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The Secretary  
Legal and Social Issues Committee  
Parliament House, Spring Street  
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**By email: [injectingcentrebill@parliament.vic.gov.au](mailto:injectingcentrebill@parliament.vic.gov.au)**

To the Secretary

cohealth welcomes the opportunity to provide a submission to the Legal and Social Issues Committee's Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017.

Please do not hesitate to contact us should you require further information or assistance in your inquiry

Yours sincerely



Lyn Morgain  
Chief Executive



## executive summary

Calls for the establishment of a supervised injecting facility in Victoria are not new, dating back nearly 20 years. In the intervening years, supervised injecting facilities have opened in many countries and cities around the world. With them has grown an ever-expanding evidence base regarding their effectiveness at both reducing overdose deaths and minimising a range of other health, social, justice and economic harms that can arise from injecting drug use. Victoria, however, has enjoyed none of these benefits and instead many hundreds of lives have been lost to preventable overdose deaths.

As a human rights based health organisation with a long history of delivering alcohol and drug services, cohealth is committed to drawing on the best available evidence and working directly with communities to design and deliver evidence based and effective responses to reduce individual and community harm and promote improved health and wellbeing. Applying this lens, the following submission outlines cohealth's views on the recommendations contained in Coroner Hawkins' Finding – Inquest into the Death of Ms A, delivered on 20 February 2017, with particular regard to the nature and extent of current, associated regulations and policing policy. In particular, and as detailed in the following document:

1. cohealth strongly supports the introduction of a supervised injecting facility trial in North Richmond, and further recommends that:
  - a. a supervised injecting trial should not be confined to North Richmond, but should facilitate similar trials in other hot-spot locations by expanding the remit of existing services; and that
  - b. any facility established for the purpose of providing a supervised injecting program should take an holistic approach to service delivery, wrapping around other health and social supports.
2. cohealth strongly supports all actions to expand the availability of naloxone to people in a position to respond to and reverse accidental overdoses. We recommend that steps be taken to enact the regulatory changes that would allow for more health and support care workers to administer naloxone, and for more community members to obtain naloxone at a subsidised, or no, cost.
3. cohealth welcomes the opportunity to work with the Victorian Government to explore options to further increase access to services for people who inject drugs. We encourage the government to consult directly with service users and providers, and to actively consider:
  - a. gaps in the provision of harm reduction services
  - b. opportunities and suggestions identified by those with lived experiences of injecting drug use.



## about cohealth

cohealth is Australia's largest not-for-profit community health service, operating across 14 local government areas. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities.

cohealth provides integrated medical, dental, allied health, mental health and community support services, and delivers programs to promote community health and wellbeing. Our service delivery model prioritises people who experience social disadvantage and are consequently marginalised from many mainstream health and other services. This includes people who are experiencing or at risk of homelessness, people who live with serious mental illness, vulnerable families, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, people who use alcohol and other drugs, recently released prisoners and LGBTIQ communities.

cohealth also recognises that health is affected by many factors including social inclusion and participation, education, housing, employment, and access to fresh food, and we are committed to addressing these underlying causes of health inequality. To this end, we work directly with people and in the community to design our services, and deliver advocacy, health promotion and education activities to improve health and connectedness.

cohealth's programs for people who use drugs (PWUD) span the full range of service responses, including:

- needle and syringe programs across six metropolitan locations
- the operation of two SAPHs (Specialist AOD Primary Health Services)
- non-residential withdrawal services
- drug and alcohol counselling, and
- family support services

We also auspice the Yarra Drug and Health Forum - which has been responding to community concerns about alcohol and drug activity for 20 years, and operate the North West Melbourne Pharmacotherapy Network (NWMPN) to support the community based Opioid Replacement Therapy (ORT) system and increase the number of GPs and pharmacists prescribing or dispensing ORT.

cohealth is also committed to supporting communities, local government and other organisations in responding to drug issues and activities and therefore plays an active role in community education, policy development and sector development.



**recommendation 1 from Coroner Hawkins' Finding – Inquest into the Death of Ms A: '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'**

The first supervised injecting facility (SIF) was opened in Switzerland in the 1980s. There are now approximately 90 SIFs worldwide, the majority of which are in Europe, with two in Canada and one located in Sydney. Evaluations of Sydney's Medically Supervised Injecting Centre (MSIC), located in Kings Cross, have found that (as of 2011) the Centre had managed more than 4400 drug overdoses without a single fatality. In addition the MSIC had:

- reduced the number of publically discarded needles and syringes in the Kings Cross area by approximately 50%;
- decreased the number of ambulance call outs to Kings Cross by 80%; and
- generated more than 9,500 referrals to health and welfare services<sup>1</sup>.

These findings mirror those from evaluations of SIFs all over the world. There have been long standing calls, for over ten years, for a SIF to be established within the Richmond/Victoria Street Precinct in the City of Yarra in particular, with strong support from the Council, local traders association, and residents. **cohealth strongly supports these calls, and recommends that a supervised injection or consumption facility be established and trialed in this key hot spot as a matter of priority.** This support is based not only on conclusions drawn from abundant evidence, but also from listening to our service users who have expressed a strong desire to be able to access a supervised injecting facility and who are, in some cases, surprised to learn that such services do not already exist.

In supporting the introduction of a trial we also wish to emphasise the importance of taking a holistic approach to the operation of a SIF. Providing a space for people who use drugs to inject under supervision and receive treatment in the event of an overdose will undoubtedly save lives and improve public amenity. However a SIF also creates a point of engagement with people who use drugs, creating opportunities for 'teachable moments' to provide education, support and referral<sup>2</sup>. Accordingly, **we recommend that any facility established for the purpose of providing a supervised injecting program should take an holistic approach to service delivery, wrapping around other health and social supports.**

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<sup>1</sup> MSIC Evaluation Committee. *Final Report of the Sydney Medically Supervised Injecting Centre*. (2003).

<sup>2</sup> The Sydney Medically Supervised Injecting Centre: reducing harm associated with heroin overdose, Ingrid van Beek, Jo Kimber , Andy Dakin & Stuart Gilmour Pages 391-406 | Published online: 21 Oct 2010



We also note that the NSW and international experience indicates that people who inject drugs are unlikely to travel any considerable distance to access a SIF. It would therefore be beneficial to establish SIF sites at a range of potential hot-spot locations in order to deliver an overall reduction in harm.

To this end we strongly recommend that a SIF trial **not** be limited to one location in North Richmond, but instead urge the consideration of additional options as follows:

#### option 1: expand the role of existing Specialist AOD Primary Health Services (SAPHS)

A number of SAPHS currently operate throughout metropolitan Melbourne 'hotspots', including:

- Innerspace, operated by cohealth on Johnston Street, Collingwood
- Healthworks, operated by cohealth on Nicholson Street, Footscray
- Living Room, operated by Youth Projects on Hosier Lane, Melbourne
- Monash Health Drug and Alcohol Service (formerly SEADS) on Foster St, Dandenong
- Access Health, operated by Salvation Army on Grey St, St Kilda
- YSAS Day Program, operated by YSAS on Langridge St, Abbotsford

Existing SAPHS operate needle and syringe programs, provide education and health promotion services, and enable people who use drugs to access comprehensive medical services. SAPHS have established relationships with many people who inject drugs, employ experienced and qualified staff, and in many instances operate from physical premises that could be easily modified in order to accommodate supervising injecting facilities.

SAPHS staff are experienced in engaging with people who use drugs about their drug use, education about safer drug use, managing physical and mental health issues, providing brief interventions and supporting access to treatment and other support services. These services strongly respond to the need of people using drugs within the SIF environment and would provide a complementary service. Additionally, given that people who use drugs experience barriers to accessing health services, access to the SAPHS services may be increased through the SIF pathway.

Locating a supervised injecting facility within an existing SAPH or SAPHS is therefore likely to be cost effective and will ensure that clients using the service can also access and benefit from a broad range of other offerings, including potential referrals to treatment.

#### option 2: mobile facility/bus

A number of proposals, inclusive of design work, have been developed for a mobile supervised injecting facility, housed within a bus that has custom fit out. This approach has been utilised in Barcelona.

Advantages of a mobile service are its ability to travel to a number of different hot spot locations, and to potentially allay any community concerns about a supervised injecting facility being 'permanently' located in their neighbourhood. However this



intermittent presence in a particular hotspot location may act as a barrier to access for people who inject drugs. In addition, the space constraints of operating the service out of a bus are likely to reduce the opportunities for longer, more meaningful engagement between health workers and clients, potentially reducing the opportunities for education and referral to treatment. We would therefore recommend that a mobile/bus-based facility only be used to fill service gaps in locations not otherwise served by an existing SAPH, and/or to provide shorter term, flexible responses in new or shifting hot-spots.

### key regulatory and policing considerations

It is cohealth's view that the current legal barriers to providing supervised injecting facilities in Victoria would be adequately addressed by the Pilot Medically Supervised Injecting Centre Bill 2017 currently under consideration. However we offer the following additional suggestions that we believe would serve to strengthen the legislation and provide the best possible operating environment for a SIF trial:

1. Refrain from any references to specific geographic locations in enabling legislation and regulations. As presented above there is good evidence for the establishment of trial sites in more than one location, and history has shown that drug hot spots move around metropolitan Melbourne and Victoria.
2. Refrain from limiting the focus of a trial SIF to only the injection of opioids. Whilst opioids present the clear and greatest risk of overdose death, the injection of methamphetamines and other drugs also carries significant risk, creates considerable community concern and can impact on public amenity. Ensuring that a trial SIF can service a person injecting any sort of drug - licit or illicit - will provide the greatest opportunity to reduce individual and community harms.
3. Avoid stipulating a service model that relies on supervision by a medical practitioner, as involving these professionals in the supervision of injections would greatly increase the costs involved and may limit the possible hours of operation. We would instead advocate for a nurse-led model, which would require a standing order for nurses working at a pilot facility to administer naloxone without medical supervision. Quality and risk could instead be appropriately managed through a clear clinical governance framework.

In relation to policing policy, it is self-evident that most people entering a trial SIF would be in possession of illicit substances. For the pilot to be successful, Victoria Police, including members of the Drug Squad, would need to be supportive of the model and avoid surveillance of the area, which would reduce or prevent access to the target population. This is currently the practice in the locations where several SAPHs operate, and we would expect to see this extended to apply to any location where a supervised injecting facility was operating. At the same time, and as with any community-based service, prompt response from Victoria Police when requested would be important for staff, client and community safety.



## evaluating the trial

cohealth recommends that a pilot should run for a minimum of three years, with independent evaluation conducted to establish effectiveness across a range of domains, including:

- impact on opioid overdose (including ambulance call-outs, presentations to emergency departments, and opioid related deaths)
- number of overdoses managed within the SIF
- numbers of referrals to treatment and other support services
- impact on incidence, prevalence and new diagnosis of injecting drug use related blood born viruses
- public amenity (including discarded syringe counts and community perception), and
- economic benefit



**recommendation 2 from Coroner Hawkins' Finding – Inquest into the Death of Ms A: '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 overdose drug overdoses in the City of Yarra'**

cohealth strongly supports all efforts to expand the availability and use of naloxone. A safe and highly effective drug for reversing overdose from heroin and other depressants, international evaluations have shown that the widespread distribution of, and education regarding the use of, naloxone contributes to a reduction in overdose deaths. Greater resources need to be devoted to ensuring that people who use drugs, all emergency responders, and all health workers (including nurses, community health workers and needle and syringe program workers) are trained in the use of, and able to access and carry, naloxone.

To this end, we advocate that attention be given to the following three key regulatory issues:

1. Scheduling. 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.
2. Nurse-initiated naloxone administration. cohealth has recently completed work on establishing the necessary clinical governance frameworks to enable appropriately trained nurses to administer naloxone without requiring the supervision of a GP. We did this to save lives. In the critical minutes, and sometimes seconds, after an overdose occurs time can be saved if a nurse can administer naloxone immediately, rather than needing to locate and obtain the authorisation of a medical practitioner. We advocate that this approach be adopted throughout the health sector.
3. Administration of naloxone by community health workers. As Naloxone is a Schedule 3 medication, there is currently some uncertainty about the ability of health professionals, including nurses and community health workers, to administer it, due to the regulatory requirements of Schedule 3 classified medications. Currently community health workers in our drug and alcohol programs occupy the somewhat absurd position of being able to train community members in the use of naloxone, but being unable to administer naloxone themselves during the course of their work.



**recommendation 3 from Coroner Hawkins' Finding – Inquest into the Death of Ms A: *'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***

As a provider of significant drug and alcohol services across metropolitan Melbourne, including in the City of Yarra, cohealth very much welcomes the opportunity to work closely with the Victorian Government to identify opportunities to improve injecting drug users' access to and engagement with services. We believe there are a number of issues for consideration, and potential opportunities for greater engagement, including:

- Expanding the role of key existing services, such as SAPHS, to allow for supervised injection services (as discussed earlier). Currently, cohealth staff occupy the difficult position of trying to build relationships with and provide services to people who inject drugs whilst simultaneously having to 'police' them - actively preventing them from injecting in what they understand to be a safe space and instead ejecting them out of the service at their moment of greatest vulnerability. Relationships between staff and clients would be greatly improved if the obligation for staff to behave in this way was removed, and staff could provide the full range of harm minimisation services.
- Assertive outreach. In locations where there is a visible drug market and other drug activity, opportunities exist to engage with people who use drugs, and to provide health messages and connections to services using an assertive outreach approach. Punitive responses to drug activity such as CCTV cameras and police operations have reduced this capacity. In some communities, such as in growth corridors, drug activity is far less visible and these punitive strategies will do little to ameliorate the issue. cohealth has recently received funding from the North West Melbourne Primary Health Network to work with Youth Support and Advocacy Service (YSAS) to trial an outreach bus in the outer west to engage with young people and provide information and access to health and drug treatment services. There are opportunities to trial a range of assertive outreach approaches to ensure that people who use drugs of any kind are able to access services. These should be inclusive of populations who would not consider their social drug use to be a problem, such as users of performance enhancing drugs, "party drugs" and other novel substances.



- Improved referral between services (eg ambulance, police, hospitals). Opportunities for referrals to health and AOD services exist as part of contacts with emergency services, emergency departments and other health facilities. Two way communication between these services and the AOD sector would be valuable and provide for timely and opportunistic referrals. For example, the approach used in response to family violence where Victoria Police is required to provide information about support services and can offer a referral, is an effective model that could be used by all emergency services to support engagement of people who use drugs with AOD services.

Emergency services may also notice trends in overdose patterns as part of attendance at overdoses. This may indicate an increased strength in opioids currently in the market, and sharing this information with AOD services, particularly NSPs and SAPHS, would allow communication of this risk to people accessing these services. It would also create the opportunity for conversations about the inherent risk associated with drug use and potentially create windows of opportunity for connection with health services and change in a person's life.

- Greater engagement with non-injecting drug users. Only a few individuals utilise injection as their route of administration when they very first start taking drugs. Instead, many will have used other routes of administration, such as ingesting or smoking. However the sector is skewed to providing outreach, drop-in and peer-based services targeted specifically to those who inject drugs. This misses a key opportunity for early intervention into a person's drug using trajectory, or to at least start building the relationships that will serve an individual if they begin injecting. For this reason, initiatives such as supervised drug *consumption* facilities (which are not restricted to those who inject), and drug (pill) testing at festivals and clubs are ideas worth exploring, both for their harm reduction merits, and because they present a valuable opportunity to build relationships earlier between service providers and potential service users.

We also strongly encourage that in addition to exploring this issue with service providers, the Government actively seek the feedback and input of service users themselves. These people are the experts of their own experience and are best placed to articulate their needs, and the barriers and enablers to their accessing services.



## conclusion

In the late 1980's and early 90's Australia responded to the looming catastrophe of HIV by responding swiftly and courageously to implement evidence-based strategies to reduce the risk of transmission. As much of the rest of the world prevaricated, we introduced needle exchange programs, addressed many of the laws criminalising at risk behaviours and populations, and worked with affected communities to find solutions. Our response was world's best, and the entire community benefitted with the HIV epidemic well contained.

Thirty years on as the overdose deaths pile up, and community concern grows about the negative health, social, and criminal consequences of drug use, it is bewildering and distressing to find that national and State governments in Australia, including here in Victoria, appear to have lost the courage and commitment to do what's needed to prevent death and harm.

The evidence of what works is even stronger than that which we relied on to combat HIV - it is neither radical, experimental, or unclear as to the kinds of reforms that need to be introduced to drug policy to save lives and reduce harm. It is our sincere hope that this Inquiry will not only recommend that the Parliament pass the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017, but that it will further recommend that:

- o the Bill be expanded so as to allow for several centres to operate in Victoria; and
- o that the Victorian Government and Parliament urgently take steps to facilitate the introduction and/or expansion of other evidence based harm-reducing and life saving strategies .

