

# TRANSCRIPT

## LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

### Inquiry into drug law reform

Melbourne — 21 August 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

Mr Sam Biondo, executive officer, and

Mr David Taylor, policy and media officer, Victorian Alcohol and Drug Association.

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

**The CHAIR** — David Taylor and Sam Biondo, both from the Victorian Alcohol and Drug Association, welcome to this hearing of the parliamentary Law Reform, Road and Community Safety Committee. As you are aware, we are looking at the issue of drug law reform. In a moment I will give you an opportunity to provide a bit of an overview of some of the issues you want to share with us and then we will follow up with some questions.

You will be aware that Hansard is recording all of our discussion and so in a couple of weeks you will get a draft of the discussion that we have had for you to just ensure that there are no technical errors made and that it represents the discussion we had, and then it will be part of the public record. I presume you understand the way the committee processes work. Thank you for your time today. We are pleased to get comments from you and we then we will flow on from there. I do not know who is going to speak first?

**Mr BIONDO** — I will start off. I would like to thank the committee for making the time available to listen to us. I suppose one of the benefits of coming towards the end of the process is that you have probably heard it all before and I will just be reiterating some elements of it —

**The CHAIR** — Possibly, yes.

**Mr BIONDO** — But you never know, I could throw in some surprises.

**The CHAIR** — That is right. You might.

**Mr BIONDO** — The Victorian Alcohol and Drug Association is a non-government peak organisation, which represents publicly funded Victorian AOD — alcohol and drug — services. We aim to support and promote strategies that prevent and reduce harms associated with alcohol and drug issues across Victoria.

There are probably six key points that I would like to make. The first is the current system of dealing with severely affected individuals with drug and alcohol issues is failing, and it is failing because of a lack of investment to address demand, a lack of appropriate policy implementation and the growing demands being placed on an overstretched and overburdened system. We think that a key driver of AOD policy development should be pragmatic and evidence-based policy. I emphasise ‘pragmatic’ because sometimes the things that get done do not necessarily work. They sound good to the public and they may sound good to make them acceptable, but they are not effective in the implementation for what they are seeking to achieve. If we can get to a much more pragmatic policy frame, it would be best for the individuals concerned and the community overall. However, I know how difficult it can be to try and push down a pragmatic road in legislative reform and program initiatives. Given the prevalence of at-risk polysubstance use in our review into AOD, alcohol and drug-related harms should provide for all substances including alcohol. Alcohol is still very much on everybody’s radar as a significant problem, and in terms of expense and harm it is way up there as probably one of the key health issues in our community.

I would like to also put in a plug for our system — that is, that treatment works, and better investment in the AOD treatment system works for both the individual affected and the broader community. Treatment is cost-effective and prevents far more expensive justice and acute health demand and costs. There is up to an \$8 return on investment for each \$1 spent on AOD treatment and a \$4 return on investment for each \$1 spent on, say, needle and syringe programs, so these are fairly effective programs and initiatives. So it is really important to address impediments to timely access to alcohol and drug treatment support. It is not good enough to say we have got a system in place; it is about the timeliness of access that can make a difference.

Today I will focus most of my formal comments on terms of reference 1. It is currently apparent that illicit substances — illegal highs — continue to be readily accessible despite a whole range of current laws and regulations that have been put in place to try to minimise supply and availability. This indicates a failure of the current policy setting and a failure to recognise that drug markets adapt to new legislation fairly quickly and that supply reduction measures are often not what was hoped to be. It does not emanate so we do not actually impact on reducing supply. The markets just adapt, so to understand alcohol and drugs in our community we need to understand displacement and what people go to next, and quite often it is a substance that is much worse than the original. We have seen this, say, with synthetic substances — the clamping down on one end just balloons it out in another area. As a result increased penalties associated with trafficking substances appear at this stage not to have had an impact on the increase in AOD-related harms afflicting our community. So increased penalties do very little in actually solving the problem — markets adapt. We have no end of disrupted supply but you see

adjustments in price. That makes it much more profitable to import and you see continued availability in the community.

We also know that certain program initiatives such as television advertising can actually work in a counterintuitive way and can lead to unintended consequences. We know that some advertising actually helps to promote the availability of some services. We have seen a burgeoning growth in unregulated private treatment providers across Victoria, and many of these are charging what I would consider to be exorbitant prices. People spend in the tens of thousands of dollars trying to gain access, often hacking into their superannuation or mortgages and taking out loans which are readily available off some of these providers' websites to set the whole thing up for their loved ones. It is a very vulnerable market and one that is easily tapped into by providers, and it is unregulated.

**Mr TAYLOR** — What triggers that really is that essentially because someone cannot get access to the funded treatment centre — and there are people who are desperate — they then rely on this for-profit unregulated sector and you really do not know what you are getting. So there is actually a fix for that.

**Mr BIONDO** — And we note through some of the research that was undertaken by NDARC — the National Drug and Alcohol Research Centre — in New South Wales there are at least 200 000 Australians who would be suitable to get into AOD treatment but cannot access the sector. There is greater demand in our sector from the forensic space — once again an area where legislative change has driven more people into prisons — and when people come out from prison they are none the better off quite often and there is a huge demand into our system for working with these individuals. We know that family violence is sending a lot of people in our direction. We know that child protection legislation is sending a lot of people in our direction, and so you start to see that a lot of the voluntary clients which traditionally get into our system are finding it harder and harder to get in unless they trip over and come back as much more complex.

The prison system itself is an interesting entity in that it is often enlarged to try to deal with people's issues and often creates greater problems than it is set up to achieve. We think that there should be an adoption of a bed-for-bed model approach of service funding for alcohol and drug residential services. What I mean by that is for every bed that gets built and put in a prison cell there should be availability of a bed in the community. Then we could start to get some real action happening.

**Ms PATTEN** — How big is the new jail?

**Mr BIONDO** — Rather than a prison-led recovery we could have a treatment-led recovery.

**Ms PATTEN** — That sounds more effective.

**Mr BIONDO** — Prisons have a high prevalence of AOD dependence, AOD-related harms as well such as bloodborne viruses and there is ample evidence around fatal overdose post release. There is a very clear need for a range of initiatives in the post-prison area and within prisons such as a NSP program within prisons to stop bloodborne viruses, the promotion and provision of naloxone to peers and family of prisoners on release — and greater availability for prisoners on release of opiate-replacement therapy would be of assistance. Also within prisons, while we do have alcohol and drug programs and a preponderance of group sessions, I think what might really be required is a look at a more efficacious one-on-one counselling approach rather than the things that may not necessarily work where you need to expose your issues in front of other prisoners, which can make you more vulnerable

I am nearly at the end. In responding to illicit substance use and harms we make the following suggestions: from a pragmatic point of view supervised injecting has a whole range of evidence around it. It should be considered. It would reduce fatal overdoses. It would reduce ambulance call-outs. It would increase referrals to services for very vulnerable individuals. It would approve local amenity through the reduction of publicly discarded injecting paraphernalia and public intravenous drug use, and we could implement this sort of strategy in those areas where there are pre-existing high levels of intravenous substance use.

We need to maximise the availability of training and access opportunities and extend programs in the area of naloxone. In some US states, as you may be aware, naloxone is made available with the prescription of opiate medications de rigeur. America is another country in more ways than one, but this sort of initiative has

probably saved thousands of lives. Our statistics on deaths from application of opiate-based medications is quite significant and is tracking US deaths, and it is quite clear that we need to take these sorts of initiatives as well.

We think that pill testing is clearly obvious. Providing pill-testing services at events and venues where pre-existing high-risk party drugs are consumed is likely to reduce deaths and provide a whole range of benefits. I note recently the Royal Society for Public Health in the UK has adopted a policy of promotion of pill testing across the UK, and I am more than happy to table this for you to consider.

**The CHAIR** — Thank you.

**Mr BIONDO** — We need to and we are doing work in Victoria on establishing a real-time prescription monitoring system. We think that that is a positive reform which will save many lives by preventing fatal and non-fatal overdoses, reduce dependence and improve prescribing practices, but only if we do it in the proper and appropriate way. We think a mandatory buy-in by doctors is critical. We think a mandatory buy-in by pharmacists is critical. They need to be in this. And we need S4 and S8 substances included, which I believe is the way that people are progressing.

We need to provide additional capacity for the downstream impact of the real-time prescription monitoring system across the community sector. We need to come to terms with pain management for an ageing population in our community given the availability of these substances which 10 years ago were not as widely available in Victoria. They were only used for cancer and now are generally available for all community members, which has created the spike in deaths. It is really important to increase the capacity to deal with the downstream impact. I reiterate that.

We would like to see a real-time drug database established, like in various other international jurisdictions, that maintains real-time information on hazardous substances determined by forensic labs, which are often operated by the police, or through pill testing if that were to occur. We can inform the public of what is happening in a timely manner rather than three days after a long weekend where three people have died.

**Mr TAYLOR** — And this is the public who are already using these substances. This is not new cohorts; it is pre-existing people who are using.

**Mr BIONDO** — We think that the new psychoactive substances bill and the increasing prohibition of substances highlights a fluidity in drug markets. Drug markets, as indicated before, are adaptable. They develop new and novel means of accessing at-risk substances. Substances are often more dangerous than what preceded them. Other jurisdictions which have implemented blanket bans have only experienced limited success. There are issues relating to the enforceability. The emergence of the dark web as a means of procuring substances has grown, and there is a transition to street-based illicit substances that can result from those sorts of reforms. So while well intentioned, the outcome can be much more negative.

We think, while we are in this conversation, everything should be on the table. We need to look at what works. This is not a policy from where I come from; it is just something I was thinking. But we need to consider at some point a regulated supply of injectable heroin. Consideration should be given to establishment of a range of this and other measures which would work. For a particularly difficult cohort of individuals who do not respond to standard treatment, such as oral methadone maintenance or residential rehab, this could be a lifesaver. From the research available, of which there is a growing amount now, it would appear that such an approach improves treatment outcomes for these very unhealthy and persistent drug users who have no other means of successfully staying alive in the long run.

**Mr TAYLOR** — The paper there, which reflects on six trials —

**The CHAIR** — This is heroin-assisted treatments?

**Mr TAYLOR** — This is heroin-assisted treatments. It discusses those populations where they have not had too much luck with standard treatment approaches — resi-rehab or with pharmacotherapy, and better results are achieved through this. So again Sam is talking about pragmatic policy. It is evidence out there. It is something which, I think, we need to consider in discussions going forward to see if it is something which can fit. There is obviously a lot of discussion about these sorts of harms currently.

**Mr BIONDO** — Thank you for listening.

**The CHAIR** — Thanks, Sam, thanks, David. Moving on to questions then. Could I just start. You are a peak body for a range of groups. We had, for example, ReGen here this morning — the Uniting Church.

**Mr BIONDO** — They are a member.

**The CHAIR** — They are a member. I am just trying to get a sense of how broad your membership is.

**Mr BIONDO** — The majority of our members are publicly funded alcohol and drug treatment services.

**The CHAIR** — So you have got most of the publicly funded drug and alcohol support sector?

**Mr BIONDO** — Yes, correct. There is a smattering of other members from a range of other people that agree with our principles and statement of purpose. We have individuals, we have organisations.

**The CHAIR** — I was just trying to get a clearer understanding of how broad your representation was on that score. You have covered a broad range of issues of course in this area, but the prisons is one that I was interested to focus on in my question. You have talked about how we could perhaps improve support for prisoners who might have drug issues one on one. Could you just expand upon some of the other things we could do in prisons overall?

**Mr BIONDO** — Provision of naloxone post-release is an easy one. We can inform prisoners while they are there. We can inform them on release. We can make it available to them and their families, and I think that there would be an appreciable benefit to the community by doing so. It would reduce what I think is a terrible waste of life post release, and we could be exploring that one a lot further. While there is a lot of conversation around justice reinvestment, we should be exploring the benefits of this. We know that a lot of prisoners come from a select group of postcodes. We know that a lot of prisoners have had terrible educational experiences or family experiences, so focusing down on some of those areas can actually at some point create greater benefits.

The prison system has become a holding pen for those with a mental illness and alcohol and drug issues. It is, I think, a stain on our community if that is the only solution we have got available to them. It is bad enough that we have got people with acquired brain injuries, who in many ways are innocent because they have got a brain injury, and that becomes the place where we put people. That is bad enough. But people with mental health and AOD issues that could be treated in other environments is really concerning, and there are solutions available in that space.

**Mr TAYLOR** — We have had a change in dynamic in the prison system in that there are a lot more people on bail. There are a lot less people getting parole and there is a lot more people getting straight releases without the support of the parole system. For those people, if they are released on pharmacotherapy, there is no support offered to their families with regard to naloxone or for their peers. That will engender a greater risk in light of the increasing prison population and the recidivism rate remaining at around 44 per cent. Forty-four per cent of 7000 is a lot higher than 44 per cent of 2000 or 3000 as it would have been 10 years ago.

For those facing straight release, for instance, without the support of parole, consideration could be given to Corrections arranging training to family, peers and friends on the use of naloxone prior to the person getting out. Because once the prisoner has walked out the door, the corrections system ceases having activity or responsibility. It needs to be that sort of pragmatic planning going forward. We know that there is already some work done with regard to pharmacotherapy, where they get free doses initially upon release, which is really positive, but certainly more can be done there. There is nowhere where this does not occur. The overdose and the fatality rate post release within the first four to six weeks is incredibly high. It is also incredibly preventable, so we do need to think about these sorts of things.

**Mr DIXON** — I was going to talk to you about private residential treatment facilities, and you have brought it up. But just to drill down a little further, what sort of regulation do you think is needed? What should we do to control this and regulate it?

**Mr BIONDO** — We do not necessarily have an accreditation or regulation system in Victoria. There are other jurisdictions, such as New Zealand and places like California that we briefly looked at, where there are certain standards that people need to meet. There is a body that maintains the standards and that sort of thing. Then there are certain criteria that agencies need to meet in terms of quality. Most of our agencies in Victoria have got quality standards. We do not know whether these private organisations have got quality standards.

Those that are a part of hospital systems or in receipt of medical benefits et cetera would be probably to a higher standard. The qualifications of the individuals that go in to support the work — we are not sure. At least with the public system you get a fair smattering of supervision and negotiation and contact with the health department, and there is regular self-maintenance as well as oversight agencies amongst others, which has lifted the public standard up.

**Mr DIXON** — Are there any jurisdictions in Australia that regulate the area at all?

**Mr BIONDO** — To my knowledge, no. I think Victoria would be one of the forerunners in terms of having minimum qualifications at least, which is a cert IV. We know in our sector that many have got postgraduate degrees. There have been recent surveys undertaken that highlight the level of other academic attainment. We have a large forensic system but we do not have forensic accreditation system, so it is all a bit ad hoc.

**Ms SULEYMAN** — I am just interested to know your opinion on the decriminalisation of illicit drugs.

**Mr BIONDO** — If you look at a place like Portugal, you can see the positive impacts it has had. There are any number of statistics, and I was just looking at some yesterday — I cannot run them out of the back of my head like David does — but the positive impact for the individuals and the community is of lasting benefit. That is pragmatic policy. That is among the sort of things we should be considering. If you look at the number of deaths per capita, which is one statistic I do remember, I think it is 43 times higher per capita in Victoria than in Portugal. If you look at it on a per capita basis of the number of ODs arising from heroin, it is 43 times.

**Mr TAYLOR** — That is actually across the board I think.

**Ms PATTEN** — I think there were 44 deaths in Portugal from an overdose last year.

**Mr BIONDO** — We had 34 in Richmond alone.

**Ms SULEYMAN** — Just a final question, in this year's announcement in this year's budget \$80 million was allocated towards alcohol treatment and other drugs, and also 30 rehab beds, treatment and counselling for families and victims and Victorian parents — 3800 or so, approximately. In your opinion do you think that is a sufficient amount of resources, or what is your view in relation to that particular announcement — the \$80 million?

**Mr BIONDO** — My view is that it is very much welcomed. It is a very positive step in the right direction. However, if you look at the enormity of the problem, if you look at alcohol alone, I might be wrong with the figures but the quantum is at like \$7 billion in tax and something like \$36 billion in damage. Our sector in Victoria might have a total of \$220 million or something to deal with its proportion of this monstrous problem. You look at policing systems and prison systems and the billions that get put into that area to deal with the consequences of these problems, and you look at the up-front investment in the prevention and the treatment side of it, it is minuscule. If you look at the numbers that go into our emergency departments and the enormous expense spent there and the revolving door sending them back in the community because the step-up and step-down capacity does not exist to link to hospitals to deal with people who have got an alcohol or drug problem — there is another question there: why isn't it? But there needs to be that sort of investment. Yes, the investment is welcomed, but it is a stepping stone.

**The CHAIR** — Bill, do you have any questions?

**Mr TILLEY** — No, I think my colleagues have covered it.

**Ms PATTEN** — Thank you, and following on because I know you did put in a budget submission, I just did not look at it before coming here, so following on from that question, how much do you think we do need to spend? So we have announced an extra \$80 million. What sort of figure do you think is required?

**Mr BIONDO** — I think the answers for this might lie in some of the work that was done in the Horizons report by Alison Ritter and the NDARC in New South Wales, the University of New South Wales. She has come up with some sort of formulation per 100 000 — what you would need. I do not know if —

**Ms PATTEN** — That is fine; we can go back and look at that. David, do you reckon you could send us a link to that?

**Mr TAYLOR** — I will find it.

**Ms PATTEN** — Just following on from that, in your submission on page 5 you talk about:

Despite the breadth of evidence indicating the health, financial and social benefits of AOD treatment, research indicates that, across Australia, the sector would need to provide for 200 000 to 500 000 individuals —

to meet demand. I think that is probably from that Horizons report.

**Mr TAYLOR** — Yes, it is from the Horizons report.

**Ms PATTEN** — Could you just clarify what that is saying — that what we are looking at is that nationally there were 38 000 people put in hospital for alcohol and other drugs, which came up to about 300 000 bed days.

**Mr TAYLOR** — That is a separate AHW report which cited that figure which was quite high. There is a separate AHW report into alcohol and drug treatment which indicates I think somewhere maybe a touch north of 30 000 people in Victoria engaged in a treatment system. That might equate to 50 000-plus treatment episodes. I can check the data and get the exact figures to you — the most recent.

So when you think about 30 000 engaging in the system and there are at least, according to Ritter, 200 000 across the nation not getting access to treatment who would be clinically defined as requiring it, we have got up approximately a quarter of the nation's population here. The rough maths on that tells a pretty dire story.

**Ms PATTEN** — Could you just say that again, David?

**Mr TAYLOR** — According to the AHW, the Australian Institute of Health and Welfare, there are around 30 000 people — and I can get the exact figures — engaging in the Victorian treatment system each financial year or the last financial year. According to Alison Ritter, there are between 200 000 and 500 000 people across the country who will be clinically in need of treatment but do not access the system. Maybe they do not access it because they cannot get in; maybe they do not access it because they do not think they need it. There could be a whole range of reasons why people do not access, and of course it is people's choice.

But given that Victoria is getting 30 000 people in our system — Victoria is about a quarter of the nation's population, a touch under — and if you think about that 200 000 which Ritter says are not accessing the treatment system, there is going to be somewhere around 50 000 in Victoria. So I guess that gives some sort of size of the scope with regard to what the system demand is, our capacity and also probably what we need to do to make sure that we are more accessible as well.

Then we need to start thinking about pending reforms, such as the real-time prescription monitoring, an unknown amount of people who may well be facing pharmaceutical problems, the strain that will put onto pharmacotherapy, the strain that could put on the treatment sector; these are unknowns. There is a range of those things going forward, and the real-time prescription monitoring system is a good reform but it needs to be done really well.

**Ms PATTEN** — But you are right because it may actually lead to more and more people entering into treatment.

**Mr TAYLOR** — Greater wait times and then it is another advertorial for the unregulated private sector.

**Ms PATTEN** — Or the illicit drug market.

**Mr TAYLOR** — Well, yes. Drug populations, as Sam said, are fluid, they shift, they adapt very well.

**Mr BIONDO** — It would be extremely concerning if we saw the same sort of shift that has occurred in New York and other places where people are medically prescribed opiate medication and move onto heroin.

**Ms PATTEN** — Have you had many reports of fentanyl coming into the market from your members?

**Mr BIONDO** — Not that it has been raised.

**Ms PATTEN** — No.

**Mr TAYLOR** — Just what we have seen in the past.

**Mr BIONDO** — There have been spates where fentanyl was being distilled down from patches and patches were being obtained from rubbish bins; we have heard of that. The evidence around the mixing of fentanyl with heroin or other substances is highly anecdotal to me, though I have heard of it.

**Ms PATTEN** — Yes. We saw a lot of it in Vancouver.

**Mr BIONDO** — Vancouver is in an exceptional situation at the moment.

**The CHAIR** — You made some comments about the new psychoactive substance legislation — that you welcome the concept — but I did not know whether you had any suggestions of ways you would like to see it improved. Are there issues that the government should consider in that space?

**Mr BIONDO** — I will make a couple of comments. I thought New Zealand was trying something quite novel and probably courageous in one sense which unfortunately, as I understand it, got caught up in politics subsequently.

**The CHAIR** — Animal testing, yes.

**Mr BIONDO** — So if the attempt is ‘Well, people are going to use this substance; Let’s try and put some regulation around it so that people can still access it’, that is a big risk but you keep the market at that level. If you try and clamp down on the market and make something illegal and non-obtainable, then you actually displace it to something else or something that is not regulated — another new substance — and people will chase that.

The way I understand the New Zealand’s circumstance is that it kept the availability for the general public in terms of these sorts of substances. It did not mean that you could not get something else which might have been more dangerous but most of the attention focused on what was available and you had reduced harm, so it was a harm reduction measure. Courageous to do but with possibly some positive benefits for the community.

**The CHAIR** — You never tell government about being courageous, do you?

**Mr BIONDO** — Yes, okay, I take your point.

**The CHAIR** — A number of these issues, as you are aware, Sam and David, have generally been covered but it is certainly useful to hear it from you as well as others that we have heard it from. Thank you very much.

**Mr BIONDO** — Thank you, and thanks for the opportunity.

**Mr THOMPSON** — Can I just place on record the great work done by Sam Biondo a number of years ago when he was working with the Victorian legal service. He has been a keen contributor to parliamentary inquiries and great outcomes have been achieved through his work.

**The CHAIR** — Very good. He seemed at home. That is good: sharing your knowledge and your learnings as you have gone along is great. Thank you.

**Witnesses withdrew.**