



PARLIAMENT OF VICTORIA

Legislative Council

Legal and Social Issues Committee

Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

Parliament of Victoria
Legal and Social Issues Committee

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Committee functions

The Legal and Social Issues Committee (Legislation and References) is established under the Legislative Council Standing Orders Chapter 23 – Council Committees, and Sessional Orders.

The committee's functions are to inquire into and report on any proposal, matter or thing concerned with community services, gaming, health, law and justice, and the coordination of government.

The Legal and Social Issues Committee (References) may inquire into, hold public hearings, consider and report on other matters that are relevant to its functions.

The Legal and Social Issues Committee (Legislation) may inquire into, hold public hearings, consider and report on any Bills or draft Bills referred by the Legislative Council, annual reports, estimates of expenditure or other documents laid before the Legislative Council in accordance with an Act, provided these are relevant to its functions.

Government Departments allocated for oversight:

- Department of Health and Human Services
- Department of Justice and Regulation
- Department of Premier and Cabinet

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This report is available on the Committee's website.

Contents

Preliminaries	
Committee functions	ii
Committee membership	iii
Committee staff	iv
Terms of reference	ix
Chair’s foreword	xi
Findings	xv
1 The Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017	1
1.1 Overview of the Bill	1
1.2 Provisions of the Bill	1
1.2.1 Division 1 – Preliminary	1
1.2.2 Division 2 – Licensing of injecting centres	2
1.2.3 Division 3 – Internal management protocols	3
1.2.4 Division 4 – Exemptions from liability	3
1.3 Scrutiny of Acts and Regulations Committee	4
1.4 The views of stakeholders regarding the Bill	5
1.4.1 North Richmond Community Health	5
1.4.2 The Australian Medical Association Victoria	5
1.4.3 The Penington Institute	5
1.4.4 Victoria Police	6
1.5 Comparison with Sydney MSIC legislation	6
1.5.1 Objectives of the Bill	6
1.5.2 Restrictions on the issue of licence	7
1.5.3 Internal management protocols	8
2 Drugs in Victoria and North Richmond	9
2.1 Drug overdose deaths in Victoria	9
2.1.1 Drug overdose deaths by local government area	11
2.2 Concerns about drug-related activity in North Richmond	13
2.2.1 Roundtable discussion with key agencies and service providers	16
2.2.2 Roundtable discussion with the Victoria Street Business Association and representatives of the Vietnamese Community in Victoria	17
2.2.3 Local residents in North Richmond	17
2.2.4 Emergency services providers	19
2.3 Services currently available to intravenous drug users in the City of Yarra	21
2.3.1 Needle and syringe programs (NSPs)	21
2.3.2 Naloxone programs in North Richmond	22
2.3.3 Other service providers	24
2.3.4 Statewide	25

3	Coroner Hawkins' Inquest into the death of Ms A	27
3.1	The Inquest	27
3.1.1	The Report	28
3.2	Coroner Hawkins' Recommendations	29
3.2.1	A trial of an MSIC in North Richmond	29
3.2.2	Expansion of naloxone distribution and education	29
3.2.3	Review of drug treatment programs	30
3.3	Evidence from the State Coroner	30
3.4	Inquest by Coroner McNamara	31
4	Medically supervised injecting centres	33
4.1	Overview of MSICs	33
4.2	Aims and objectives	34
4.2.1	Services offered	34
4.2.2	MSIC models	34
4.2.3	Ideal requirements for an MSIC	35
4.2.4	Location	36
4.3	North Richmond as a location for an MSIC	37
4.4	Previous attempts to establish an MSIC in Victoria	38
4.5	Evaluations of MSICs and DCRs in Europe	39
4.5.1	Overdose mortality and morbidity	39
4.5.2	Injecting risk behaviours	40
4.5.3	EMCDDA Review	40
4.6	Evaluation of the MSIC in Sydney	40
4.7	The views of submitters and stakeholders	42
5	International, national and state drug policy	47
5.1	Drug policy and reform	47
5.1.1	International drug policy – United Nations treaties	47
5.1.2	The Australian drug policy framework	48
5.1.3	Evaluation of previous strategies	49
5.1.4	Harm reduction strategies	50
5.1.5	Criticisms of the concept of harm reduction	50
6	Policing policy	53
6.1	Introduction	53
6.2	Commonwealth drug laws	53
6.2.1	Commonwealth <i>Criminal Code Act 1995</i>	54
6.3	Victorian drug laws	54
6.3.1	Trafficking	54
6.3.2	Possession	55
6.3.3	Use	56
6.4	Local policing – Victoria Police strategies	56
6.5	Police in Kings Cross	58

Appendices	
1 Submissions	59
2 Public hearings	61
Extracts of proceedings	63
Minority Reports	65

Terms of reference

Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

On 22 February 2017, the Legislative Council agreed to the following motion:

That this Bill be referred to the Legal and Social Issues Committee for report, no later than 5 September 2017, on a review and consideration of the —

1. recommendations in Coroner Hawkins' Finding – Inquest into the Death of Ms A, delivered on 20 February 2017 and other relevant reports;
2. nature and extent of current, relevant regulations;
3. and nature and extent of associated, relevant policing policy.

Chair's foreword

On 22 February 2017, the Legislative Council referred the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 (“the Bill”) to the Legal and Social Issues Committee for review. The Committee was directed to consider recommendations in Coroner Hawkins’ Finding – Inquest into the Death of Ms A, which was delivered only a few days before the referral, and other relevant reports. It was also required to examine the nature and extent of current and relevant regulations and the nature and extent of associated, relevant policing authority.

The Bill proposes an 18-month trial of a medically supervised injecting centre at an unspecified location in North Richmond, and is a response to the escalating and open sale and use of illicit drugs in that area. This parliamentary inquiry has arguably become the most obvious activity at state government level in response to a situation that is clearly intolerable for many who live and work in North Richmond.

The Committee received evidence of support for a supervised injecting centre trial in North Richmond, including from residents and North Richmond Community Health, as well as from other individuals and organisations who are not local. We also heard from those who oppose an injecting centre trial in North Richmond, most notably local traders as well as some residents.

Those who advocate for a supervised injecting centre in North Richmond say it will save lives and improve local safety and amenity. Those who oppose a supervised injecting centre in North Richmond argue that it will entrench the drug culture in North Richmond and the negative impacts that accompany this.

The Committee invited submissions and conducted one public hearing. It considered existing literature on supervised injecting centres, and key aspects of this are incorporated into Chapter 4 as context and background about supervised injecting centres in other jurisdictions. Similarly, Chapter 5 summarises international, national and state drug policy.

The Committee visited Australia’s only supervised injecting centre in Kings Cross and met with its staff and local police. The Committee also visited North Richmond, where we took part in a roundtable discussion with staff and other stakeholders at the North Richmond Community Health Centre, and another roundtable discussion with the Victoria Street Business Association and representatives of the Vietnamese community. We also walked through streets and laneways in the area to see conditions for ourselves. Along the way, we encountered a number of residents and spoke with them about their experiences and views. The anecdotal feedback we received from the people we met along the way was frank and compelling.

The Committee is grateful for a short submission from Victoria Police which included useful CAD data, general information on policing and specific comment about policing in North Richmond. The Victoria Police submission did not endorse or oppose a supervised injecting centre in North Richmond but offered comment on aspects of a trial if one were undertaken. We did not meet with local police during our site visit to North Richmond, nor did we see any uniformed police in the area.

Evidence confirmed that the open trade and use of illicit drugs in North Richmond is creating a dangerous, unpleasant and intolerable situation for many residents, local traders and local health care providers. Residents and staff of North Richmond Community Health are at the frontline: cleaning up the detritus of rampant drug use, helping people who are heavily affected by drugs and, most disturbing of all, responding to overdoses and deaths in local streets. There is also a significant burden on emergency services, including first responders from Ambulance Victoria, Victoria Police and the MFB.

This report makes a series of findings about the Bill, and compares it to the equivalent legislation in New South Wales, which is the *Drug Summit Legislative Response Act 1999* ("the Act"). While the Bill largely replicates the Act, we note several differences and these are explored in Chapter 1.

In particular, the Act includes a requirement for the supervised injecting centre to have a sufficient level of community and local government acceptance, and that the location of the centre must have regard for its visibility from the street and its proximity to schools, child care centres and community centres. The Bill does not include requirements of this kind.

As put in evidence to the inquiry, there is a marked difference between Kings Cross and North Richmond; unlike North Richmond, Kings Cross has been a red light district for decades. Yet North Richmond is the epicentre of heroin overdose deaths in the City of Yarra, the local government area with the highest frequency of heroin overdose deaths in Victoria for the past seven years, as well as that with the highest frequency of heroin-related ambulance attendances.

The Committee believes that the views of the community, all stakeholders and local government must be considered when deciding matters relating to a supervised injecting centre. The Committee was not set the task of confirming the level of local support and had practical restrictions on its capacity to do so definitively. One of the most contentious issues for the Committee was reaching a shared understanding of the level of support for a supervised injecting centre in North Richmond; the list of submissions confirms that while most were in favour of a trial, these were from organisations from outside North Richmond.

The inquiry also found there is a shortage of doctors and chemists dispensing methadone in North Richmond and a shortage of drug rehabilitation beds across Victoria. The cost of over-the-counter naloxone was described to the Committee as prohibitive for many who may need it locally.

I thank my colleagues on the Committee for working together to deliver this report. I also wish to record my thanks, and that of the Committee, to the secretariat staff who ably and helpfully supported the Committee in conducting the inquiry and in the production of this report: Mr Patrick O'Brien, Mr Kieran Crowe, Mr Pete Johnston and Mrs Prue Purdey.

A handwritten signature in black ink, appearing to read 'Margaret Fitzherbert', with a horizontal line underneath.

Margaret Fitzherbert MLC
Chair

Findings

1 The Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

FINDING 1: The Victorian Bill proposes an 18-month trial of an MSIC in North Richmond. It does not specify a street or location. The MSIC’s licence would only continue if the centre were to satisfy a review determining whether the trial met its objectives. 4

FINDING 2: It is appropriate that an MSIC is supervised by a medical practitioner during operating hours. 5

FINDING 3: The objectives of the Bill reflect the health and community harms associated with intravenous drug use. The inclusion of these objectives provides a clear framework for an assessment of a trial. 7

FINDING 4: The views of the community, all stakeholders and local government must be considered when deciding matters relating to an MSIC. 7

FINDING 5: Both the NSW Act and the Victorian Bill require health professionals to form part of the MSIC staff. In addition, the Victorian Bill requires mental health services to be provided. 8

2 Drugs in Victoria and North Richmond

FINDING 6: Drug use in North Richmond has reached crisis level. It is a major concern for residents, business owners and emergency services. 21

FINDING 7: There is a shortage of doctors and chemists dispensing methadone in North Richmond and a shortage of drug rehabilitation beds across Victoria. 25

4 Medically supervised injecting centres

FINDING 8: MSICs improve the health of injecting drug users and reduce signs of drug use in surrounding streets. 40

FINDING 9: Evaluations of the MSIC in Sydney found evidence of public amenity benefits to the local community and reduced demand for ambulance services. The evaluations did not find evidence of the MSIC having a ‘honey pot’ effect on crime. . . . 42

FINDING 10: 46 of 49 submissions in this Inquiry, of which three were from local residents, support a trial of an MSIC in North Richmond. 45

5 International, national and state drug policy

FINDING 11: Harm reduction strategies based on public health principles, such as needle and syringe programs, do not contravene international conventions. **48**

1 The Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

1.1 Overview of the Bill

The Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 (the Bill) seeks to amend the *Drugs, Poisons and Controlled Substances Act 1981* (the Principal Act), to provide for the licencing and operation of a medically supervised injecting centre (MSIC) for a trial period of 18 months. It seeks to do this by inserting a new part: VIAB (the part), into the Principal Act.

1.2 Provisions of the Bill

1.2.1 Division 1 – Preliminary

Division 1 outlines the definitions of the terms used in the Bill, the objectives of the Bill, arrangements for a review into the proposed MSIC and the expiry of the part at the end of the trial period.

The terms used in the Bill are defined under Section 98A. This includes a definition of ‘responsible authority’, the administrators who would have ultimate authority over the licenced injecting centre. These administrators would be ‘the Secretary’ and the Chief Commissioner of Police. The Bill does not provide further definition of who the Secretary should be. Presumably, this would be the Secretary of a Victorian Government agency. However, the sponsor of the Bill, Ms Fiona Patten MLC, indicated in the Bill’s second reading speech that the Secretary of the Department of Health and Human Services would be the responsible authority in conjunction with the Chief Commissioner of Police.

The limited operation of the Bill is outlined in Section 98B. It allows the responsible authority to issue one licence for an MSIC in one location for a trial period of 18 months.

The objectives of the Bill are outlined in Section 98C. They are:

- To reduce the number of deaths from drug overdoses

- To provide a gateway to health and social assistance for clients of the injecting centre, including drug treatment, health care and counselling
- To reduce drug overdose-related ambulance attendances
- To reduce the number of discarded needles and syringes and the incidence of drug injecting in public places
- To improve the amenity of the neighbourhood for residents and traders in the vicinity of the licenced injecting centre
- To assist in reducing the spread of blood borne diseases, including but not limited to HIV infection and hepatitis C.

A requirement to collect data and conduct ongoing reviews is outlined in Section 98D. This section requires the collection of data to conduct a review of the MSIC to determine if the trial meets the objectives. The review would determine what, if any, amendments should be made to the part, with a view to informing legislation mandating a permanent centre. The Bill requires the collection of data for the review to commence six months after the trial begins and be tabled in both houses of the Victorian Parliament upon completion.

Section 98E provides for the expiry of the part at the end of the trial period.

1.2.2 Division 2 – Licensing of injecting centres

Division 2 of the Bill deals with the licencing of an MSIC. It permits the issuing of a licence, outlines the restrictions and conditions on the licence as well as penalties for contravention of the conditions.

The restrictions on the licence are outlined in Section 98G. The licence can only be issued if the responsible authority determines that internal management protocols are satisfactory and the premises suitable for an injecting centre, having regard for public health and safety. Any building works must comply with the Building Code of Australia.

Section 98H gives the licence holder the option to surrender the licence after consultation with the responsible authority.

The conditions of the licence are outlined in Section 98I. This section gives power to the responsible authority to impose conditions on the licence. It does not define the scope of these conditions. However, conditions on the licence are to be made in consultation with the holder of the licence.

Further conditions on the licence are set out in Section 98J. They are that no child is to be admitted to the part of the centre that is used for the administration of drugs and that the centre's internal management protocols are to be observed at all times.

The penalties for the contravention of the licence conditions are given in 98K. They include a written warning, a fine, or suspension or revocation of the licence by the responsible authority.

1.2.3 Division 3 – Internal management protocols

Division 3 sets out matters that should be considered by the licensee of the MSIC when forming the internal management protocols for the centre. This includes the requirements for the supervision of the centre and the services the centre must facilitate access to.

Sections 98L(a) and (b) set out that the centre must be under the supervision of a supervisor, who must have a general oversight role of the centre’s clinical operations and ensure their adequacy.

Under Section 98L(c), the centre must facilitate access to:

- Primary health care services, including medical services and mental health services
- Drug and alcohol services
- Health and education services
- Drug and alcohol detoxification and rehabilitation services
- The services of an opioid substitution treatment provider
- Services for testing for blood borne and sexually transmittable diseases
- Services involving a needle and syringe program.

1.2.4 Division 4 – Exemptions from liability

Division 4 creates exemptions from criminal liability for the use of illicit drugs in the MSIC as well as exemptions from criminal or civil liability for those who work at the centre.

The quantity of drugs which would attract exemption from criminal liability is defined in Section 98N(1) as a ‘small quantity’ of a drug of dependence. A small quantity is set out in Schedule 11 of the Principal Act. It differs depending on the drug in question, but for heroin a small quantity is one gram.¹

Section 98N(2) provides that it is not illegal to be in possession of no more than the exempt quantity of drugs at an injecting centre, however possession of an amount that would constitute supply of a drug of dependence would remain illegal. It also makes it lawful for a person at an injecting centre to be able to use an exempt quantity of a drug of dependence.

Section 98N(3) states that exemptions do not affect the conditions of any sentence, or the conditions of bail or parole. For example, if a person is granted bail on the condition they do not use a drug of dependence, they would be in breach of bail if they use a drug at the MSIC.

¹ *Drugs, Poisons and Controlled Substances Act 1981*, Schedule 11, Part 3, Column 4.

Police may use discretion when charging people with possession in the vicinity of the centre or travelling to the centre for the purpose of attending the centre. This is set out in Section 98N(4). Section 98N(5) outlines the intent for Victoria Police to formulate written guidance addressing the exercise of this discretion.

The Bill also provides staff with exemption from criminal and civil liability in course of their work. Section 98O sets out the position that it is not unlawful for a person to be engaged in the conduct of the injecting centre, and in particular does not commit an offence under section 181, 323 or 234 of the *Crimes Act 1953*. These relate to aiding and abetting offences and complicity in commission of offences.

Section 98P states that anything done in connection to the conduct of the facility does not subject the staff and the responsible authority nor the Crown to any action, liability or claim, if the thing done was in good faith for the purpose of the Bill, and was not done in a reckless or grossly negligent manner.

FINDING 1: The Victorian Bill proposes an 18-month trial of an MSIC in North Richmond. It does not specify a street or location. The MSIC's licence would only continue if the centre were to satisfy a review determining whether the trial met its objectives.

1.3 Scrutiny of Acts and Regulations Committee

The Scrutiny of Acts and Regulations Committee (SARC) of the Parliament of Victoria provided an analysis of the Bill's compatibility with section 28 of the *Charter of Human Rights and Responsibilities Act 2006* (the Charter).²

SARC noted section 96J(a), which states that no child is to be admitted to that part of the centre that is used for the purpose of the administration of any drug of dependence,³ may not be compatible with 'the right of every child to such protection as is in his or her best interests and is needed by him or her by reason of being a child'. SARC confirmed via Ms Patten that this right is not contravened.

SARC also had reservations about section 98K(1)(a)(i), which provides for a fine to be imposed for breaking MSIC regulations. The Charter requires such fines to be specified as a criminal offence or otherwise so that people may have the right to have criminal charges determined by a court or tribunal and to not be punished more than once for an offence. SARC confirmed via Ms Patten that this section does not impose a criminal penalty and the Charter's criminal process rights do not apply.

SARC also touched on Clause 2 of the Bill, which provides for a delayed commencement of a trial of an MSIC. SARC believed this was justified because the drafters of the Bill did not know the date when an MSIC would open and the Bill would come into effect.

² See Scrutiny of Acts and Regulations Committee, Alert Digest No. 2 of 2017.

³ Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017, s.96J(a).

1.4 The views of stakeholders regarding the Bill

Several stakeholders provided the Committee with suggestions regarding where the Bill might be improved.

1.4.1 North Richmond Community Health

The submission from the North Richmond Community Health argues against the requirement that the director or supervisor should be a medical professional as set out in Section 98L (a) and (b). However, the Bill currently sets out in its definitions that ‘director’ means a medical practitioner while ‘supervisor’ means a medical practitioner or qualified health professional nominated by the director.⁴

1.4.2 The Australian Medical Association Victoria

The Australian Medical Association Victoria recommends that the Bill define what constitutes a small quantity of drugs as set out in Section 98N. It says this would provide protections for medical practitioners from potential criminal or civil liability.⁵

The Committee notes that ‘a small quantity of a drugs’ is defined in the Principal Act, in Schedule 11, part 3, column 4. A small quantity is between 0.75 grams and one gram for most illegal drugs.

1.4.3 The Penington Institute

The Penington institute recommended more far reaching changes to the Bill. These were:

- An extension of the trial period to three years
- An interim evaluation after 18 months
- Removal of the restriction on the number of MSIC licences that can be issued (currently proposed to be capped at one licence) or, alternatively, removal of the restriction on the number of premises that can be issued under a single licence
- Replacement of the age restriction with a youth-specific support strategy within MSICs
- Maintaining medical oversight of MSICs without a requirement for every site to be directly overseen by a medical doctor.⁶

FINDING 2: It is appropriate that an MSIC is supervised by a medical practitioner during operating hours.

⁴ North Richmond Community Health, *Submission 15*, p.6.

⁵ Australian Medical Association, *Submission 22*, p.6.

⁶ Penington Institute, *Submission 46*, pp.2-3.

1.4.4 Victoria Police

The submission from Victoria Police discusses four issues relevant if a trial of an MSIC were to occur:

- Victoria Police would continue to enforce the *Drugs, Poisons and Controlled Substances Act 1981* ‘...in accordance with relevant policies, guidelines and manuals applicable to police operations and discretions’.
- The Secretary of DHHS should be the main decision-maker regarding the licencing of an MSIC, which would ‘...reflect the MSIC’s function as a health response to drug-related harm, rather than a law enforcement response’.
- All staff should undergo assessment for their suitability to work at an MSIC.
- The trial period should be longer than 18 months to allow a thorough trial measuring health, social and justice indicators.⁷

1.5 Comparison with Sydney MSIC legislation

The Bill is in parts identical to the legislation put in place in New South Wales to establish the MSIC in the Sydney suburb of Kings Cross. That legislation is the *Drug Summit Legislative Response Act 1999*.

This section provides an examination of the two pieces of legislation and outlines where they differ. The Bill is referred to as the Victorian Bill and the New South Wales legislation is referred to as the NSW Act.

The text below deals only with the key clauses that have significant differences.

1.5.1 Objectives of the Bill

VIC Bill

98C Objects of this Part

The objects of this Part are as follows—

- to reduce the number of deaths from drug overdoses;
- to provide a gateway to health and social assistance for clients of the licensed injecting centre, including drug treatment, health care and counselling;
- to reduce drug overdose related ambulance attendances;
- to reduce the number of discarded needles and syringes and the incidence of drug injecting in public places;
- to improve the amenity of the neighbourhood for residents and traders in the vicinity of the licensed injecting centre;
- to assist in reducing the spread of blood borne diseases, including but not limited to HIV infection or Hepatitis C.

⁷ Victoria Police, *Submission 49*, p.4.

Section 98C of the Victorian Bill above is not replicated in the NSW Act. The section sets out the objectives of the Bill. These objectives are referred to in Section 98D, which specifies that a review of the centre must be conducted. The review must contain an assessment of the extent to which the objectives set out in 98C are met.

FINDING 3: The objectives of the Bill reflect the health and community harms associated with intravenous drug use. The inclusion of these objectives provides a clear framework for an assessment of a trial.

1.5.2 Restrictions on the issue of licence

NSW Act

36F Restrictions on issue of licence

- (1) A licence for the conduct of premises as an injecting centre must not be issued unless the responsible authorities are of the opinion:
 - (a) that the internal management protocols for the proposed centre have been finalised and are of a satisfactory standard, and
 - (b) that there is a sufficient level of acceptance, at community and local government level, for the establishment of an injecting centre at the premises, and
 - (c) that the premises are suitable for use as an injecting centre, having regard to all relevant matters including the following:
 - (i) public health and safety,
 - (ii) the visibility of the premises from the street,
 - (iii) the proximity of the premises to schools, child care centres and community centres,
 - (iv) any matters prescribed by the regulations for the purposes of this section.
- (2) If a community drug action plan is in force in relation to the area within which the premises of the proposed injecting centre are situated, the responsible authorities must have regard to that plan in forming an opinion as to the matters referred to in subsection (1) (b) and (c).
- (3) Without limiting subsection (1), a licence for the conduct of premises as an injecting centre must not be issued unless the responsible authorities are of the opinion:
 - (a) that any building work that is carried out for the purposes of the centre will be carried out in accordance with the *Building Code of Australia*, and
 - (b) that any building that is used for the purposes of the centre will comply with the *Building Code of Australia*.
- (4) In subsection (3), *building*, *Building Code of Australia* and *building work* have the same meanings as they have in the *Environmental Planning and Assessment Act 1979*.

Section 36F of the NSW Act defines the restrictions on the issue of the licence for a MSIC. The Victorian Bill, in Section 98G, contains a nearly identical section on the restrictions of the licence. The parts of the section that differ between the NSW Act and the Victorian Bill are shown above in red. The additional restrictions outlined in the NSW Act include a requirement for the MSIC to have a sufficient level of community and local government acceptance and that the location of the centre must have regard for its visibility from the street and its proximity to schools, child care centres and community centres.

FINDING 4: The views of the community, all stakeholders and local government must be considered when deciding matters relating to an MSIC.

1.5.3 Internal management protocols

NSW Act

36L Matters for consideration in relation to internal management protocols

In considering the internal management protocols for a proposed injecting centre for the purposes of section 36F, the responsible authorities must have regard to whether provision needs to be made to ensure that any or all of the following requirements are met:

- (a) The centre must be under the supervision of a supervisor.
- (b) The supervisor must have a general overseeing role of the centre's clinical operations and responsibility for ensuring the adequacy of the clinical procedures used in the centre. This paragraph does not prevent the supervisor from being personally involved in clinical activities in the centre.
- (c) All staff directly supervising injecting activities in the centre must be qualified health professionals.
- (d) The centre must contain or have satisfactory access to:
 - (i) primary health care services, including medical consultation and medical assessment services, and
 - (ii) drug and alcohol counselling services, and
 - (iii) health education services, and
 - (iv) drug and alcohol detoxification and rehabilitation services, and
 - (v) the services of a methadone provider, and
 - (vi) services for testing for blood-borne and sexually transmissible diseases, and
 - (vii) services involving a needle and syringe exchange program.
- (e) Procedures are to be established to enable staff to ascertain in appropriate cases whether a person seeking admission to the centre is a child.
- (f) At least one member of staff:
 - (i) must be a person with satisfactory qualifications or experience in child protection and youth support, and
 - (ii) must be in attendance at the centre, or available on call to attend the centre, at all times while it is being used as an injecting centre.
- (g) The health and safety of staff and users of the centre are to be protected, having regard to the design and services of the centre.
- (h) Services are to be available and procedures established to ensure compliance or ability to comply, at or in connection with the centre, with the relevant requirements of:
 - (i) this Part, and
 - (ii) the regulations, and
 - (iii) the centre's licence conditions, and
 - (iv) any other provisions of the centre's internal management protocols.
- (i) Any requirements prescribed by the regulations for the purposes of this section.

The NSW Act sets out in Section 36L the matters that should be considered by the licensee of an MSIC when forming internal management protocols. The NSW section is similar to Section 98L of the Victorian Bill. The parts of the section that differ are shown in red above. These include a requirement that staff directly supervising injecting centre activities must be qualified health professionals and that at least one member of staff should be qualified in child protection and youth support and on hand at all times while the centre is in operation. The Victorian Bill does not contain these provisions but adds a requirement to include mental health support and to provide for opioid substitution treatment (rather than the more narrowly defined methadone treatment in the NSW Act).

FINDING 5: Both the NSW Act and the Victorian Bill require health professionals to form part of the MSIC staff. In addition, the Victorian Bill requires mental health services to be provided.

2

Drugs in Victoria and North Richmond

2.1 Drug overdose deaths in Victoria

A Coroners Prevention Unit (CPU) investigation into heroin overdose deaths in the City of Yarra that found:

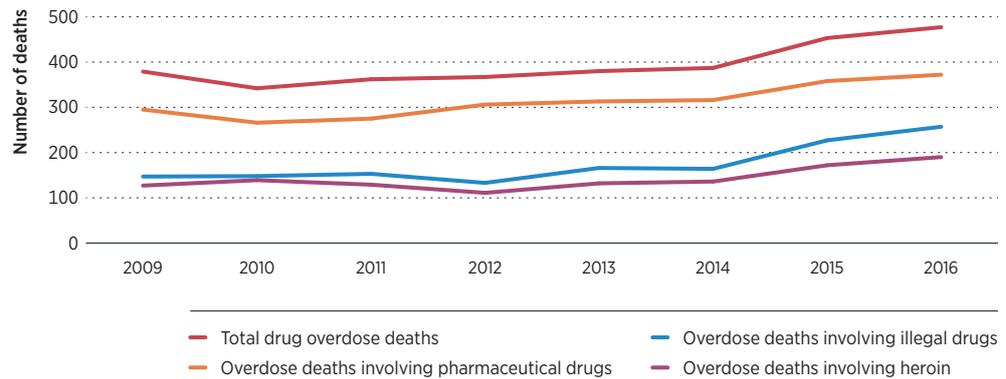
- In 2015, there were 172 heroin overdose deaths in Victoria, the greatest annual frequency since the height of heroin-related deaths at the end of the 1990s
- Approximately 75 per cent of Victorians who fatally overdosed using heroin in 2015 had a ten-year or greater history of drug dependence
- The average age of those who fatally overdosed using heroin in 2015 was just over 41 years old
- There is a common theme of complex interrelated health and social issues in heroin overdose deaths
- The City of Yarra has been the local government area with the highest frequency of heroin overdose deaths for the past seven years
- A large number of deaths occurred in an area centred on Victoria Street and surrounding streets in Richmond and Abbotsford
- The City of Yarra is the local government area with the highest frequency of heroin-related ambulance attendances.⁸

The Coroners Court provided further data about drug overdose deaths in Victoria in its submission to the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform. A selection of the data is provided in Figure 2.1 and Figure 2.2.

Figure 2.1 shows that the total number of drug overdose deaths in Victoria since 2009 has increased by 25.8 per cent, from 379 in 2009 to 477 in 2016. The number of drug overdose deaths involving illegal drugs has risen by 74.8 per cent, from 147 in 2009 to 257 in 2016. Of those illegal drugs, the number of overdose deaths where heroin was a factor has risen 49.6 per cent, from 127 in 2009 to 190 in 2016.

The number of overdose deaths where pharmaceutical drugs are a factor is relatively high compared to illegal drugs. Pharmaceutical drugs include types such as benzodiazepines, antidepressants and antipsychotics. The number of deaths involving pharmaceutical drugs increased by 26.1 per cent over the period, from 295 in 2009 to 372 in 2016.

⁸ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.7.

Figure 2.1 Drug overdose deaths in Victoria between 2009 and 2016

Source: Coroners Court of Victoria, Submission to the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform, *Submission 178*, Attachment 2, pp.6-8.

Victoria's State Coroner, Judge Sara Hinchey, told the Committee that the figures for heroin overdose deaths in particular remained relatively steady over the period 2009 until 2014, before increasing from 2014 to 2016:

It is clear from our overdose deaths register, which contains data from 2009 onwards, that there were between 110 and 140 fatal Victorian heroin overdoses annually in the period from 2009 to 2014...

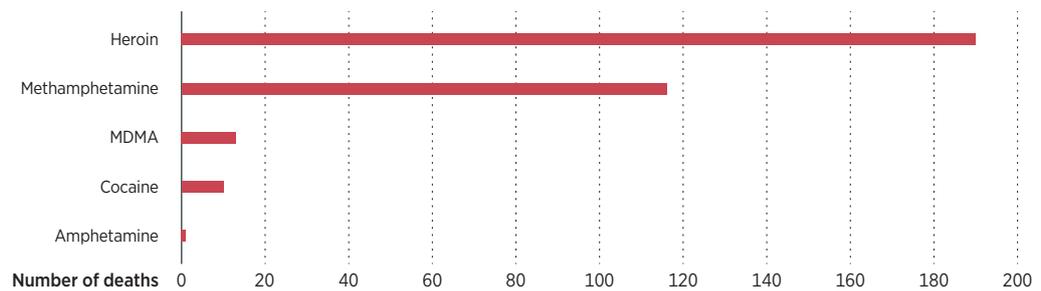
Heroin re-emerged as a central focus in the Victorian Coroners Court in 2016 when evidence mounted of an unusual increase in heroin-related harm. Data from the court's overdose deaths register showed that 172 overdose deaths occurred in 2015 involving heroin, which was an increase of 26 per cent compared to the 136 deaths which had occurred in 2014. As well, the court received calls from concerned members of the alcohol and drug treatment sector who had noted elevated levels of heroin use and related harm, particularly in public places in the North Richmond area.⁹

Combined toxicity

The Coroners Court submission to the Law Reform, Road and Community Safety Inquiry notes that most overdose deaths in Victoria are a result of combined drug toxicity. In 2016, the proportion of drug overdose deaths involving multiple drugs was 72.3 per cent.

Figure 2.2 breaks down the 257 overdose deaths involving illegal drugs in Victoria in 2016. There were 190 overdose deaths involving heroin in 2016 and it was a factor in 73.9 per cent of overdose deaths involving illegal drugs.

⁹ Judge Sara Hinchey, State Coroner, *Transcript of Evidence*, 7 June 2017, p.3.

Figure 2.2 Illegal drug overdose deaths in Victoria in 2016 by drug

Source: Coroners Court of Victoria, Submission to the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform, *Submission 178*, Attachment 2, p.8.

2.1.1 Drug overdose deaths by local government area

The Coroners Court submission includes information about drug overdoses in each local government area (LGA) in Victoria for the period 2009 to 2016. Metropolitan councils recorded the highest frequency of drug overdoses, with the City of Yarra recording the highest number of deaths, followed by the City of Port Phillip, the City of Melbourne, Frankston City Council and Brimbank City Council.

Table 2.1 lists the average annual rate of drug overdose deaths in each LGA per 100,000 population between 2009 and 2016. This data provides a comparable rate of drug overdose deaths proportionate to the population in each municipality.

Table 2.1 Drug overdose deaths in Victoria by local government area (metropolitan) 2009–2016 – per 100,000 population

Local government area	Average annual rate (%)
City of Yarra	23.7
City of Port Phillip	19.0
City of Melbourne	16.4
Maribyrnong City Council	12.5
Frankston City Council	11.6

Source: Coroners Court of Victoria, Finding Into Death With Inquest, Finding into the death of David Leslie Chapman.

The Coroners Court also provided the Legal and Social Issues Committee with the findings of an investigation into the death of a 39-year-old male who died in the City of Yarra in June 2016 from complications following a heroin overdose¹⁰ in similar circumstances to those of Ms A (discussed in Chapter 3).

¹⁰ The medical cause of death was hypoxic ischaemic brain injury.

The investigation by Coroner Jamieson notes the similarities between the two cases and includes additional data from the CPU about drug overdose deaths in Victoria.¹¹

The first set of data relates to the place of usual residence of the deceased and the area where the overdose took place. The second set of data relates to the type of location at which an overdose death occurs. This includes information about whether an overdose occurs at an individual's own home, another residence or in a non-residential setting, such as a park or other public place.

These two sets of data are for the period 2012–2016 and are summarised in Tables 2.2 and 2.3 below.

Table 2.2 Percentage of drug overdose deaths in Victoria by local government area of fatal overdose and local government area of residence between 2012 and 2016

Local government area	Residence in same local government area of fatal overdose (%)	Residence in different local government area of fatal overdose (%)
City of Yarra	31.3	68.8
City of Melbourne	69.0	31.0
City of Port Phillip	75.0	25.0
Brimbank City Council	81.8	18.2
Greater Dandenong	82.5	17.5

Source: Coroners Court of Victoria, Finding Into Death With Inquest, Finding into the death of David Leslie Chapman.

Table 2.3 Percentage of drug overdose deaths in Victoria by type of location where the overdose occurred between 2012 and 2016

Local government area	Own home (%)	Another's home (%)	Non-residential (%)
City of Yarra	28.1	23.4	48.4
City of Melbourne	58.6	8.6	32.8
City of Port Phillip	72.9	18.8	8.3
Brimbank City Council	63.6	18.2	18.2
Greater Dandenong	80.0	10.0	10.0

Source: Coroners Court of Victoria, Finding Into Death With Inquest, Finding into the death of David Leslie Chapman.

The data in Tables 2.2 and 2.3 illustrates two distinctive features about drug overdoses in the City of Yarra. The first is that a high percentage of individuals who fatally overdose in the City of Yarra do not reside in the area but travel to the City of Yarra to purchase and then consume drugs.

¹¹ Coroners Court of Victoria, Coroner Audrey Jamieson, Finding Into Death With Inquest, *Finding into the death of David Leslie Chapman*, 8 May 2017, p.8.

The second feature relating to the location of overdose correlates with the finding that many people travel to the City of Yarra to purchase and then consume drugs. The finding that nearly half of overdose deaths occur in non-residential areas, such as ‘carparks, public toilets, restaurant toilets, cars, and on streets’,¹² suggests that those who did fatally overdose most likely did have had a residential setting in the area in which to consume drugs.

Tables 2.4 and 2.5 contain data from Victoria Police’s computer-aided dispatches (CAD) system for drug overdose in Victoria and the City of Yarra.

Table 2.4 Total Victoria Police CAD events related to drug overdoses in Victoria

Financial year	Drug overdoses not involving violence	Drug overdoses involving violence	Total drug overdoses
2012/13	1,035	1,211	2,246
2013/14	1,189	1,422	2,611
2014/15	1,555	1,943	3,498
2015/16	1,977	2,269	4,246
2016/17	2,338	2,536	4,874

Source: Victoria Police, Submission 49, p.2.

Table 2.5 Total Victoria Police CAD events related to drug overdoses in the City of Yarra

Financial year	Drug overdoses not involving violence	Drug overdoses involving violence	Total drug overdoses
2012/13	73	38	111
2013/14	91	43	134
2014/15	89	47	136
2015/16	129	51	180
2016/17	142	74	216

Source: Victoria Police, Submission 49, p.2.

2.2 Concerns about drug-related activity in North Richmond

In June 2017, the Committee carried out a site visit of the North Richmond area identified in Coroner Hawkins’ inquest as a drug ‘hot spot’. The intersection of Victoria and Lennox Streets in North Richmond and the surrounding streets, parks and alleyways have been a known location of a street market for heroin

¹² Ibid, p.6.

and other drugs for over a decade. Recent media coverage includes reports about the challenges faced by local residents,¹³ discarded injecting equipment¹⁴ and street-based drug dealing.¹⁵

The Committee was guided on its tour of North Richmond by Mr Greg Denham, Executive Director of the Yarra Drug and Health Forum and Ms Judy Ryan from Residents for Victoria Street Drug Solutions. Mr Denham and Ms Ryan showed the Committee a number of locations known for heroin use. These locations were often in secluded alleyways out of sight of the thoroughfare of Victoria Street, but close to where drugs are bought (usually around the intersection of Victoria and Lennox Streets).

Figure 2.3 Used and discarded syringe found in North Richmond



The Committee spent 90 minutes walking through the streets and in this time saw at least ten people who were clearly affected by heroin, as well as several open drug deals and drug paraphernalia (see picture above). Members of the Committee spoke with one resident as he was washing his driveway of the mess created by a drug user who had passed out. The resident, who has lived in the area for around 15 years, had helped the drug user regain consciousness and told the Committee that this sort of event happens several times each week.

¹³ 'The street with no taps: ground zero for Melbourne's new heroin crisis', Liam Mannix, *The Age*, viewed 1 June 2017, <www.theage.com.au/victoria/the-street-with-no-taps-ground-zero-for-melbournes-new-heroin-crisis-20170421-gvpofy.html>.

¹⁴ 'Inside Melbourne's sinister four-block 'heroin rectangle' where more than 20 drug users die from overdoses every YEAR - and syringes litter streets just metres from trendy \$1m hipster homes', Josh Hanrahan, *The Daily Mail*, published 11 December 2016, viewed 1 June 2017, www.dailymail.co.uk/news/article-4021470/Melbourne-s-sinister-heroin-rectangle-20-people-die-overdoses-year.html.

¹⁵ The Herald Sun, Andrew Jefferson, *Drug dealers ply trade on Victoria and Lennox streets, Richmond*, published 1 February 2016, viewed 1 June 2017, www.heraldsun.com.au/news/victoria/drug-dealers-ply-trade-on-victoria-and-lennox-streets-richmond/news-story/fe0df3c211602bd238cbfca5793053ee.

The Committee also visited William Street in Abbotsford and talked to some local residents about their experience with drug use in the area, anti-social behaviour and discarded drug paraphernalia. The Committee saw how residents disable garden taps to discourage drug users entering their properties to obtain water to dilute and prepare heroin for injection (see picture below).

Figure 2.4 Disabled garden tap in Abbotsford



The submission from the Yarra Drug and Health Forum outlined factors that have contributed to the growth of a drug market in North Richmond, including:

- Easy accessibility to the area by public transport and cars
- Location of housing estates that house numerous people involved in the drug market
- The physical nature of the laneways, alleys, car parks, rear of shops and streetscape
- Displacement of the illicit drug market from the Melbourne CBD, Footscray and Collingwood.¹⁶

The submission goes on to say that the area ‘...has been described by police as the perfect storm in terms of the type of environment where a drug market can survive and thrive’.¹⁷

A report by the Burnet Institute in 2013 that incorporated observations, interviews and data from service providers in the area also found evidence of a drug market in North Richmond, including discarded injecting paraphernalia. Of the 15 injecting drug users interviewed for the report, 13 reported injecting in a public place. The key reasons given were not being able to wait and not wanting to be found by police in possession of drugs.

¹⁶ Yarra Drug and Health Forum, *Submission 4*, p.2.

¹⁷ Ibid.

2.2.1 Roundtable discussion with key agencies and service providers

The Committee held a roundtable discussion at North Richmond Community Health with a number of local agencies and service providers. The Committee listened to their views about drug-related activity in North Richmond and the proposed trial of an MSIC. The participants at the roundtable discussion were:

- Demos Krouskos, Penny Francis, Ele Morrison and Matt Honey – North Richmond Community Health
- Greg Denham – Yarra Drug and Health Forum
- David Taylor – Victorian Alcohol and Drugs Association
- Judy Ryan – Victoria Street Drug Solutions
- Malcom McCall and Sarah Jaggard – City of Yarra
- Peter Wearne – Youth Support and Advocacy Service
- Dr Martyn Lloyd-Jones – St Vincent’s Hospital
- Meghan Fitzgerald – Fitzroy Legal Service
- Cameron Wallace, Hieng Lim and Matthew Cocomozo – Neighbourhood Justice Centre
- Sally Mitchell – Cohealth Ltd.

Representatives from the City of Yarra told the Committee that the Victorian Government is installing CCTV cameras on the corner of Victoria and Lennox Streets to improve community safety. The City of Yarra expressed concern that installing CCTV may merely displace drug use from the commercial areas of Victoria Street to surrounding residential areas.

Other participants spoke about the need to engage intravenous drug users to help them to access primary health and other social services. However, they acknowledged that there is a shortage of services – such as methadone providers and rehabilitation beds – in North Richmond and across Victoria more widely.

All participants were aware that, as discussed earlier, many drug users come from outside the City of Yarra to buy and use heroin in the area.

The City of Yarra also provided information about the services it contracts to remove needles and syringes from disposal bins around the area and discarded drug paraphernalia from the surrounding streets. The Committee saw several disposal bins, a number of which had needles on the ground around them.

The Committee also heard from North Richmond Community Health about its alcohol and other drugs program. Both of these are discussed further below.

2.2.2 Roundtable discussion with the Victoria Street Business Association and representatives of the Vietnamese Community in Victoria

The Committee met with representatives of the Victoria Street Business Association and representatives of the Vietnamese Community in Victoria. The Victoria Street Business Association represents a number of traders that operate near the drug market. The traders believed that their businesses are adversely affected by the anti-social behaviour of drug-affected people on Victoria Street and the negative publicity from media reports about drug use in the area.

They believed such a facility would entrench drug-related activity and drive away family-orientated business along the Victoria Street restaurant strip. They told the Committee they would like more CCTV cameras installed in areas known for drug-related activity to deter drug dealers and drug users, as well as an increased police presence to shut down the drug market in the area. Their submission stated:

For many years, we have advocated for a for specific solutions including CCTV cameras, extra monitoring of police in uniform and non-uniform, extra lighting, street beautification and other avenues that support users, increase safety and reduce interruptions in business activity.¹⁸

2.2.3 Local residents in North Richmond

The Committee acknowledges the significant hardships and dangers faced by local residents in North Richmond as a result of the local drug market. The Committee heard that residents frequently experience confronting scenes of drug use, drug dealing, anti-social behaviour, and discarded needles and syringes. Residents have reported finding drug-affected people on their properties, attending to overdoses on the street and discovering people who have died from an overdose. Others report anxiety about the effects of the drug problem on their children, including needle stick injuries (the Committee spoke with one resident whose young son had been pricked by a used needle) and witnessing drug-related activities. Judge Hinchey classified these concerns as a ‘...health-related issue for those who are exposed to the debris associated with injecting drug use’.¹⁹

The Committee met with several residents during its site visit. It is undeniably clear that residents are frustrated, angry and fearful as a result of the rampant drug use that occurs in their neighbourhood. This undoubtedly affects their quality of life.

The excerpts below are from submissions from residents of North Richmond and Abbotsford to the Law Reform, Road and Community Safety Committee’s Inquiry into Drug Law Reform. They illustrate some of the challenges faced by the residents:

¹⁸ Victoria Street Business Association, *Submission 48*, p.2.

¹⁹ Judge Sara Hinchey, State Coroner, Coroners Court of Victoria, *Transcript of evidence*, 7 June 2017, p.4.

I cannot step out of my front door and make a return visit to Victoria St without confronting users publicly injecting, managing overdoses, or hunting for a dealer. I see dealers blatantly selling, spruiking, arguing all along Victoria St. I see the drug affected in doorways, on porches, between rubbish bins and in our gardens. I clean litter, faeces, and vomit from my pathway.²⁰

We have found syringes in our front and back gardens, and asked users to get off our property on multiple occasions. I have opened my carport to see a user with a blood filled syringe in his arm directly opposite.²¹

Another resident wrote:

Let me talk you through a normal day here - Monday 9am, out the front door to walk the dog, luckily my son is strapped in the pram, as a drug-affected man is walking up the street, I walk fast but I still spot two syringes in the gutter, one uncapped. That afternoon on the way to the shops, my son and I pass a woman sitting in the gutter between two cars, she is injecting into her groin. My son is on foot this time; he refused to get into the pram. I spot the woman in time to scoop him up into my arms and distract him by making silly noises.²²

A number of residents also reported providing medical assistance to drug-affected people who may have been in danger of overdosing as well as encountering overdose victims:

I cannot count the number of times I've called triple 0 for someone I see prone and apparently unconscious in a lane, gutter or footpath. Every neighbour has a story of waiting with an overdose victim until help arrives. My son was traumatised by seeing a body in our lane. My neighbour told me how she found an unconscious body in her lane. She wrestled with how she might provide CPR while waiting for an ambulance. Locals should not have to take on responsibility for life and death in this way.²³

Less than a year ago I walked out of a shop to find myself faced with an IV drug user who had overdosed on Victoria Street. I jumped into action and performed CPR until medics and police arrived. I believe the man survived, however I believe that if he had access to a safe space to inject, instead of a public toilet on a corner, he would have been less likely to OD in the first place, plus he would have had access to medical attention sooner, placing him and the rest of the community at less risk. As a nurse I'm now used to these incidents occurring at work, but I shouldn't have to take responsibility for people's lives on my day off as well.²⁴

One woman described to me a group of children running up to a person who had died of an overdose on the grounds of the estate, and touching the deceased person's body. She expressed her great distress at this, including because of the impact on these children of seeing such a death.²⁵

20 Margot Foster, Submission to the Law Reform and Road Safety Committee's inquiry into Drug Law Reform, *Submission 96*, p.2.

21 Name withheld, Submission to the Law Reform and Road Safety Committee's inquiry into Drug Law Reform, *Submission 101*, p.2.

22 Ibid.

23 Margot Foster, Submission to the Law Reform and Road Safety Committee's inquiry into Drug Law Reform, *Submission 96*, p.2.

24 Rosa Roberts, Submission to the Law Reform and Road Safety Committee's inquiry into Drug Law Reform, *Submission 66*, p.1.

25 Kathleen Maltzahn, Submission to the Law Reform and Road Safety Committee's inquiry into Drug Law Reform, *Submission 195*, p.2.

All 15 submissions from individual residents of Abbotsford and North Richmond to the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform supported a trial of an MSIC. Overall, 88 submissions to that Inquiry were supportive of an MSIC in North Richmond.

2.2.4 Emergency services providers

The Committee received a submission from Ambulance Employees Victoria describing the significant challenges faced by emergency service personnel routinely called to respond to drug overdoses in North Richmond. The submission includes an example of a paramedic who received a needle stick injury:

The crew treated the patient by securing an airway, performing ventilations and administering naloxone (Narcan). The crew ventilated the patient for several minutes before administering Narcan to reduce cerebral hypoxia (this helps prevent the patient from becoming violent when Narcan suddenly reverses the effects of Narcotics). Despite her efforts to ensure her own safety, disaster struck while sliding the patient up the stretcher. She carefully placed her gloved hand under the patient's armpit and she felt a sharp sting on a fingertip. The patient had an uncapped needle floating somewhere in their clothing and even when grabbing the patient under the armpit she received a needle-stick injury. The patient was transported to hospital where Lucy was also triaged by nursing staff. She received precautionary blood tests, as did the patient. The hospital confirmed the patient had Hepatitis C and Human Immunodeficiency Virus (HIV). Nearly six months later, she is still undergoing tests to determine if she has contracted either of these conditions.²⁶

The submission gave another example of a paramedic who was threatened by a suspected overdose patient following the administration of naloxone to reverse the effects of an overdose:

The crew went to work securing the patient's airway, suctioned away the vomit and ventilating him and administering Narcan after several minutes of ventilation. The patient responded well to the Narcan and awoke soon after. At that stage he wasn't aggressive and even thanked Nathan and his partner and was provided with oxygen while he recovered. After several minutes the small car parked up the street moved up to the scene and a man and a woman who both appeared drug affected approached. They too were non-aggressive and assisted the patient to his feet. After several minutes of polite discussion the patient began to feel unwell and vomited several times. Nathan explained that it was the effects of the sudden withdrawal of the drugs he had taken. The patient became angry and shouted "no it's that shit you gave me". The patient was clearly agitated and aggressive and he could hear him muttering threatening comments quietly towards the crew. The drug affected bystanders attempted to assist and calm the patient but he responded aggressively towards them and violently shoved the man away. He wandered to the back of the vacant block and the crew used this opportunity to gather their gear and withdraw from the area.²⁷

²⁶ Ambulance Employees Victoria, *Submission 20*, p.4.

²⁷ *Ibid.*

Ambulance Employees Victoria told the Committee that patients who have been given naloxone may develop agitation, sweating, nausea, vomiting, and occasionally tremor and convulsions. Patients may be confused, irrational and combative. Ambulance Employees Victoria reports that many paramedics have been assaulted after resuscitating overdose patients.²⁸

The United Firefighters Union (UFU) of Australia Victoria Branch also provided a submission on behalf of its members in the Metropolitan Fire Brigade (MFB) and the Country Fire Authority (CFA). One of the key functions of MFB and CFA units is to act as emergency medical responders when an emergency call is made, meaning firefighting units will respond and stabilise a patient until the arrival of paramedics who provide a more advanced medical response.²⁹

The UFU reports an upward trend in drug-related emergency response calls, from 16 per cent of emergency response calls in 2015 to 24 per cent in 2016.³⁰ These calls can involve physical risk to firefighters:

Our members tell of being called to overdoses in laneways, stairwells and disused buildings, and having to work on a patient in conditions which are unhygienic and at times dangerous, as well as on occasion having to contend with other drug users on the site who are panicked and distressed and may also be unpredictable in their behaviours. Circumstances can also change very quickly, for example if a patient becomes violent or aggressive when paramedics arrive and administer medication to reverse the effect of the drug which caused the overdose.³¹

The submission also outlines the psychological impact on firefighters who respond to such call outs:

Our members believe that out of all the emergency services, their exposure to trauma as first responders is perhaps the greatest. A firefighter is exposed to traumatic situations as soon as they are on station after their initial training. While their role until they have completed their certification is to observe, report and assist only, they are still exposed to the incident, and many of our younger members at the start of their careers have spoken of the initial shock they experienced when they first started attending EMR calls.³²

The Committee acknowledges the often traumatic situations endured by emergency services responding to suspected drug overdoses, including needle stick injury or aggressive patients. The psychological impact of responding to these emergency situations may contribute to long-term mental health problems including post-traumatic stress disorder or depression.³³

Figure 2.5 shows the number of ambulance call outs for heroin in the City of Yarra from 2005/06 – 2014/15.

²⁸ Ambulance Employees Victoria, *Submission 20*, p.4.

²⁹ United Firefighters Union Victoria Branch, *Submission 24*, p.3.

³⁰ *Ibid*, p.5.

³¹ *Ibid*, p.7.

³² *Ibid*, p.9.

³³ *Ibid*.

Figure 2.5 Heroin-related ambulance attendances, City of Yarra, 2005/06–2014/15

Source: <amboadstats.org.au/VicLGA>; accessed 29 August 2017.

FINDING 6: Drug use in North Richmond has reached crisis level. It is a major concern for residents, business owners and emergency services.

2.3 Services currently available to intravenous drug users in the City of Yarra

2.3.1 Needle and syringe programs (NSPs)

North Richmond Community Health Service (NRCH) operates the largest NSP in North Richmond from its site on Lennox Street. It reports that an average of 150 clients access the service each day, and that an estimated 60,000 and 70,000 syringes are distributed each month, a figure it believes is increasing.³⁴

Cohealth is another large provider of NSP services in the North Richmond area. Cohealth runs an after-hours outreach service that organises sterile injecting equipment to be delivered to the surrounding areas.³⁵

The Youth Support and Advocacy Service runs a secondary NSP as part of its day program at a site in Abbotsford.³⁶

The City of Yarra told the Committee it supports NSPs. Its *Municipal Public Health and Wellbeing Plan (2013-2017)* advocates:

...extending the hours of needle and syringe programs, increasing outreach to people who inject drugs during evenings and weekends, enabling peer distributed needles and syringes, and installing syringe vending machines.³⁷

The City of Yarra contracts providers to remove and safely dispose of needles and syringes from designated needle disposal boxes (see picture below) as well as discarded needles and other drug paraphilia left in the streets and alleyways of North Richmond and Abbotsford. The majority of needles and syringes collected

³⁴ North Richmond Community Health Service, *Submission 15*, p.2.

³⁵ Cohealth Ltd, *needle and syringe program*, <www.cohealth.org.au/health-services/drugs-and-alcohol/needle-syringe-program>, viewed 14 June 2017.

³⁶ YSAS, *Harm Minimisation*, <www.ysas.org.au/topics/harm-minimisation>, viewed 14 June 2017.

³⁷ The City of Yarra, *Submission 9*, p.3.

are deposited in the designated needle disposal boxes in areas of high drug use. In 2016, a total of 76,736 needles and syringes were collected by the City of Yarra – 66,915 from needle disposal units and 9,708 from street sweeps.³⁸

Figure 2.6 City of Yarra needle disposal box



2.3.2 Naloxone programs in North Richmond

Coroner Hawkins highlighted the work of North Richmond Community Health and Harm Reduction Victoria in providing training in the use of naloxone.³⁹ Harm Reduction Victoria is funded by the Department of Health and Human Services to run an opiate overdose peer education module for people who inject heroin. The program includes the identification of overdose risks, resuscitation techniques, and a discussion about naloxone administration and how to access the drug.⁴⁰

North Richmond Community Health provides overdose training to people who inject drugs and provides naloxone for users to take home in the event of an overdose. According to Coroner Hawkins, approximately 70 people have been trained as part of this program.⁴¹ North Richmond Community Health also employs drug outreach workers to carry and administer naloxone.

³⁸ Correspondence, City of Yarra to Legal and Social Issues Committee, 19 June 2017.

³⁹ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.12. Naloxone blocks or reverses the effects of opioids, especially in overdoses.

⁴⁰ Harm Reduction Victoria, *Submission 32*, p.12.

⁴¹ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.12.

Cohealth expressed concerns about the cost of over-the-counter naloxone purchased without a prescription. It said:

The current price of naloxone is prohibitive for many members of the community who may be in a position to intervene in opioid overdoses. This could be addressed by health services such as cohealth facilitating access to subsidised or free naloxone – however the listing of naloxone as a Schedule 3 drug requiring pharmacist dispensing prohibits this from taking place. Whilst we acknowledge drug scheduling is a Federal issue, we would encourage the Victorian government to advocate to the Federal Government for the rescheduling of naloxone.⁴²

North Richmond Community Health’s alcohol and other drugs program

North Richmond Community Health’s alcohol and other drugs (AOD) program includes the services discussed above, as well as blood borne virus education, health promotion, outreach in the local community and overdose response services.

The overdose response services include an emergency response team of doctors, nurses and AOD workers who respond to overdose cases in the area surrounding the NRCH building with naloxone, oxygen and the provision of bystander management. A number of outreach workers also respond to overdoses in the community with the provision of naloxone, first aid, bystander management and calls to emergency services.⁴³ The AOD team connects with people who have survived an overdose to provide follow-up care and education.

A survey conducted as part of a 2016 evaluation of the AOD program found that of the 201 clients surveyed:

- Two-thirds were male
- One-third were Aboriginal
- More than 90 per cent were unemployed
- Less than 20 per cent had completed year 12 schooling
- 37 per cent were in unstable accommodation
- 76 per cent were rated as having high psychological distress
- 93 per cent had been exposed to hepatitis C
- 63 per cent were living with chronic hepatitis C
- 57 per cent reported a mental health problem.⁴⁴

⁴² Cohealth Ltd, *Submission 25*, p.8.

⁴³ North Richmond Community Health, *North Richmond Community Health’s Alcohol and Other Drug Program*, (2017), p.2.

⁴⁴ *Ibid*, p.1.

The Committee acknowledges the important work undertaken by AOD program staff. The services provided help to treat and prevent overdoses, as well as providing pathways for intravenous drug users to access primary health and other services. The Committee believes these efforts help to improve the lives of some of the most marginalised people in our community.

The submission from North Richmond Community Health advocates the expansion of the availability of naloxone to those who are in a position to intervene in overdose deaths in North Richmond. It also stresses that increased availability must be matched by appropriate training for health care providers:

This measure, while an important and necessary component of any overdose management plan, is simply not enough to maintain the health and wellbeing of our clients (or other people who inject drugs) in a context where opioid overdose is unacceptably high.⁴⁵

Our perspective at NRCH is that it must be recognised that naloxone is not an absolute panacea. There are limitations with bystanders being tasked with the administration of naloxone which include; being responsible for overdose reversals can amount to a lot of pressure for some individuals.⁴⁶

Standalone naloxone does not address poly-drug overdoses where, for example, benzodiazepines and alcohol are heavily involved. These situations require specialised medical care, potential transport to a tertiary site within the health system, close observation and rely on the usage of skilled airway management techniques.⁴⁷

2.3.3 Other service providers

A number of non-government service providers in North Richmond provide primary health, education and support services to intravenous drug users. Harm Reduction Victoria runs a number of programs, including the drug overdose prevention education program discussed above. It also oversees a peer network program, which trains and supports ‘peer networkers’ to distribute needles and syringes to their friends and associates, as well as providing education about safer drug use.⁴⁸

Another service provider in the City of Yarra is the Youth Support and Advocacy Service, which operates a day centre in Abbotsford for young people to receive respite care and access AOD services. The services include a primary health clinic, access and referral to other support services, therapeutic and skill building programs, supervised recovery spaces, and basic assistance such as food packs, showers and washing machines.⁴⁹

⁴⁵ North Richmond Community Health, *Submission 15*, p.3.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ Harm Reduction Victoria, *The Peer Networker Program*, <hrvic.org.au/safer-drug-use/the-peer-networker-program>, viewed 20 June 2017.

⁴⁹ Youth Support and Advocacy Service, YSAS Abbotsford Day Program, <www.ysas.org.au/ysas-abbotsford-day-program>, viewed 20 June 2017.

A submission to the Law Reform, Road and Community Safety Committee from Turning Point, an addiction treatment centre, states ‘...Victoria has few GPs and pharmacists who are able to manage the number of Victorians needing opiate pharmacotherapy...New South Wales by way of contrast has almost 10 times the numbers of addiction doctors in training as Victoria’.⁵⁰

2.3.4 Statewide

In 2016, Victoria had the second lowest number of drug rehabilitation beds in Australia (0.45 / 10,000 population).⁵¹ There are currently 240 drug rehabilitation beds in Victoria. There are plans for more to come online in the coming years including 60 beds across three new sites in the Gippsland, Barwon and Hume regions and 20 beds in Ballarat.⁵²

FINDING 7: There is a shortage of doctors and chemists dispensing methadone in North Richmond and a shortage of drug rehabilitation beds across Victoria.

⁵⁰ Turning Point, *Submission to Law Reform, Road and Community Safety Committee Inquiry into Drug Law Reform 116*, p.5.

⁵¹ ‘Lack of beds forces Victorians to travel interstate for drug rehab’, Chloe Booker, *The Age*, 6 February 2017.

⁵² Committee Correspondence, Department of Health and Human Services, 30 August 2017.

3

Coroner Hawkins' Inquest into the death of Ms A

3.1 The Inquest

On 20 February 2017, the Coroners Court of Victoria released its findings of an Inquest into the death of 'Ms A'. The Inquest was carried out by Coroner Jacqui Hawkins.

Ms A is a pseudonym for a 34-year-old woman who died from complications following a heroin overdose in North Richmond on 30 May 2016. Ms A's death is considered a 'reportable death' under the *Coroners Act 2008* as it appears to have been unexpected and unnatural.⁵³ The Coroners Court is required to investigate all reportable deaths in Victoria⁵⁴ and, if possible, determine the identity of the deceased, the medical cause of death and the circumstance in which the death occurred.⁵⁵

The Court may also decide to hold an Inquest to determine the cause of death and make recommendations to help prevent similar deaths in the future. The decision to hold an Inquest is usually at the discretion of the Coroner.⁵⁶

Coroner Hawkins held an Inquest into the death of Ms A to:

- 'Explore the nexus between heroin-related harms and deaths and the City of Yarra, with particular focus on potential prevention opportunities in the Richmond area
- 'Contribute to the reduction of the number of preventable deaths and the promotion of public health and safety' as outlined in the preamble to the *Coroners Act 2008*.⁵⁷

As part of an Inquest, a Coroner may invite submissions and call witnesses to give evidence in person. Coroner Hawkins invited submissions from stakeholders 'in relation to their knowledge and observations of what is currently being done in the Richmond area, what more could be done to prevent such deaths and explore any opportunities for me to make any potential recommendations'.⁵⁸

⁵³ *Coroners Act 2008*, s.4.

⁵⁴ *Coroners Act 2008*, s.15.

⁵⁵ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.3.

⁵⁶ This occurs only where it is not mandatory to hold an Inquest under *the Coroners Act 2008*. Cases where it is mandatory to hold an Inquest are when the Coroner suspects the death is a result of homicide, when the deceased was placed in custody or care immediately before death or the identity of the deceased is unknown, (Coroners Court of Victoria, *Guidance on Whether to Request an Inquest*, 2015, p.1).

⁵⁷ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.8.

⁵⁸ *Ibid.*

Coroner Hawkins received 20 submissions, all of which supported establishing an MSIC in North Richmond. Coroner Hawkins also invited the following witnesses to give evidence in person at the Inquest:

- Dr Jeremy Dwyer, Acting Manager of the Coroners Prevention Unit, Coroners Court of Victoria
- Professor Paul Dietze, Deputy Director for Population Health, Burnet Institute
- Mr Demos Krouskos, Chief Executive Officer, North Richmond Community Health
- Mr Greg Denham, Executive Officer, Yarra Drug and Health Forum
- Ms Judith Abbott, Director of Prevention, Population, Primary and Community Health, Department of Health and Human Services
- Dr Marianne Jauncey, Medical Director, Sydney Uniting Medically Supervised Injecting Centre.

3.1.1 The Report

Coroner Hawkins provided the following summary of the events leading to Ms A's death:

On 29 May 2016 at approximately 12.20pm, Ms A attended Hungry Jacks on Hoddle Street, Richmond. CCTV footage depicts Ms A entering the Hungry Jacks toilet by herself at 12.21pm. Ms A then leaves the toilet to obtain a spoon from the store counter before returning to the toilet 20 seconds later, on her own.

At approximately 1pm, Ms A was located unconscious in the toilets by a staff member, with a syringe sticking out of the top of her leg and fresh track marks in the groin area. Emergency services were called and staff commenced cardiopulmonary resuscitation (CPR). Attending paramedics assisted by the Metropolitan Fire Brigade (MFB) assessed Ms A to be in asystole and took over resuscitative efforts.

Ms A was transferred to St Vincent's Hospital where a computed tomography (CT) scan showed hypoxic brain injury. She was admitted to the intensive care unit and given inotropic support and continued ventilation, however despite maximal medical treatment her clinical condition deteriorated. On 30 May 2015 at approximately 3.05am, Ms A suffered a cardiac arrest and died.⁵⁹

The cause of death was established as global cerebral ischaemia secondary to mixed drug toxicity including a substance consistent with heroin.⁶⁰ The toxicology result found both heroin and a class of pharmaceutical drug, benzodiazepine, in Ms A's system. The Coroner indicated the likely cause of death as being heroin and benzodiazepine depressing the part of the brain controlling breathing, or that vomit or posture while unconscious obstructed Ms A's airways.⁶¹

59 Ibid, p.7.

60 Ibid, p.4.

61 Ibid, p.5.

3.2 Coroner Hawkins' Recommendations

The *Coroners Act 2008* allows a Coroner to make recommendations as part of their Inquest or investigation. Recommendations can be made to any Minister, public statutory authority or entity.⁶² Coroner Hawkins made three recommendations, one to the Minister for Mental Health and two to the Department of Health and Human Services. These are discussed below.

3.2.1 A trial of an MSIC in North Richmond

Recommendation 1 of Coroner Hawkins' Inquest into the Death of Ms A states:

That the Honourable Martin Foley MP as Minister for Mental Health take the necessary steps to establish a safe injecting facility trial in North Richmond.⁶³

The Minister responded to the Coroner on 5 May 2017. The Minister did not commit to establishing an MSIC in North Richmond, nor did he rule one out. The Minister instead referred Coroner Hawkins to the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform, which he anticipated would consider the establishment of an MSIC in North Richmond. He noted that the Inquiry is due to report in March 2018 and that the Government will await its recommendations.⁶⁴

3.2.2 Expansion of naloxone distribution and education

Recommendation 2 of Coroner Hawkins' Inquest into the Death of Ms A states:

That Ms Kym Peake, Secretary, Department of Health and Human Services Victoria, take the necessary steps to expand the availability of naloxone to people who are in a position to intervene and reverse opioid drug overdoses in the City of Yarra.⁶⁵

In February 2017, the Victorian Government announced funding of:

- \$350,000 to subsidise the cost of naloxone
- \$850,000 to trial an overdose response service in the City of Yarra and five other local government areas
- \$100,000 to 'expand overdose prevention education'.⁶⁶

⁶² *The Coroners Act 2008*, s.72(2).

⁶³ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.24.

⁶⁴ Correspondence from the Hon Martin Foley MP, Minister for Mental Health to Coroner Jacqui Hawkins, 5 May 2017.

⁶⁵ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.24.

⁶⁶ Correspondence from Kym Peake, Secretary, Department of Health and Human Services to Coroner Jacqui Hawkins, 2 May 2017, p.1.

Naloxone is co-listed as a schedule 3 and schedule 4 medicine under the pharmaceutical benefits scheme. This means that it is available over the counter at pharmacies starting at \$25 per ampule⁶⁷ and by prescription at a subsidised price.⁶⁸

3.2.3 Review of drug treatment programs

Recommendation 3 of Coroner Hawkins' Inquest into the Death of Ms A states:

That Ms Kym Peake, Secretary, Department of Health and Human Services Victoria, review current DHHS-funded services that support the health and wellbeing of injecting drug users in the City of Yarra, and consult with relevant service providers and other stakeholders, to identify opportunities to improve injecting drug users' access to and engagement with these life-saving services.⁶⁹

Recommendations 2 and 3 were accepted by the Victorian Government.

3.3 Evidence from the State Coroner

The Committee spoke with Judge Sara Hinchey, the State Coroner, about the Inquest into the Death of Ms A. Judge Hinchey began her evidence by referring to a report on heroin deaths released by the then State Coroner, Mr Graeme Johnstone, in April 2000. The report made recommendations on areas that remain relevant to this Inquiry, including: reform in treatment delivery to drug-dependent people; the availability of drug treatment services; drug harm education; prescription monitoring; and the distribution of naloxone.

The Victorian Coroners Court again focused on heroin in 2016 when deaths from the drug began to climb, leading to Coroner Hawkins' report. As part of her Inquest, Coroner Hawkins received submissions from a range of stakeholders, including drug experts, local authorities and health organisations. Judge Hinchey informed the Committee that no submissions opposed establishing a medically supervised injecting centre in the City of Yarra.

Judge Hinchey also spoke about the finding of Coroner Audrey Jamieson in the death of David Leslie Chapman, which followed Coroner Hawkins' report. Coroner Jamieson stated:

...I must support Coroner Hawkins' recommendations relating to safe injecting facilities and complementary interventions...if a safe injecting facility can shift drug injecting from public locations to a clinically supervised environment, this would be hoped to lessen the impact of injecting drug use and overdose death on local residents who are exposed to these activities in their everyday life.⁷⁰

⁶⁷ Harm Reduction Victoria, *Submission 32*, p.11.

⁶⁸ Simon Lenton, Paul Dietze and Marianne Jauncey, *Australia Reschedules Naloxone for Opioid Overdose*, *Medical Journal of Australia*, 204 (4) (2016), pp.146-147.

⁶⁹ The Coroners Court of Victoria, Coroner Jacqui Hawkins, Finding into death with inquest, *Findings into the death of Ms A*, 20 February 2017, p.24.

⁷⁰ Coroners Court of Victoria, Coroner Audrey Jamieson, Finding Into Death With Inquest, *Finding into the death of David Leslie Chapman*, 8 May 2017, p.6.

Judge Hinchey told the Committee:

The core purpose of a Victorian coroner in conducting a death investigation is to identify opportunities for prevention by considering evidence which identifies the means to reduce the risk that similar deaths might occur in the future. It is in this context of the prevention mandate that those two coroners have recently concluded that it is desirable for a supervised injecting facility trial to be established in North Richmond.⁷¹

Judge Hinchey added that, as is the case in Sydney, an MSIC can work in partnership with local police. She said:

...there is no reason why law enforcement cannot be part of the solution, but that does not also mean that place-based intervention should not be part of the solution as well. What the Coroners Court has seen when it has conducted its inquiries and received evidence from all sorts of people who have contributed to the inquiries — including, I might add, residents of the North Richmond area and the local traders and other economic groups who have been able to comment on the fact that they actually would like to see these types of interventions trialled — is there is no doubt that it has to be a multifaceted approach.⁷²

The Committee was also interested in Judge Hinchey's views on the dangers of misuse of pharmaceutical drugs. Judge Hinchey stated that while misuse of these drugs is an issue that needs to be addressed, the recommendation regarding an MSIC is intended to address a specific problem in a specific part of Melbourne. Judge Hinchey told the Committee:

So people who have injected heroin may well also have consumed pharmaceuticals but not all pharmaceutical-related deaths involve heroin. It is the associated harms that the safe injecting facility would seek to redress — that is, the fact that where someone has been adversely affected by heroin, for instance, the administration quickly of naloxone and appropriate other resuscitative measures can actually save that person's life. So that is an example of why a safe injecting facility is desirable.⁷³

3.4 Inquest by Coroner McNamara

In 2017, Coroner Gregory McNamara investigated the death of Mr Sam O'Donnell, who died in August 2016 of a heroin overdose in a laneway in Abbotsford.

Coroner McNamara found that Mr O'Donnell had tried detoxification several times. Mr O'Donnell died less than nine hours after being released from a rehabilitation clinic in Geelong.

Coroner McNamara supported Coroner Hawkins' recommendation for the trial of an MSIC in North Richmond. His report states:

⁷¹ Judge Sara Hinchey, State Coroner, Coroners Court of Victoria, *Transcript of evidence*, 7 June 2017, p.4.

⁷² *Ibid*, p.5.

⁷³ *Ibid*, p.6.

This death again demonstrates that the City of Yarra bears a disproportionate burden of drug-related harms for the entire State of Victoria, and emphasises the importance of taking measures to reduce the impact of drug use in this particular area.

Accordingly, I support the recommendations made by Coroner Hawkins in her finding following an inquest into the death of Ms A.⁷⁴

74 Coroners Court of Victoria, Coroner Gregory McNamara, *Finding Without Inquest into the Death of SO*, 7 July 2017, p.6.

4 Medically supervised injecting centres

4.1 Overview of MSICs

Medically supervised injecting centres (MSICs) are one type of drug consumption room (DCR)⁷⁵ where drug users bring externally acquired illicit drugs to use:

Consumption rooms aim to establish contact with difficult-to-reach populations of drug users, provide an environment for more hygienic drug use, reduce morbidity and mortality risks associated with drug use — in particular street-based drug injecting — and promote drug users’ access to other social, health and drug treatment services. They also aim to reduce public drug use and improve public amenity near urban drug markets.⁷⁶

MSICs tend to be established where there are significant ‘open’ drug markets where large numbers of users congregate and inject in public. The first officially state-sanctioned drug consumption room opened in Berne, Switzerland in 1986. This was at a time of increasing concern about the spread of HIV/AIDS, a significant increase in drug-related overdose deaths, a growth in open public drug use in European cities and the apparent ineffectiveness of drug policy approaches focusing exclusively on abstinence or incarceration.

Ten countries now operate some form of drug consumption room. Eight European countries as well as Canada and Australia (Kings Cross).⁷⁷ This brings the number of DCRs / MSICs to a total of 90 worldwide.⁷⁸ France was the most recent country to establish a DCR in October 2016. In May 2017, Ireland passed legislation to establish a trial MSIC in Dublin.

MSICs are seen by some as an extension of needle and syringe programs (NSPs) and are often located in the same physical location as an NSP. In Australia, the widespread establishment of NSPs ensured HIV rates remained consistently low. NSPs have support even among groups opposed to MSICs. For example, Mr Dan Flynn from the Australian Christian Lobby gave evidence that NSPs “...ensure absolute basic sanitation”.⁷⁹

75 When discussing the administration of drugs in a supervised location generally, particularly in the European context the term DCR is used. When the discussion is focused specifically on the establishment of a service to allow people to safely inject drugs in Melbourne as outlined in the Bill, the term MSIC is used. Another term is supervised injective facility (SIF).

76 Hedrich, D., Kerr, T. and Dubois-Arber, F, ‘Drug consumption facilities in Europe and beyond’, in, *EMCDDA MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges* (2010), p.305.

77 DCRs operate in Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, Switzerland, Canada and Australia. A DCR did operate in Greece but was closed in 2014.

78 As at the date of publication.

79 Australian Christian Lobby, *Transcript of Evidence*, Wednesday 7 June 2017, pp.26-27.

The Australian Drug Foundation has pointed out the ‘perverse’ outcome whereby Victoria does not permit MSICs because it might condone drug use ‘when for 30 years Victoria has ensured people who inject drugs have access to a supply of clean needles and syringes’.⁸⁰

4.2 Aims and objectives

MSICs have both public health and public order objectives. Ultimately, it is intended that users not only administer their drugs in safer settings but, because of well-designed ‘integrated’ service delivery, also receive on-site health care, counselling, and referral to treatment and social services.⁸¹

The four main objectives (and benefits) of MSICs according to Australian drug academics Dolan et al are:

- Reduction in public nuisance (including inappropriately discarded injecting equipment public injecting and intoxication and visible drug dealing)
- Reduction in opioid-related overdoses (both fatal and non-fatal)
- Reduction in blood borne virus (BBV) transmission, particularly HIV and hepatitis C
- Improved access to medical care, treatment, health, information and welfare services.⁸²

MSICs have also been found to improve public order in the areas where they are located.⁸³

4.2.1 Services offered

Staffing at the facilities usually consists of a mixture of doctors, nurses, counsellors and social workers. A range of other services may be incorporated into the model, including medical care, counselling, food, laundry and showers, as well as assessment and referral to ongoing health, welfare, and in some cases housing and employment services. In some European countries, particularly the Netherlands, rooms for supervised smoking or inhaling of illicit drugs are also provided.

4.2.2 MSIC models

There are three main MSIC models: integrated, specialised and mobile facilities.

⁸⁰ Australian Drug Foundation, submission to the Law Reform, Road and Community Safety Committee, Inquiry into Drug Law Reform, *Submission 218*, p.27.

⁸¹ Cohealth, submission to the Law Reform, Road and Community Safety Committee, Inquiry into Drug Law Reform, *Submission 140*.

⁸² Dolan, K et al, ‘Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia’, *Drug and Alcohol Review – Harm Reduction Digest 10 (19) (2000)*, p. 338.

⁸³ Hedrich, D., Kerr, T. and Dubois-Arber, F, ‘Drug consumption facilities in Europe and beyond’, in, *EMCDDA MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges (2010)*, p.307.

The vast majority of drug consumption rooms are integrated in low-threshold facilities. Here, supervision of drug consumption is one of several ‘survival-oriented’ services offered at the same premises. These include providing food, showers and clothing to those who live on the streets, prevention materials including condoms and sharps containers, and counselling and drug treatment.

Specialised consumption rooms only offer the narrower range of services directly related to supervised consumption: the provision of hygienic injecting materials, advice on health and safer drug use, intervention in case of emergencies, and a space where users can remain under observation after consumption.

Mobile facilities currently exist in Barcelona and Berlin. They provide a geographically flexible deployment of the service, but typically cater for a more limited number of clients than fixed premises.⁸⁴ It has also been suggested that in localities where there is heightened opposition to the presence of an MSIC, mobile services may operate as a more palatable compromise to a fixed site or at least operate as a ‘stepping stone’ to a more permanent fixture.⁸⁵

4.2.3 Ideal requirements for an MSIC

Ideally, MSICs should be established as part of a ‘combination intervention’ – that is, they should comprise a package of interventions specifically tailored to the needs of the local setting and be based on harm reduction principles and practice. Such a package could combine an MSIC with an NSP, opiate substitution therapies, counselling, education, peer interventions and ultimately referrals to treatment services.

Community support

Services such as MSICs not only need to reach and be accepted by their target group, they should also gain acceptance by the wider and local community, including traders and businesses, local law enforcement, and non-drug using residents and visitors.⁸⁶ Engagement with key stakeholders throughout the processes of needs assessment, planning, implementation and evaluation is critical.⁸⁷ In particular, the needs assessment and planning process should reflect local concerns about reduced public amenity.⁸⁸

⁸⁴ Schäffer, D., Stöver, H., Schatz E. and Weichert, L., European Harm Reduction Network, *Drug consumption rooms in Europe: models, best practice and challenges* (2014), p.7.

⁸⁵ *Ibid*, p.8.

⁸⁶ Hedrich, D., Kerr, T. and Dubois-Arber, F, ‘Drug consumption facilities in Europe and beyond’, in, *EMCDDA MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges* (2010), p.311.

⁸⁷ Beletsky et al, ‘The law (and politics) of safe injection facilities in the United States’ in *Government, Politics and Law*, 98(2), (2008) pp.231-237; Broadhead et al ‘Safer injection facilities in North America: Their place in public policy and health initiatives’, *Journal of Drug Issues*, 2002, p.337; Schneider & Stover, *Guidelines for the operation and use of consumption rooms*, in proceedings of the conference: Consumption rooms as a professional service in addictions-health (2000), p.5.

⁸⁸ Yarra Drug and Health Forum, *The potential and viability of establishing a Supervised Injecting Facility (SIF) in Melbourne: Position Paper* (2009), p.9.

Law enforcement on side

The support of law enforcement is crucial. Relationships between police and MSIC providers can have an impact on the success or otherwise of an MSIC. This has been the case in Europe, Vancouver and Sydney.⁸⁹ There are signs, in the western world at least, that police and security forces are realising that the ‘war on drugs’ may not be winnable and that a partnership approach between police and health authorities that addresses substance use as a health issue may in the long term be more productive. In Portugal, for example, police play a key role in referring drug users to treatment facilities. In other jurisdictions, police may direct users to needle exchange sites or supervised injecting facilities, or use their discretion not to arrest users for minor use or possession offences, thereby conserving their limited resources to investigate more serious drug supply offences.⁹⁰

Suitable staffing

An essential element of successful MSICs and related services is the selection of good staff. The qualifications of staff at MSICs currently operating worldwide are predominantly in nursing, social work and counselling.⁹¹ Non-judgemental attitudes among staff and experience working with IDUs are essential.⁹² Training in recognising the signs and symptoms of overdose are also necessary, as is the presence of one staff member in the injecting area at all times.⁹³

4.2.4 Location

According to the Yarra Drug and Health Forum, the necessary requirements for locating an MSIC include:

- Prominence of public injecting
- Near drug markets
- High numbers of fatal and non-fatal overdoses occurring in public places
- Community concern around publicly discarded injecting equipment.⁹⁴

Such conditions currently exist in Melbourne, particularly in the North Richmond area.

⁸⁹ Broadhead et al ‘Safer injection facilities in North America: Their place in public policy and health initiatives’, *Journal of Drug Issues*, 2002, p.337; Schneider & Stover, *Guidelines for the operation and use of consumption rooms*, in proceedings of the conference: Consumption rooms as a professional service in addictions-health (2000), p.5.

⁹⁰ Hedrich, D., Kerr, T. and Dubois-Arber, F, ‘Drug consumption facilities in Europe and beyond’, in, *EMCDDA MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges* (2010), p.319.

⁹¹ Kimber et al ‘Survey of drug consumption rooms: service delivery and perceived public health and amenity impact’ *Drug and Alcohol Review*, 24, (2005), pp 21-24.

⁹² Fast et al, ‘The perspectives of injection drug users 27 regarding safer injection education delivered through a supervised injection facility’, *Harm Reduction Journal*, 5 (32), (2008), para 36.

⁹³ Yarra Drug and Health Forum, *The potential and viability of establishing a Supervised Injecting Facility (SIF) in Melbourne: Position Paper* (2009), p.13.

⁹⁴ *Ibid*, p.4.

The proposed trial in North Richmond meets the aims and objectives of MSICs as set out by Dolan et al in Section 4.2.

4.3 North Richmond as a location for an MSIC

The majority of evidence received by the Committee supported North Richmond as the preferred location for an MSIC, in particular because of the demand for an MSIC created by the drug market in North Richmond. This support came from local stakeholders, including the City of Yarra, Yarra Drug and Health Forum and North Richmond Community Health (see Section 4.8 below).

The Penington Institute also expressed support, telling the Committee, ‘... given particularly elevated concern about drug harms in North Richmond and stakeholders’ existing progress in generating local support for a SIF, implementation should occur there’.⁹⁵

However, this support was not unanimous. The Victoria Street Business Association, a group that represents traders and businesses on Victoria Street in North Richmond, provided a submission that raised concerns about the lack of consultation and consideration about the impact an MSIC may have on businesses in the area. It states:

As business operators, we are concerned for the safety of patrons, our staff and their family members. Many business operators are managed by family or extended family members.

In addition, the nature of the business activity here are also diverse, ranging from consultancy, professional services, retail, to hospitality. The business community has contributed significantly to the economic prosperity and cultural vibrancy of Yarra, and we are uncertain if any study of the adverse impact to this segment of the community has been considered, nor any meaningful consultation undertaken.

We remain keenly interested in what the Maribyrnong Council did when they were faced with a similar situation in the 1990s and early 2000s, and would like further information on why Richmond is considered the most relevant location for this trial, when other local government areas also experience terrible overdose challenges.⁹⁶

The Committee also met with representatives from the Victoria Street Business Association as part of its site visit to North Richmond. The site visit is discussed later in this chapter.

⁹⁵ The Penington Institute, *Submission 46*, p.3.

⁹⁶ Victoria Street Business Association, *Submission 48*, p.3.

4.4 Previous attempts to establish an MSIC in Victoria

This Inquiry is not the first time a proposal for an MSIC has been considered. In 1997, the Victorian Parliament's Drugs and Crime Prevention Committee gave qualified support for the introduction of an MSIC in its review of the implementation of the Government's *Turning the Tide* Drug Policy.⁹⁷

Among the Committee's findings were:

1. There are few interventions other than an MSIC specifically suited to comprehensively deal with the range of harms arising from public street injecting.
2. MSICs may be effective in dealing with the harms of street injecting (particularly public nuisance), but only if they are properly targeted and sensitively managed in the context of community consultation and education.
3. There are potential dangers and possible disadvantages associated with MSICs. The extent to which these disadvantages would actually arise, and what the true balance of costs and benefits would be, will best be determined through a controlled trial.

Prior to the 1999 Victorian election, the Victorian Labor Party, then in opposition, announced a drug strategy which included a controlled multiple-site trial of MSICs throughout Melbourne. Five sites were nominated: the CBD; Springvale; St Kilda; Footscray; and Fitzroy/Collingwood.

The policy was put forward at a time of high levels of injecting drug (heroin) use concentrated in these locations. On winning the election the Labor Government appointed a Drug Policy Expert Committee (DPEC) chaired by Professor David Penington.⁹⁸ The DPEC was to develop recommendations regarding implementation of the Government's drug policy, particularly to report on the establishment of a five-site trial of supervised injecting centres in Melbourne.⁹⁹

The Drugs, Poisons and Controlled Substances (Safe Injecting Facilities Trial) Bill 2000 was introduced in parliament in June 2000. The Bill was negatived in the Legislative Assembly and the trial was dropped from consideration with Premier Bracks stating that an MSIC 'would not be funded during the life of the Victorian Labor Government'.¹⁰⁰

⁹⁷ Parliament of Victoria, Drugs and Crime Prevention Committee, *Safe Injecting Facilities: Their justification and viability in the Victorian setting*, Occasional Paper Number Two, 1997.

⁹⁸ Ibid.

⁹⁹ Yarra Drug and Health Forum, *The potential and viability of establishing a Supervised Injecting Facility (SIF) in Melbourne: Position Paper* (2009), p.18.

¹⁰⁰ Ibid.

4.5 Evaluations of MSICs and DCRs in Europe

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) undertook a major review of the evidence for effectiveness of all forms of drug harm reduction in 2010. The Review concentrated primarily on:

- NSPs
- Opioid substitution treatment
- Peer naloxone distribution
- MSICs/DCRs.

While the following section concentrates only on the evidence as it pertains to MSICs and/or DCRs, it is inappropriate to isolate the effect of one intervention alone in according success (or failure) in drug-related outcomes. MSICs should always be seen as one part of a continuum in addressing drug-related harms alongside approaches in prevention, treatment and enforcement.

It has also been noted by the EMCDDA (and many other evaluations/reviews) that in measuring the effect of any harm reduction initiative, and particularly programs such as NSPs and MSICs, a reduction in harm occurring is the key indicator of ‘success’, not a reduction in use per se, however desirable this otherwise might be.

The EMCDDA Review found that harm reduction measures such as those listed above had a general net benefit in reducing the harms associated with illicit drug use. One of the research studies undertaken as part of the Review process noted, however, that the evidence linking MSICs to the reduction of drug-related harms was less robust than that for interventions such as opioid substitution treatment. This was largely because fewer ‘gold standard’ evaluations had been done of MSICs compared to opioid substitution treatment.¹⁰¹

4.5.1 Overdose mortality and morbidity

With regard to drug-related overdoses, however, there is stronger evidence that MSICs/DCRs lead to a lower incidence of overdoses.¹⁰² For example, a study of drug-related deaths in four German cities ‘found a significant association between the operations of DCRs and the reduction of drug-related deaths’.¹⁰³ In fact, there has never been a death from a drug overdose in an MSIC.¹⁰⁴ The Sydney MSIC has managed over 6000 overdoses without any fatalities.¹⁰⁵

¹⁰¹ Kimber et al, ‘Harm reduction among injecting drug users — evidence of effectiveness’, in, EMCDDA *MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges* (2010), p.115.

¹⁰² Dagmar Hedrich, EMCDDA, *European report on drug consumption rooms*, 2004, p.51; Kerr et al, *Circumstances of First Injection Among Illicit Drug Users Accessing a Medically Supervised Safer Injection Facility*, 2007, para 2.

¹⁰³ Poschade et al, *Evaluation of the Work of the Drug Consumption Rooms in the Federal Republic of Germany*, Federal Ministry for Health, Germany, (2003), pp.24-25.

¹⁰⁴ Uniting Care, *Cross Currents: The Story Behind Australia’s first and only Medically Supervised Injecting Centre*, (2014), p.29.

¹⁰⁵ Salmon et al, ‘The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia,’ *Addiction*, 105(4), (2010), pp. 676-683.

4.5.2 Injecting risk behaviours

There is evidence from multiple studies that MSICs/DCRs are associated with reduced injecting risk behaviours, including safer injecting practices and better hygiene. It is surmised that this is largely due to the presence of professional staff, particularly nurses, who can instruct on safer practices.¹⁰⁶

4.5.3 EMCDDA Review

A 2016 Review by the EMCDDA found that:

- MSICs increase uptake both of detoxification and of drug dependence treatment, including opioid substitution therapy
- DCRs are associated with a decrease in public injecting and a reduction in the number of syringes discarded in the vicinity
- DCRs do not appear to lead to either an increase or decrease in thefts or robberies around the facility.¹⁰⁷

The EMCDDA states that any reservations are due to a lack of robust research studies in this area. When research studies are undertaken, there may also be methodological challenges in knowing when any positive (or negative) change is due to MSIC/DCR intervention compared to the effect of broader local policy, community or ecological changes (changes in drug markets, effect of other harm reduction interventions etc).¹⁰⁸

FINDING 8: MSICs improve the health of injecting drug users and reduce signs of drug use in surrounding streets.

4.6 Evaluation of the MSIC in Sydney

Evaluations of the MSIC in Kings Cross have widely been recognised as the most comprehensive undertaken of an MSIC.

The official evaluation of the MSIC commissioned at the time of its establishment examined the effect of the MSIC on blood borne virus incidence and prevalence in Sydney. It found no conclusive evidence of either an increase or decrease in incidence of notifications for infections in the locality of the injecting room compared to control localities away from the MSIC.¹⁰⁹

¹⁰⁶ Kimber et al, 'Harm reduction among injecting drug users — evidence of effectiveness', in, *EMCDDA MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges* (2010), p.142.

¹⁰⁷ EMCDDA, *Drug Consumption Rooms: An overview of provision and evidence*, (2017), p.5.

¹⁰⁸ Hedrich, Kerr and Dubois-Arber, 'Drug consumption facilities in Europe and beyond', in, *EMCDDA MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges*, 2010, p.305.

¹⁰⁹ MSIC Evaluation Committee, *Final Report of the Sydney Medically Supervised Injecting Centre*, (2003), p.66.

As with evaluations done in Europe, there was stronger evidence positing a link between the MSIC and a reduction in overdose deaths in the vicinity. However a review of the evidence of the Sydney MSIC, noted that such a reduction could have been due to a number of other confounding variables:

The time series study of DCR operation and overdose deaths and ambulance call-outs to suspected opioid overdoses in Sydney, was inconclusive due to confounding changes in the drug market after the opening of the DCR that led to a significant reduction in heroin use.¹¹⁰

An evaluation of the centre by KPMG in 2010 also found that the MSIC had:

- Reduced the number of publically discarded needles and syringes in the Kings Cross area by approximately 50 per cent
- Decreased the number of ambulance call outs to Kings Cross by 80 per cent¹¹¹
- Generated more than 8500 referrals to health and welfare services.¹¹²

The MSIC has not measured the number of injecting drug users who take up referrals to other health services.

The NSW Bureau of Crime Statistics and Research has conducted five evaluations of the MSIC, all of which found the Centre has had no negative effect on drug-related crime and dealing (sometimes referred to as the ‘honey pot’ effect). The most recent update states:

The NSW Bureau of Crime Statistics and Research has conducted four previous studies examining the impact of Sydney’s Medically Supervised Injecting Centre (MSIC) on recorded incidents of robbery, theft and illicit drug offences in the Kings Cross Local Area Command (LAC). The initial evaluation conducted by Freeman et al. (2005) covered the period January 1999 through September 2002 and compared changes in the frequency of recorded incidents of theft and robbery in the Kings Cross LAC (after the opening of the MSIC in May 2001) with trends in the rest of Sydney. This study also measured changes in the number of drug-related loiterers outside the MSIC.

Freeman et al. (2005) found no evidence of any increase in robbery or theft incidents in the Kings Cross LAC after the MSIC commenced, nor any increase in drug-related loitering. Rather, the Australia-wide heroin shortage, which had become apparent just after Christmas 2000 (Rouen et al. 2001) was the major explanatory factor for changes in the frequency of these crimes in Kings Cross, rather than the MSIC itself. Specifically there was an initial increase in robbery incidents around the time of the heroin shortage which has been linked to a transient increase in the availability of cocaine (Degenhardt, Conroy, Gilmour, & Collins, 2005; Donnelly, Weatherburn, & Chilvers, 2004). This was then followed by a consistent declining trend in robbery and theft thereafter. There was no significant change in the level of either robbery or theft incidents in Kings Cross.¹¹³

¹¹⁰ Kimber et al, Harm reduction among injecting drug users – evidence of effectiveness in *EMCDDA MONOGRAPHS 10 Harm reduction: evidence, impacts and challenges* (2010), p.143.

¹¹¹ The report noted that a reduction in the availability of heroin also contributed to this decline.

¹¹² KPMG, *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011)*, (2010), pp.28 and 118.

¹¹³ New South Wales Bureau of Crime Statistics and Research, Trends in property and illicit drug crime around the Medically Supervised Injecting Centre in Kings Cross: 2012 update, Issue Paper No. 90, July 2013, p. 1.

Further, a 2010 review of the Centre found:

The burden on ambulance services of attending to opioid-related overdoses declined significantly in the vicinity of the Sydney SIF after it opened, compared to the rest of NSW. This effect was greatest during operating hours and in the immediate MSIC area, suggesting that SIFs may be most effective in reducing the impact of opioid-related overdose in their immediate vicinity. By providing environments in which IDUs receive supervised injection and overdose management and education SIF can reduce the demand for ambulance services, thereby freeing them to attend other medical emergencies within the community.¹¹⁴

In its submission to this Inquiry, Victoria Police notes the ‘strong evidence’ received by the Committee that the MSIC in Sydney has reduced the number of overdose deaths and improved access to drug treatment, health and welfare services.¹¹⁵

Attitudes of local businesses near the MSIC in Kings Cross were evaluated by the National Centre in HIV Epidemiology and Clinical Research. In 2005, nearly 70 per cent agreed with the establishment of the centre, which was an increase from 63 per cent in 2002 and 58 per cent in 2000.¹¹⁶ The National Drug Strategy Household Survey in 2010 also found that a majority of those surveyed support MSICs.¹¹⁷

FINDING 9: Evaluations of the MSIC in Sydney found evidence of public amenity benefits to the local community and reduced demand for ambulance services. The evaluations did not find evidence of the MSIC having a ‘honey pot’ effect on crime.

4.7 The views of submitters and stakeholders

The vast majority of submitters to this Inquiry and the Inquiry currently being carried out by the Law Reform, Road and Community Safety Committee support the establishment of an MSIC. This includes overwhelming support among the drug policy and practice arena and related medical, health and legal fields. For example, the Australian Medical Association (Victoria) in its submission to the inquiry said an MSIC trial has the potential to:

- Lessen the public impact of street-based injecting
- Improve clients’ access to primary medical care, drug treatment and health and other welfare services
- Reduce the incidence of fatal heroin-related overdoses
- Assist in reducing blood borne viral transmission.¹¹⁸

¹¹⁴ Salmon et al, The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia (2010).

¹¹⁵ Victoria Police, *Submission 49*, p.1.

¹¹⁶ National Centre in HIV Epidemiology and Clinical Research, Sydney Medically Supervised Injecting Centre Interim Evaluation Report No. 2: Evaluation of Community Attitudes towards the Sydney MSIC, (2006), p.16.

¹¹⁷ Commonwealth Government, Australian Institute of Health and Welfare, *2010 National Drug Strategy Household Survey report*, 2011, p.179.

¹¹⁸ The Australian Medical Association (Victoria), *Submission 22*, p.9.

Similarly, the Penington Institute told the Committee it supported the introduction of an MSIC. It said such a centre would assist in:

Providing settings for the supervised consumption of drugs is likely to generate significant benefits for the health, safety, economy and amenity of Victorians. Importantly, many of the benefits of supervised injecting facilities (SIFs) cannot be achieved through alternative interventions. There are also few, if any, tangible downsides to supervised consumption. In this sense, the more challenging question is not whether Victoria should implement supervised consumption, but rather how and where to do it.¹¹⁹

A number of significant stakeholders in North Richmond area also added their support for the establishment of an MSIC. The City of Yarra told the Inquiry that it:

...urges the Victorian Government to act on the extensive evidence available that supports the establishment of a SIF [Safe Injecting Facility] as a means of reducing drug-related harm in our community can calls on the Victorian Government to implement the recent recommendations made by Coroner Hawkins.¹²⁰

North Richmond Community Health (NRCH) gave its strong support to the introduction of an MSIC, telling the Committee: 'It is an evidence-based opportunity to improve health outcomes for those that use drugs, reduce the likelihood of death, improve amenity and link those that most need it into the appropriate services.'¹²¹ NRCH also expressed interest in running such a facility.

A number of residents of North Richmond and Abbotsford also expressed their support for an MSIC. This sentiment was expressed in submissions to the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform, two of which are included below:

I strongly support a safer supervised injecting room for Richmond. It has been shown to work extremely well in Sydney and other places overseas. It does not encourage drug use but reduces the harm that is being done by injecting on the street. There is also a significant toll on health workers and members of the local community who have to deal with the aftermath of overdoses and for children to see people in public in such a terrible state.¹²²

I am a small business owner, a taxpayer, and a resident of Yarra. I support a supervised injecting facility at the North Richmond Medical Centre because residents and taxpayers of Yarra are struggling with a public injection and discarded needles epidemic.¹²³

119 The Penington Institute, *Submission 46*, p.3.

120 City of Yarra, *Submission 9*, p.4.

121 North Richmond Community Health, *Submission 15*, p.8.

122 Richard Smithers, Law Reform, Road and Community Safety Committee's inquiry into Drug Law Reform, *Submission 88*, p.1.

123 Name Withheld, Law Reform, Road and Community Safety Committee's inquiry into Drug Law Reform, *Submission 102*, p.1.

The 46 stakeholders to this Inquiry who called for the establishment of an MSIC in Melbourne, or support the concept generally, include the following organisations:

- City of Yarra
- Royal Australian College of Physicians
- Australian Medical Association
- Yarra Drug and Health Forum
- Family Drug Support
- Families and Friends for Drug Law Reform
- Turning Point
- Burnet Institute
- Australasian Professional Society on Alcohol and Other Drugs
- Victorian Alcohol and other Drugs Association
- National Drug and Alcohol Research Centre
- Alfred Health
- Community Legal Services/Community Health Services
- Beyond Blue
- Windana Drug and Alcohol Recovery
- Victorian AIDS Council
- Australian Drug Foundation.

However, MSICs were opposed by two organisations to this inquiry: Drug Free Australia; and the Australian Christian Lobby. Both submitters cited what they perceived as inconsistencies with the evaluations of the Sydney MSIC. They also articulated the view that the establishment of MSICs would appear to condone illicit drug use.

The Committee heard evidence from Mr Dan Flynn, Victorian Director of the Australian Christian Lobby at a public hearing. Mr Flynn outlined concerns that an MSIC could imply that harmful illicit drugs are safe to use in a supervised setting, and that this could lead to an increase in drug use:

We have taken great efforts federally to stop the import of illicit drugs into Australia, and yet what we are considering here is sending a message that injecting illicit drugs can be safe and that people can attend these premises, use their illicit drugs and then emerge out on the streets and there will be no particular consequences that anybody should be concerned about. We are concerned that this will result in increased drug use.¹²⁴

124 Dan Flynn, Victorian Director, Australian Christian Lobby, *Transcript of Evidence*, Wednesday 7 June 2017.

The Submission from Drug Free Australia questioned the efficiencies of MSICs. It argued that the Sydney MSIC has the capacity to supervise 300 injections per day. This figure, if matched by a proposed Victorian MSIC, would only meet the demand of a fraction of Victoria's intravenous drug users.¹²⁵

Not all Christian churches and organisations take this position. The Uniting Church for many years has been a supporter of MSICs and is the auspicing body for the MSIC in Sydney. As well, the Salvation Army has released a policy paper in which it examines the evaluations of MSICs in Sydney and elsewhere and endorses the establishment of MSICs.¹²⁶

Finally, the Victoria Street Business Association told the Committee that it does not oppose MSICs in principle and supports harm minimisation approaches. However, as mentioned above, the Association objects to North Richmond being chosen as the only location for an MSIC. Its submission states:

We also understand the Kings Cross pilot has yielded positive results including death prevention. We also understand that in each study, the specifics contribute a great deal to the results including location, other actions by other organisations and departments.¹²⁷

The Victoria Street Business Association recommended the following actions in its submission:

1. Consider the CCTV camera solution as a first step, with other supporting solutions to create a safe, clean and well monitored environment for all patrons, visitors and people who work and live here.
2. Provide a working group with a clear term of reference, expertise and resources to oversee this approach including an evaluation report.
3. Engage in ongoing discussions with appropriate levels of government, health professionals, researchers, the business sector and the community to identify a holistic and appropriate solution in the longer term.¹²⁸

Most expert evidence that supports the establishment of MSICs, including the proposal for an MSIC in Melbourne, understands that one intervention alone will not provide a total solution to problems associated with illicit drugs. Rather, such advocates argue MSICs should be seen as part of a continuum of support services for both the user and the local community. Such extended supports should by no means exclude encouraging users to access treatment programs.

FINDING 10: 46 of 49 submissions in this Inquiry, of which three were from local residents, support a trial of an MSIC in North Richmond.

¹²⁵ Drug Free Australia, *Submission 45*, p.4.

¹²⁶ <www.salvationarmy.org.au/en/find-help/Alcohol-and-Other-Drugs/Fact-Sheets/Supervised-Injecting-Facilities>, accessed May 16, 2017.

¹²⁷ Victoria Street Business Association, *Submission 48*, p.2.

¹²⁸ *Ibid*, p.3.

5 International, national and state drug policy

5.1 Drug policy and reform

An understanding of current approaches to drug policy and control including the current Australian drug policy framework requires an overview of the origins of drug regulation and interventions such as MSICs.

5.1.1 International drug policy – United Nations treaties

The United Nations established a new framework for drug control policy in the years following the Second World War. The three international treaties pertaining to drug control established in the post-war period which are still in operation today are the:

- 1961 Single Convention on Narcotic Drugs
- 1971 Convention on Psychotropic Substances
- 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

These conventions have been signed by the great majority of the world's nations, guaranteeing almost universal coverage.

Collectively, the treaties have the dual objective of penalising illicit use of psychoactive substances, while at the same time establishing an international governance system for the legitimate scientific and medical use of drugs. The International Narcotics Control Board has the role of monitoring and overseeing both aspects of the treaties and their observance by individual nations.

Until recently, the International Narcotics Control Board has been committed to a prohibitionist model of drug control and largely opposed to harm reduction strategies. Article 3 of the 1988 Convention states that possession or purchase of any narcotic or psychotropic substance, other than for approved medical or scientific purposes, should be a punishable criminal offence under domestic law.

However, this commitment has eased recently. The International Narcotics Control Board's 2016 annual report states:

With respect to “drug consumption rooms”, the Board wishes to reiterate its frequently expressed concern that, in order for the operation of such facilities to be consistent with the international drug conventions, certain conditions must be fulfilled. Chief among those conditions is that the ultimate objective of these measures is to reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking. “Drug consumption rooms” must be operated

within a framework that offers treatment and rehabilitation services as well as social reintegration measures, either directly or by active referral for access, and must not be a substitute for demand reduction programmes, in particular prevention and treatment activities.¹²⁹

Further, a paper for the think tank Australia 21 suggests MSICs are arguably not in breach of the contraventions:

The requirement that the treaties have effect subject to Australia's 'constitutional principles and the basic concepts of its legal system' means that we have considerable flexibility on how we implement the prohibition regime, so long as we retain the offences specified in the treaties. This flexibility is illustrated by the COAG Illicit Drug Diversion Scheme and the legislation covering Sydney's Medically Supervised Injecting Centre.¹³⁰

Australia is a signatory to the UN drug control treaties and has fulfilled its obligations under the agreements. However, Australia has had a 30-year history of drug law reform that has to some extent challenged aspects of the prohibitionist model. These reforms include harm minimisation policies such as NSPs.

FINDING 11: Harm reduction strategies based on public health principles, such as needle and syringe programs, do not contravene international conventions.

5.1.2 The Australian drug policy framework

The key strategy guiding Australian drug policy is the National Drug Strategy (NDS). The overarching aim of the NDS, which has been in place since 1985, is to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic consequences.¹³¹

The NDS operates as a guiding framework on drug policy at both national and state levels, although the states and territories have latitude to develop policies, laws and programmes that accommodate local circumstances and preferences.¹³² It also acts as a key document to inform expenditure decisions in drug policy.¹³³

Australia's drug policy is based on three 'pillars': demand reduction; supply reduction; and harm reduction. Demand reduction includes prevention and treatment with a focus on reducing the number of people using drugs. Supply reduction refers to policing and customs activities that aim to reduce the availability of drugs. Harm reduction refers to the strategies aimed at those who continue to use drugs to effect the minimisation of harms to individuals, families and the community from drug use (see Section 5.1.4 below).

¹²⁹ The International Narcotics Control Board, *2016 Annual Report*, p.91.

¹³⁰ David McDonald, *What are the likely costs and benefits of a change in Australia's current policy on illicit drugs?*, A Background Paper for an Australia 21 Roundtable, (2011), p.15.

¹³¹ Ministerial Council on Drug Strategy, *National Drug Strategy 2010–2015 A framework for action on alcohol, tobacco and other drugs* (2011), p.ii.

¹³² Australia 21, *What are the likely costs and benefits of a change in Australia's current policy on illicit drugs*, report prepared by David McDonald (2011), p.9.

¹³³ Alison Ritter, Kari Lancaster, Katrina Grech, Peter Reuter, report for the Drug Policy Modelling Program, Monograph 21, *An assessment of illicit drug policy in Australia (1985–2010) Themes and Trends* (2011), p.7.

The concept of harm reduction remains the primary direction of the NDS for the next ten years. This includes a continued emphasis on a partnership between the health and law enforcement sectors, which has generally been viewed as a major success of the NDS.

5.1.3 Evaluation of previous strategies

There have been two formal evaluations of the NDS, in 2003 and in 2009.

The 2003 evaluation of the NDS noted:

Based on the data and literature analysis as well as the consultations for this evaluation, the NDS is considered to be successful by having created an environment for a consistent national approach while providing the flexibility to respond to State and Territory issues. This has been achieved through: cooperation by State, Territory and Commonwealth governments; bipartisan support; and through being visionary in providing leadership within Australia without being too mired in ideologically driven approaches and activities in dealing with drug use.¹³⁴

A further evaluation in 2009 noted:

The NDS policy framework has successfully informed development and implementation of drug policies and strategies at many levels and across government and the public, private and non-government domains. The NDS is broad and flexible enough to enable State and Territory and local drug strategies to be tailored to local needs and priorities Victorian drug strategies.¹³⁵

Victoria along with most other states has localised drug strategies addressing drug-related problems that arise in or are specific to this State. The most recent general framework produced at state level was *Reducing the alcohol and drug toll: Victoria's plan 2013–2017*, a whole-of-government strategy to reduce the impact of alcohol and drug abuse on the Victorian community.

The strategy was developed with input from an independent expert advisory group comprised of members from the health, education, justice, business, and local government and community sectors. It sets out a 15-point plan that provides a comprehensive response to the three major drug types: alcohol; pharmaceutical drugs; and illegal drugs. It also focuses on care, treatment and recovery as well as strengthening leadership and coordinated action in reducing the alcohol and drug toll.

This strategy largely lapsed with the change of government in November 2014. It has been replaced by other specialist policies and programs concerning individual drugs, such as: Victorian Ice Action Plan; Community Based Alcohol and other Drug Service Provision Review; Alcohol and Drug Workforce Framework; and Alcohol and Other Drug Data, Research Planning.

¹³⁴ SuccessWorks, *Evaluation of the National Drug Strategic Framework 1998-99 – 2003-04* (2003), p.3.

¹³⁵ Siggins Miller, *Evaluation and Monitoring of the National Drug Strategy 2004-2009 Final Report* (2009), p.viii.

5.1.4 Harm reduction strategies

The International Harm Reduction Association describes harm reduction as:

Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities without requiring decrease in drug use.¹³⁶

Such a perspective results in a set of strategies that aim to reduce harm to the person and the community in which he or she lives. Increasingly, these strategies address the harms associated with and arising from drug policies that result in arrest, imprisonment and negative health outcomes, such as the spread of disease through unsafe drug injecting practices.¹³⁷ Yet interventions that aim for abstinence/non-use are compatible with a harm reduction philosophy.

A key aspect of harm reduction interventions is that they promote the integration/re-integration of a drug user into society. As discussed in Chapter 4, MSICs can provide a range of comprehensive practical and rehabilitative services that are linked to broader public health and social services.¹³⁸

5.1.5 Criticisms of the concept of harm reduction

Some believe the concept of harm reduction may condone drug use or ‘send the wrong message’ and result in adverse consequences, including: encouraging drug use; preventing drug users from getting out of the drug lifestyle; and not reducing harms. For example, a submission to the Senate Inquiry into Substance Abuse in 2002 from the Community Coalition for a Drug Free Society is indicative of the views held by those opposed to the liberalisation of Australia’s drug laws and policies:

Sadly, I am aware of many ordinary Mums and Dads who would love to tell you what they think of the current situation regarding substance abuse in our nation. They are, in fact, worried stiff that the continued promotion of illegal drugs and substance abuse through ‘HARM MINIMISATION’ will eventually be the DEATH of their children. Sadly for some they will be right. Any nation which tells its young people, “We know you’re going to do it, so we will not say don’t, we will just show you how to reduce harm” or “How to do it safely” as one youth worker told me he had to say, clearly has little real compassion for its youth or consideration for the long term future of its citizens. This policy is a cop-out and too many State governments are doing it.¹³⁹

¹³⁶ Neil Hunt, Mike Ashton, Simon Lenton, Luke Mitcheson, Bill Nelles and Gerry Stimson, *A review of the evidence-base for harm reduction approaches to drug use* (2002), p.4.

¹³⁷ Davoli, M, Simon R and Griffiths P, European Monitoring Centre for Drugs and Drug Addiction, EMCDDA Scientific Monitoring Series No 10, *Harm reduction: evidence, impacts and challenges* (2010), p.438.

¹³⁸ A Ball, Broadening the scope and impact of harm reduction for HIV prevention, treatment and care among injecting drug users in *EMCDDA Scientific Monitoring Series No 10, Harm reduction: evidence, impacts and challenges*, (2010), p.89.

¹³⁹ Community Coalition for a Drug Free Society, Submission to the Standing Committee on Family and Community Affairs Inquiry into substance abuse in Australian communities, *Submission 251*, p.1.

The Australian Christian Lobby's submission to this Inquiry argues:

Offering drug-injecting rooms sends the wrong message to people dealing with drug addiction; it sends the erroneous message that the practice can be safe. Drug users often become slaves to their addiction, we should be doing all we can to help them overcome the addiction.¹⁴⁰

140 Australian Christian Lobby, *Submission 21*, p.2.

6 Policing policy

6.1 Introduction

The Terms of Reference of the inquiry require the Committee to consider the nature and extent of relevant policing policy in relation to MSICs.

This Chapter briefly outlines both Commonwealth and State legislation for drug offences and the penalties specified in the legislation. It then focuses on the sentencing schemes in place to deal with drug users, particularly those schemes that aim to divert people from the criminal justice system and focus on the rehabilitation of offenders.

The Committee was also provided information from Victoria Police about the operational strategies used in North Richmond to police drug-related activity. This includes the work undertaken in partnership with community stakeholders to reduce crime and enhance safety in the area.

6.2 Commonwealth drug laws

Criminal offences for drugs are principally the responsibility of the states and territories. However, the Commonwealth can enact legislation relating to drugs as part of its external affairs jurisdiction.¹⁴¹ Commonwealth drug legislation primarily concerns offences for the import and export of drugs, cross-border and extra-territorial issues, and Australia's international treaty obligations.

The primary piece of Commonwealth legislation that governs drug offences is the *Criminal Code Act 1995*. The Commonwealth also administers the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*, which deals with the traffic of drugs and psychotropic substances in accordance with the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. This includes offences for cross-border issues, including: drugs on Australian ships and planes;¹⁴² dealing and conspiracy outside Australia with a view to commit or commission of an offence in Australia; and offences associated with the receipt and concealment of the proceeds of drug offences.¹⁴³

141 Australian Constitution, Section 51, xxix

142 *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* (cth), Part 2, ss.10-11

143 *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* (cth), Part 2, ss.12-14 and 15A-15C

6.2.1 Commonwealth *Criminal Code Act 1995*

The offences outlined in the *Criminal Code Act 1995* relate primarily to the import and export of drugs. The drugs covered by the Act include well-known illegal drugs such as heroin, cocaine, MDMA (ecstasy), methamphetamine and cannabis.¹⁴⁴ The *Criminal Code Act 1995* outlines an offence for trafficking, which is defined as selling, preparing, transporting, guarding or possession of a trafficable quantity of a drug.¹⁴⁵

The penalties outlined in the *Criminal Code Act 1995* are based on the quantity of the drug involved. Table 6.1 outlines the classifications and penalties for offences involving Heroin.

Table 6.1 Commonwealth drug quantity classifications and penalties for trafficking and the importing and exporting of heroin

	Drug	Quantity	Maximum penalty for trafficking, and importing/exporting
A trafficable quantity	Heroin	2 g	Imprisonment for 10 years or 2,000 penalty units or both
A marketable quantity	Heroin	250 g	Imprisonment for 25 years or 5,000 penalty units or both
A commercial quantity	Heroin	1.5 kg	Imprisonment for life or 7,500 penalty units or both

Source: *Criminal Code Act 1995* (cth), Volume 2, div.302.1-302.4; div 307.1-307.3; and *Criminal Code Regulations 2002* (cth), Schedule 3, Columns 2-4.

6.3 Victorian drug laws

In Victoria, the legislation that relates to drug offences is the *Drugs, Poisons and Controlled Substances Act 1981* (the Act). Part 5 of the Act outlines offences for trafficking, cultivation, possession and use of 'drugs of dependence', which are the same as in the Commonwealth Act.¹⁴⁶

6.3.1 Trafficking

Trafficking under the Act is defined as preparing, manufacturing and selling or agreeing to sell a drug of dependence.¹⁴⁷ An offence is committed if a person is in possession of a trafficable quantity of a controlled drug. Like the Commonwealth Act, the penalties for trafficking are classified according to the amount of the drug. Table 6.2 outlines these penalties.

¹⁴⁴ Criminal Code Regulations 2002, Schedule 3, Column 1, items 127, 67, 173 and 157

¹⁴⁵ *Criminal Code Act 1995* (cth), Volume 2, div.302, s.302.1

¹⁴⁶ *Drugs, Poisons and Controlled Substances Act 1981*, Schedule 11.

¹⁴⁷ Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamine in Victoria* (2014), Volume 2, pp.382-383.

Table 6.2 Victorian drug quantity classifications and penalties for trafficking heroin

	Drug	Quantity	Maximum penalty for trafficking
A small quantity	Heroin	1 g	N/A
A trafficable quantity	Heroin	3 g	Level 4 imprisonment, with a maximum of 15 years
A commercial quantity	Heroin	250 g (when pure) 500 g (when diluted)	Level 2 imprisonment with a maximum of 25 years
A large commercial quantity	Heroin	750 g (when pure) 1.0 kg (when diluted)	Level 1 imprisonment (life) with a minimum of 14 years in addition a penalty of not more than 5,000 penalty units ^(a)

(a) At July 2016, the value of a penalty unit in Victoria is \$155.46.

Source: *Drugs, Poisons and Controlled Substances Act 1981*, Part V, ss.71(1)-(2), 71AA, 71AC; and Schedule 11, Part 3, Columns 1A – 4.

6.3.2 Possession

The Fitzroy Legal Service Law Handbook gives a description of the common law interpretation of possession, as it is applied in the Act:

Under common law, a person is in possession of a drug if they have physical control or custody of the drug. The prosecution must prove knowledge by the person of the presence of the drug and an intention by the person to possess the drug.

In many cases, custody of a drug may be sufficient evidence of possession, including the necessary mental element. This is because the inference of knowledge may often be drawn from the surrounding circumstances (*Williams v The Queen* [1978] HCA 49).¹⁴⁸

The Act states that a person will also be in possession of a drug if it is on any land or premises occupied by that person.¹⁴⁹

The penalty for possession under the Act for a drug that is not cannabis and the court is satisfied is not for the purpose of trafficking (i.e. a small quantity) is 30 penalty units or a maximum of one year imprisonment.¹⁵⁰ In the case of cannabis, for a small quantity, the maximum penalty is five penalty units with no specified term of imprisonment.¹⁵¹ Criminal justice diversion strategies for the possession of small quantities of drugs are discussed below.

¹⁴⁸ Fitzroy Legal Service, the Law Handbook 2017 (2017), p.120.

¹⁴⁹ *Drugs, Poisons and Controlled Substances Act 1981*, Part 1, s.5.

¹⁵⁰ *Ibid*, Part V, s.73(b).

¹⁵¹ *Ibid*, Part V, s.73(a).

6.3.3 Use

The use of drugs under the Act is defined as the smoking or inhalation of a drug of dependence or the introduction of a drug of dependence into a person's body.¹⁵² The penalty for use of a drug of dependence that is not cannabis is 30 penalty units or a maximum of one year imprisonment.¹⁵³

6.4 Local policing – Victoria Police strategies

The Committee heard from submitters about the operational approach to drug-related activity in North Richmond in the past:

Toward the end of the 2000s and up until 2011 Victoria Police conducted several major intensive operations known as 'Operation Elizabeth'. This was a biannual 'crackdown' that involved several arms of policing saturating the area and arresting people suspected of being involved in the illicit drug market. Police units involved included mobile patrols, dog squad, mounted police and foot patrols. It was not uncommon during these campaigns to see police interrogating and searching suspects in the street.¹⁵⁴

A major impact of these policing operations was the displacement of the drug market, including public injecting, into areas that had not experienced the drug market previously. Areas that began to emerge as new drug zones because of the shift in the market included East Melbourne and Abbotsford.¹⁵⁵

Victoria Police adopts a harm minimisation approach incorporating the three pillars of demand reduction, supply reduction and harm reduction as outlined in the Australian Drug Strategy. Their submission states it takes this approach '...with the aim of balancing health, social and economic outcomes for the community, individuals and Victoria Police members'.¹⁵⁶

While efforts are primarily focused on supply reduction, they align with demand reduction and harm reduction strategies. For example, in relation to non-fatal overdoses:

Victoria Police policy is that before pursuing any investigation for 'use' and 'possess' offences at incidents of non-fatal overdoses, members are required to consider firstly whether this action is in the best interests of the community. The rationale for this approach is removing the fear of prosecution will tend to encourage those people present at overdoses to call for an ambulance without delay, thereby reducing the risk of death or serious injury.¹⁵⁷

North Richmond Community Health Service spoke about this approach:

¹⁵² Ibid, Part V, s.70.

¹⁵³ Ibid, Part V, s.75(a).

¹⁵⁴ Yarra Drug and Health Forum, *Submission 4*, p.3.

¹⁵⁵ Ibid.

¹⁵⁶ Victoria Police, *Submission 49*, p.2.

¹⁵⁷ Ibid, p.3.

The negative outcomes of a heavy public injecting scene in North Richmond are further exacerbated during periods of increased police presence, which is especially the case during a police ‘blitz’/‘operation’. During these periods people who inject drugs often do so in more of a hurry than usual. Safer injecting steps are rushed or skipped altogether, people use in less accessible and often less hygienic places, and are more likely to leave used syringes and other paraphernalia in the area. Records kept at NRCH have found that spikes in overdose have coincided with (intensive) local police blitz operations.¹⁵⁸

Since 2015, Operation Kevlar has aimed to detect, investigate and disrupt mid-level drug dealing in the Victoria Street Precinct. The operation uses both overt and covert investigation methodologies.¹⁵⁹

In addition, Victoria Police has established:

- A procedure for identifying the principal adult and youth offenders involved in drug related offending within the area
- A Human Source Management Team, which is responsible for managing registered human sources within the area regular foot patrols of the Victoria Street precinct by uniform and plain clothes members
- A Melbourne Divisional Response Unit, which provides a targeted criminal investigation capability across the Melbourne and Yarra areas through two teams dedicated to the investigation of drug-related offending
- A Yarra Criminal Investigation Unit, which is responsible for investigating criminal activity across the Fitzroy, Collingwood and Richmond areas, with one team dedicated to the investigation of drug-related offending.¹⁶⁰

The Victoria Police submission also outlines work done in conjunction with community stakeholders including the City of Yarra, the Department of Health and Human Services, local traders, and community support services. This strategy, known as the Victoria Street Richmond Precinct Community Safety Strategy, is ‘...a recognition that Victoria Police cannot tackle drug-related harm alone’.¹⁶¹

The purpose of the Strategy is to:

- Foster relationships and strengthen existing partnerships between police and local stakeholders to work together to reduce crime and enhance perceptions of safety in the Victoria Street precinct
- Improve safety through integration of communication and information from all community role players
- Create a sustained, safe and attractive environment for residents, traders and the community in Victoria Street precinct.¹⁶²

¹⁵⁸ North Richmond Community Health Service, *Submission 15*, p.5

¹⁵⁹ Victoria Police, *Submission 49*, p.3.

¹⁶⁰ *Ibid*, p.4.

¹⁶¹ *Ibid*, p.3.

¹⁶² *Ibid*, p.4.

6.5 Police in Kings Cross

In May 2017, the Committee travelled to the MSIC in Sydney and spoke with the local police. The Committee learnt that the police in Kings Cross support and have a very good relationship with the Centre. Police have the right to enter the MSIC at any time. Officers are told to use their discretion when it comes to making arrests. This usually means that users with small amounts of drugs are not arrested while making their way to the Centre. Drug dealers and suppliers are still targeted.

The Commissioner of NSW Police holds oversight responsibility of MSIC jointly with the Secretary of the Ministry of Health. The NSW Police also form part of the MSIC's Community Consultation Committee.¹⁶³

¹⁶³ New South Wales Government, 'Report on the Statutory Review of Part 2A of the Drug Misuse and Trafficking Act 1985 (NSW)', 2016.

Appendix 1

Submissions

Submission no.	Name
1	Marion Crooke
2	David Stanley & Robert Richter
3	Dr Kate Seear
4	Yarra Drug & Health Reform
5	Nicholas Wallis
6	The Salvation Army
7	Living Positive Victoria
8	Public Health Association Australia
9	City of Yarra
10	UnitingCare ReGen
11	The Royal Australasian College of Physicians
12	Victorian Alcohol and Drug Association
13	Royal Australian and New Zealand College of Psychiatrists
14	Drug Advisory Council of Australia
15	North Richmond Community Health
16	Medically Supervised Injecting Centre Consumer Action Group
17	Professor Mike McDonough
18	Inner South Community Health
19	Andrew Hartwich
20	Ambulance Employees Australia - Victoria
21	Australian Christian Lobby
22	Australian Medical Victoria
23	Uniting NSW & ACT
24	United Firefighters Union Victoria Branch
25	Cohealth
26	The Burnet Institute
27	Windana
28	Alcohol and Drug Foundation
29	Australian Injecting Illicit Drug Users League
30	Neighbourhood Justice Centre
31	Cherie Short
32	Harm Reduction Victoria
33	Fitzroy Legal Service
34	Darebin Community Legal Centre

Submission no.	Name
35	Students for Sensible Drug Policy
36	Turning Point
37	Pharmacy Guild of Australia-VIC Branch
38	Victorian Healthcare Association
39	Victorian AIDS Council
40	Victorian Trades Hall Council & Australian Nursing and Midwifery Federation
41	Professor Lisa Maher & Dr Ingrid van Beek
42	Anglicare
43	Royal Australian College of General Practitioners
44	Dr Martyn Lloyd-Jones, Dr Keri Alexander, Dr Raymond Chan, Dr Jon Cook, Dr David Jacka, Dr Dianne Kirby, Dr Benny Monheit, Dr Noel Plumley and Dr Helen Sweeting
45	Drug Free Australia
46	Penington Institute
47	Kirby Institute
48	Victoria Street Business Association
49	Victoria Police

Appendix 2

Public hearings

Wednesday 7 June 2017 - Melbourne

Name	Title	Organisation
Judge Sara Hinchey	State Coroner	Coroners Court of Victoria
Dr Jeremy Dwyer	Case Investigation Officer, Coroners Prevention Unit	
Mr Robert Richter QC	President, Victorian Chapter	Australian Drug and Law Reform Foundation
Mr David Stanley	Treasurer	
Mr Geoff Munro	National Policy Manager	Alcohol and Drug Foundation
Ms Daisy Brooke	Head, Program Development and Evaluation	
Mr Dan Flynn	Victorian Director	Australian Christian Lobby

Extracts of proceedings

Legislative Council Standing Order 23.27(5) requires the Committee to include in its report all divisions on a question relating to the adoption of the draft report. All Members have a deliberative vote. In the event of an equality of votes, the Chair also has a casting vote.

The Committee divided on the following questions during consideration of this report. Questions agreed to without division are not recorded in these extracts.

Committee Meeting – 31 August 2017

Chapter 1

Ms Springle moved, That Chapter 1, as amended, stand part of the Report.

The Committee divided.

Ayes 5	Noes 1
Ms Fitzherbert	Mrs Peulich
Mr Mulino	
Ms Patten	
Ms Springle	
Ms Symes	

Motion agreed to.

Chapter 2

Ms Symes moved, That Chapter 2, as amended, stand part of the Report.

The Committee divided.

Ayes 5	Noes 1
Ms Fitzherbert	Mrs Peulich
Mr Mulino	
Ms Patten	
Ms Springle	
Ms Symes	

Motion agreed to.

Tabling of Report

Ms Patten moved, That the Final Report, including Chapters 1-6, preliminaries, appendices and extracts of proceedings, as amended, be the Final Report of the Committee to be tabled on 7 September 2017.

The Committee divided.

Ayes 5	Noes 1
Ms Fitzherbert	Mrs Peulich
Mr Mulino	
Ms Patten	
Ms Springle	
Ms Symes	

Motion agreed to.

Minority Reports

Minority Report

Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

Nina Springle

The prospect of a trial of a Medically Supervised Injecting Centre (MSIC) in North Richmond has overwhelming support based on the submissions and testimony to the Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 from drug and alcohol services, public health experts, faith based organisations, emergency services, local residents, legal practitioners, academics and researchers.

It is important to note that many of these contributors have based their submissions on evidence and evaluations of MSICs both locally and internationally. Some MSICs overseas have been in operation longer than the facility in Sydney, providing a solid evidence base to draw from.

The aims and objectives of the establishment of an MSIC in North Richmond are clearly stated in Part 2 98C of the Bill and align with findings from the evaluations described above. The Australian Medical Association (Victoria) summed up what many submissions have reiterated;

‘MSIFs (Medically Supervised Injecting Facilities) have been shown to:

- reduce deaths and injuries due to drug overdose;
- reduce ambulance call-outs;
- increase referral to health and social services, including detoxification and drug addiction treatment; and
- reduce public drug injecting and numbers of discarded needles.

MSIFs produce larger financial savings comparative to financial costs’

What is also clear from the bulk of the submissions and testimonies the committee received is that an MSIC facility should be viewed as just one part of a suite of responses to areas of chronically high and public drug use. That a facility such as this serves as a vehicle to keep drug users alive until they are ready to be transitioned into other health and social services including rehabilitation. Given this, the establishment of an MSIC should not be assessed on its contribution, or lack thereof, to supply and demand reduction strategies but as a pure harm minimisation strategy alone – one piece, in a complex puzzle of responses.

In essence, a MSIC runs on the same principles as Needle and Syringe Programs that have been operational in Victoria and successful in curbing blood born viruses for decades. To not support the establishment of an MSIC in a high need area would run contrary to harm minimisation responses that have been and remain a critical part of our public health strategies in Victoria.

I would like to draw attention to several specific points raised through the submission process that I feel are particularly important.

- Victoria Police outlines in their submission dated 28th August 2017;

‘Although Victoria Police supports an inter-agency collaborative regulatory approach, if an MSIC is piloted, it believes that the Secretary of DHHS should be principal decision-maker in respect of the licencing of an MSIC. This would reflect the MSICs function as a health response to drug-related harm, rather than a law enforcement response.’ p4

The focus on an MSIC as part of an integrated public health solution is paramount. The now somewhat clichéd line; ‘we cannot arrest our way out of this problem’ is particularly pertinent when examining what is first and foremost a health issue. Therefore, appointing the Secretary of the Department of Health and Human Services as the principle decision maker in respect to licencing would be wholly in line with this as a foundational principle of this area of social and public health policy.

- ‘If an MSIC is piloted, Victoria Police supports a robust and evidence-based evaluation of the trial incorporating a range of health, social and justice indicators. Accordingly, Victoria Police support a trial period longer than the 18 months proposed by the Bill to ensure there is sufficient evidence to assess whether the objects of the Bill are being achieved.’ p4

Likewise, the Pennington Institute in its submission recommends ‘an extension of the trial period to three years’ with an ‘interim evaluation after 18 months’.

A longer period of data collection would allow for a more rigorous interrogation of the trial, resulting in a more robust evidence base. This would establish a thorough foundation for any expansion of the program to other areas in need that are deemed necessary in the future.

- ‘Stigma can also delay or impede people’s willingness to seek help or healthcare. A number of international organisations, key stakeholders and bodies are becoming increasingly cognisant of the prevalence of AOD-related stigma, the adverse dimensions of stigma, the need to understand its origins and to address them. The law has come into an increasing focus as a result...A supervised injecting facility would be a valuable harm reduction measure that could, among other things, facilitate connections to other valuable social and community services for those who need and want them. For these reasons, such a reform would likely have a destigmatising effect among people who use and inject drugs. Given the potential for a supervised injecting facility to have a number of ancillary benefits, including a reduction in AOD-related stigma, there is a sound public policy basis for considering reform.’ Dr Kate Seear, Monash University, Submission 3

Chronic, public drug use has far reaching ramifications for not only the communities where the use occurs and, obviously, the user, but also the extended networks of the user, including family, friends, work colleagues and their own community. This is a whole of society problem. Addressing the stigmatisation and psycho-social contributors to drug use needs to be part of a holistic response. Without that, we are only addressing part of the problem.

Recommendation:

Based on the evidence presented to the Legal and Social Issues Committee as part of this inquiry, it is my view that the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 should be supported to enable the establishment of a MSIC trial in North Richmond.

I would like to take this opportunity to thank the Secretariat for their hard work and support and all the contributors to this inquiry, without whom we could not do the work that we do. It is very much appreciated.

Signed:



Nina Springle MLC

Deputy Chair

Member for South-Eastern Metropolitan

Legal and Social Issues Committee of the Legislative Council

Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017

Minority Report by Inga Peulich MLC

Member for South Eastern Metropolitan Region

As a member of the Legal and Social Issues Committee I, am unable to support the proposal for the establishment of a drug injecting facility in Victoria Street Richmond's because:

1. The terms of reference are too narrow to adequately consider the ramifications of establishing a drug injecting centre on:
 - a. The overarching national drug strategy;
 - b. The impact of such a facility on public attitudes towards drug use, and therefore the broader impact of such a facility on the health and wellbeing of Victorians, their attitudes to drug use and therefore the longer-term incidence of drug use;
 - c. There are few parallels between the location of the drug injecting facility at Kings Cross and the proposed facility in Victoria Street, Richmond, and
 - d. What impact the drug injecting room proposed in this bill would have on the provision and funding of rehabilitation services available for other forms of drug addiction treatment.
2. Whilst there has been a well organised pro drug injecting room campaign around the committee's and the parliament's consideration of this bill by visible and vocal pro drug injecting room activists and sector, there has been chronically inadequate consultation with residents by either the City of Yarra or Ms Fiona Patten, MLC, the proponent of the bill. In fact, only 3 residents made written submissions to the LSIC inquiry on this bill.
3. The methodology of this inquiry was, in my opinion, deeply problematic given that the proponent of the bill, Ms Patten, is also a member of the LSIC and has been able to use her position on the committee, as well as her position on the Law Reform, Road and Community Safety currently undertaking a related Inquiry into the Illicit and Synthetic Drug and Prescription Medication to affect the processes and the formulation of a report on legislation she has also introduced into the parliament.

In closing, I welcome the decision by the LSIC decision to not make formal recommendations in its report, leaving this important debate to the parliament and the Victorian public for closer scrutiny and consideration.

Yours sincerely,



Inga Peulich MLC

Member for South Eastern Metropolitan Region

