacement treatment of naltrexone implants?

Judge HINCHEY — Yes.

Mr TILLEY — Do you have any particular view, and joining with any toxicology, have there been incidents where naltrexone or a derivative appears in any deaths in the state of Victoria?

Judge HINCHEY — It is certainly not included in the statistics that we have provided. It is very low indeed, I am informed by Dr Dwyer. You might be aware, if you have read Coroner Hawkins's decision — and for those of you who perhaps have not had a chance to, I would be happy to supply the full text to you; it is also available on our website — Ms A was actually about to go onto naltrexone implant therapy. Her family were in the process of trying to raising the funds to do that for her. So she recognised that she had a problem. She was on that awful merry-go-round of heroin use, descending to the lowest point, resolving to try to get clean and then some other family or social crisis would beset her and she would start using again. Certainly the Coroners Court and the evidence indicates that naltrexone is a very useful drug for the reversal of heroin.

Naltrexone is of course a very useful replacement therapy. Had she had the opportunity to have that implant put in and had she had the funding to do it, she may well still be alive today.

Ms PATTEN — As always, fascinating data, and I would have to suggest that Dr Dwyer is more than a font. I think he is actually closer to a reservoir.

Judge HINCHEY — I agree.

Ms PATTEN — It was interesting the Penington Institute raised some issues around overdoses in rural areas and the significant increase in that. It is kind of reflected, I suppose, because it is small numbers in all those local areas; you do not see those numbers so much in the data. They noted that particularly middle-aged Victorian men were most at risk, and that the overdose deaths in rural Victoria had grown 57 per cent and the number of deaths had risen by 64 per cent. Have you seen that in your data? I am assuming that, looking at all the other data, it will be a mixture of benzodiazepine and other illegal drugs, or possibly out there it might not even be an illegal drug it may be benzos and an opioid.

Judge HINCHEY — What we need of course is a better way to compare the figures, because, as you say, in regional Victoria the numbers are quite low, so if you just look at a table that sets out the raw numbers, it is hard to compare, but if you look at it as a percentage by occurrence per 100 000 of population, what you can see is that in fact the annual rate of Victorian overdose deaths between 2009 and 2016 has been almost identical between the Melbourne metropolitan region and regional Victoria. Certainly the Coroners Court does not wish to detract from any party who submits to you that regional Victoria has an increasing illegal drug problem; that may well right. We are just looking at the raw statistics which talk about overdose drug deaths, and what we see is that for one reason or another, or from one source or another, the rate of overdose drug deaths in the regions is approximately similar to Melbourne metropolitan statistics.

The Coroners Court would say to the committee that it is perhaps not such a useful comparison to talk about region versus metro. What perhaps needs to be done is an even more detailed study because there is a vast variation between even Melbourne metro areas, say, the City of Yarra versus the city of — —

Ms PATTEN — Nillumbik or something.

Judge HINCHEY — Exactly. I was going to say Darebin, but that is actually one of the quite higher ones.

Ms PATTEN — No, it is quite high.

Judge HINCHEY — But Nillumbik is a good example. What you see also is that even if you look at the raw figures you might be tempted to say, 'Well, Yarra, Melbourne, Frankston and Port Phillip are all pretty similar', but if you convert that to the per 100 000 of the population, you will find that the City of Yarra is the outlier in terms of the occurrence of drug overdose deaths. So it is a better comparison to look at per 100 000 of population in terms of occurrence of drug overdose deaths, and that is when you see the really dramatic differences between council areas.

Ms PATTEN — Just following on from that, because I think we have been talking about the data and quite often how difficult it is to establish whether that is around the number of drug users in our society or, as you have done amazingly here, the drug-related deaths, I note that you have excluded some drug-related deaths, where they might be in car accidents. There are a couple of others, but I cannot find the piece of paper with that.

Judge HINCHEY — So the deaths that are excluded are where the drug was a secondary influence, if I could put that that way.

Ms PATTEN — So the smash might have killed them.

Judge HINCHEY — They might have died in a car accident under the influence of drugs, but it was not the cause of death. So this is again the kind of way — it is not an artificial way — where by virtue of our legislation we have to focus on what was the cause of the death. The cause of the death in a motor vehicle accident was the injuries suffered in the crash. The reasons or background circumstances may well have included drug taking or, for instance, someone may have committed suicide in the context of drug addiction but they may not have used drugs to end their life. So they are the types of deaths where, unless the figures frankly demonstrate drugs as a direct cause, those deaths are excluded. What that means, and I suppose it is something that the committee will be aware of, is that our statistics actually slightly underestimate the contribution of drugs to deaths in Victoria.

Ms PATTEN — That is right.

Judge HINCHEY — The other point I think worth making is that whilst our drug overdose death data is by reference to the Victorian population quite a small proportion of people, although it is an alarmingly high number — we think nearly 500 per year in recent years — by reference to the Victorian population of course it is a minuscule sample. I believe Turning Point are addressing you later today.

The CHAIR — They will be next up.

Judge HINCHEY — They will be able to confirm that the non-fatal drug overdose data in terms of its make-up and the contribution of particular drugs, mixed drug toxicity and all of those other issues that we have highlighted, is almost exactly reflected in the non-fatal overdose data as well. I am not saying you were considering thinking that we were quite a small proportion and therefore we could be ignored, but just to reassure you if you look at the people who did not die, the stats are about the same.

Ms PATTEN — That is interesting. I just wanted to judge whether you would agree that there would be some benefit in maybe some legislative reform, if required, to enable you to report on that drug-related death that may not have been the actual cause of death, because having that data would be beneficial to creating that big picture.

Judge HINCHEY — Yes. Certainly, for instance, in family violence homicides, there is a dedicated unit within our court which looks at that proportion of homicides that do have a family violence component. So that is the type of work that might usefully be able to be done where, as a secondary factor, you could note the involvement of drugs as a background feature of the person's presentation in life, and that certainly would be useful data to collect. It is not that it is not collected; it is just that as a matter of caution for compiling these statistics they were excluded so as not to ignite a debate about whether or not our statistics were accurate.

Mr THOMPSON — Your Honour, I appreciate your able researcher being a font or reservoir or an ocean of information in terms of its precision and the ability to formulate policy based upon exact data. I have a couple of questions. In terms of the City of Yarra deaths, are they calculated on the basis of place of death or place of residence at time of death?

Judge HINCHEY — It is place of death, as I understand it. I would just check that.

Dr DWYER — That is correct.

Judge HINCHEY — Yes. The statistics you have before you are place of death. Place of residence is also being looked at and the interesting feature of the City of Yarra is of course that it is well understood and acknowledged that people travel there to obtain the drugs and also tend to use the drugs once they are in the City of Yarra, so a lot of them do not take them home again.

Mr THOMPSON — Yes, I noted it. It can be a variable that is important, nevertheless, to take into account in terms of where they may have travelled from originally, where might be their place of residence when medical treatment might be appropriate. The second issue is: mental illness is described. What are the definitions of mental illness, and I am happy for that to be supplied in one sense whether it covers depression or whether there might be a bipolar disorder or schizophrenia. But I do have a question as to whether, from the

work of the coroner's office, there are any predictive factors pertaining to mental illness that might be described which might be able to be redressed, because it is a horrific correlation between mental illness and drug use, and whether that is subdivided to a particular category of mental health and wellness.

Judge HINCHEY — We include all categories of mental health that the committee might understand as rightly being included, so everything from anxiety and depression right up to other more severe forms of mental health such as schizophrenia, bipolar disorder.

Mr THOMPSON — I would be particularly interested in any further breakdown of that that might have some predictive elements.

Judge HINCHEY — Yes, certainly. We can supply that to the committee and would be pleased to do so. What I should say, and I think it is made plain in the submission, is that we have excluded mental health issues that have arisen as a result of the drug use, of course, so these are only statistics that relate to people who have had a diagnosed mental illness in conjunction with their drug use, not as a result of it. Of course there is a whole cohort of people who suffer from drug-induced psychosis and other related problems just as a result of the social effects that they experience through their drug use.

Mr EIDEH — On mental health, your submission highlights the role of the Victorian mental health system in reducing drug-related health, social and economic harm. Just briefly can you elaborate on this view?

Judge HINCHEY — It is part of the broader theme of taking a holistic approach to addressing drug-related harm, and that is recognising that most people — and I do not think I am overstating it when I say that — who end up suffering from a drug-related overdose, especially those we see at the court that result in death, have some other comorbidity, if I can put it that way. So the Coroners Court can, I think, usefully draw together those statistics to enable the committee to better understand that it is not a matter of saying, 'If we control consumption of methadone, we are going to solve this problem, or if we control consumption of heroin or methamphetamine, we are going to solve this problem'.

All of these issues are wrapped up together. I think Mr Ryan made the point very strongly as well that it is an approach to addressing health issues that needs to be taken rather than focusing on one area or the other and saying, 'This is the solution'. Not one of those things is the solution, but the difficult job for the committee, of course, is to make recommendations about how a suite of measures can be taken and best coordinated to have the greatest effect.

If I might just get one last plug in, in our view that would be the proper introducing of real-time prescription monitoring, especially including all drugs that are prescribed, and for the rescheduling of benzodiazepines to schedule 8. One drug in the benzodiazepine family, alprazolam, was rescheduled to schedule 8, and we saw an immediate drop in its participation in drug overdose deaths. Sadly what happened was that people just shifted to clonazepam. However, that illustrates two things: if you focus on one drug, you will not catch everybody, but the rescheduling, pleasingly, had the effect of an immediate elimination of alprazolam from the equation. I think that is a stunning statistic

The CHAIR — Thank you, Judge Hinchey. It has been very interesting to have both the information you have presented to us and then your discussion beyond that. I think you are aware of the procedure from here. You will get the notes from today in a couple of weeks for you to look over, and then they will go onto the public record. Thanks for your time.

Judge HINCHEY — Thank you very much. It was a great pleasure.

Witnesses withdrew.