LRRCSC - INQUIRY INTO DRUG LAW REFORM
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Burnet Institute
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DIRECTOR and CEO – Professor Brendan Crabb AC PhD
PATRON-IN-CHIEF – The Honourable Linda Dessau AC, Governor of Victoria

Mr Geoff Howard, MP
Chair, Law Reform, Road and Community Safety Committee
Parliament House
Spring Street
MELBOURNE VIC 3002

Dear Mr Howard

Re: INQUIRY INTO DRUG LAW REFORM

I am responding on behalf of the Burnet Institute to your request for a submission to the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform.

The Burnet Institute is one of Australia's leading medical research institutes. Burnet is in a unique position to provide information relevant to the Inquiry, having conducted research with people who use drugs for over 25 years. Our findings have greatly advanced knowledge of the nature of drug use, related harms and responses. We apply a public health approach to drug use – particularly injecting drug use – to improve the health and wellbeing of people who consume drugs and the communities around them.

Our responses to the Terms of Reference of the Inquiry into Drug Law Reform by the Parliamentary Law Reform, Road and Community Safety Committee are framed within our understanding of the Draft National Drug Strategy and its focus on harm minimisation. We believe that the Inquiry is an important opportunity to make fundamental change to Victorian drug laws to improve outcomes for the whole community, through recognising that drug laws and their enforcement are not only crucial for minimising harm but can also lead to the production of harm.

Our response is framed around nine points that directly relate to the Committee's terms of reference. A summary is presented first to highlight the key points. Each of the nine points is then discussed in detail, with brief reference to relevant evidence.

Please do not hesitate to contact us if you have any queries about our submission. We would welcome the opportunity to discuss any of the recommendations with the Inquiry.

Yours sincerely,

[redacted]

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Executive Summary

1. *Drug use and drug possession for personal use*

We recommend the decriminalisation of drug use and drug possession for personal use by law *(de jure)*.

In addition to removing criminal penalties for these offences, we recommend improving consistency and clarity on quantities and definitions of possession for personal use across substances.

2. *Incarceration of people who inject drugs*

We recommend:

- a consistent and mandated approach to diversion programs for drug-related offences, whereby incarceration is treated as an absolute last resort for people who commit non-violent drug-related offences (e.g., possession, use, acquisitive crime);
- increased resourcing of support programs for people on community orders, including for programs beyond those related to drug dependence treatment (e.g., housing and employment support);
- the replacement of punitive responses (e.g., reincarceration) for breaches of community orders that involve ongoing drug use with responses that address the reasons for relapse, in order to minimise recurrence;
- changes to the parole system that allow early release for more prisoners with drug-related offences so they have better access to post-release support, to minimise ongoing problematic patterns of drug use and recidivism; and
- Victoria trial a prison needle and syringe program, taking into account operational environments and control systems to ensure the safety of prisoners and prison staff.

3. *Supervised injecting facilities*

We recommend amendments to current legislation to allow for the establishment of supervised injecting facilities (SIFs) in Victoria.

SIFs enable people to consume drugs in an environment that minimises risks of harm, including reducing overdoses, improving linkage to other services, and improving public amenity by regulating public injecting.

4. *Take-home naloxone and overdose responses*

We recommend the expansion of Victoria's take-home naloxone program and other overdose responses.

Naloxone is an opioid overdose reversal drug. Expansion of take-home naloxone programs and other overdoses responses in Victoria would be achieved by:

- issuing clear standing orders to allow appropriately trained non-medical persons to train others in take-home naloxone use;
- providing specific exemption from liability in the case of naloxone administration 'in good faith', as in the UK and many jurisdictions in the USA;
- training police and fire personnel in naloxone administration as well as overdose response; and
- providing take-home naloxone to prisoners on release from prison.

5. *A real-time drug monitoring system through a public-facing forensic testing service*

We recommend that Victoria trials a fixed-site public-facing laboratory service that tests drugs for composition and purity using laboratory-grade equipment.

This health-focused service will minimise the harms associated with drug use, particularly among younger Victorians, by informing consumers of the contents of their drugs. This service should be evaluated to determine its effectiveness in reducing drug-related harms.

6. *Opioid substitution therapy take-away guidelines*

We recommend the development of guidelines and policy on unsupervised dosing of opioid substitution therapy (OST) that will facilitate and retain more people in OST. Any reassessment of current OST take-away policy must ensure consumers are receiving evidence-based clinical care and support.

7. *Peer distribution of sterile needles and syringes*

We recommend the decriminalisation of peer distribution of sterile needles and syringes in Victoria.

Access to sterile needles and syringes is integral to reducing harms associated with drug use, in particular, preventing the acquisition of blood-borne viruses such as HIV and hepatitis C virus (HCV).

Peer distribution of sterile needles and syringes already occurs in the community and is legal in Tasmania, the ACT and the Northern Territory. Similar amendments to legislation in Victoria should be considered.

8. Roadside drug testing

We recommend that Victoria reconsiders its detection thresholds to correspond with impaired driving and expands the types of drugs that are screened to include other drugs known to produce significant impairment (such as benzodiazepines).

These reconsiderations of drug-driving laws should take into account recent evidence on appropriate threshold levels and the need for further research into appropriate threshold levels and drugs to be included in screening procedures.

9. Recurrent presentations of warrants

Administrative systems need strengthening and streamlining to ensure that all outstanding warrants are presented simultaneously so that people with outstanding warrants receive a fair and appropriate response from the criminal justice system.

We also recommend the development of more targeted and accessible support for the transition from prison to the community; this would improve the health and social outcomes of those integrating into the community following incarceration.

1. Drug use and drug possession for personal use

Decriminalisation of drug use and drug possession for personal use refers to the removal of criminal penalties for these offences, but does not legalise use and/or possession. Evidence suggests individuals who avoid a criminal record have improved social, educational and employment outcomes (Hughes et al., 2016). Available evidence suggests that these improvements reduce costs to both the individuals involved and the wider community (Hughes et al., 2016).

Decriminalisation can also reduce the demands on and costs to the criminal justice system. Evidence suggests that decriminalisation leads to reduced need for and use of police, court and prison resources. For example, in California, total law enforcement costs were substantially reduced (from $17 million in the first half of 1975 to $4.4 million in the first half of 1976) after decriminalisation in 1975 (Single, Christie, & Ali, 2000).

Various countries around the world, most notably Portugal, have decriminalised drug use and/or possession. The Portuguese model of decriminalisation, which is widely misunderstood, includes the decriminalisation of the use and possession of all illicit drugs and the provision of drug treatment, harm reduction and social reintegration programs. This model allows for a reinvestment in demand reduction, drug treatment and rehabilitation. Importantly, Portugal's model of decriminalisation has led to reduced individual and societal level costs associated with drugs, including reduced burden and costs to the criminal justice system (including reduced pressures on prisons and the need to build new ones), reduced incidence of new blood-borne viral infections, fewer drug-related deaths and no or very small effects on the rates of drug use (Goncalves, Lourenco, & Silva, 2015; Hughes & Stevens, 2010). Exploring options such as those used in Portugal should be a priority for drug law reform in Victoria.

We recommend options for the decriminalisation of drug use and drug possession for personal use by law *(de jure)* be explored in Victoria. As part of this change, increased consistency and clarity on the quantities and definitions of possession for personal use (versus traffickable quantities) across substances should also be considered, as per recent work undertaken in relation to the ACT criminal code (ACT Government, 2014; Hughes & Ritter, 2011).

2. Incarceration of people who inject drugs

The cost of imprisonment in Australia is $100,000 per inmate per year (Glass, 2014), a figure that does not include indirect costs to social and health systems or families (Baldry, Dowse, McCausland, & Clarence, 2012). People who use drugs are grossly over-represented in Australian prisons and therefore make a disproportionate contribution to imprisonment costs. For example, people with a history of injecting drug use constitute up to 58% of the prisoner population (Reekie et al., 2014) and have extremely high reincarceration rates (the 10-year reincarceration rate among people who inject drugs (PWID) is 90% (Larney, Toson,

Burns, & Dolan, 2012), compared with 40% for all Australian prisoners (Zhang & Webster, 2010)). In this context, interventions to reduce incarceration and reincarceration among drug users, such as decriminalisation (considered above), are urgently needed.

Diversion programs currently exist as alternatives to incarceration and involve community corrections orders with varying levels of monitoring and supervision. These are not currently optimally or consistently applied. A policy framework should be enforced to mandate community orders for non-violent drug-related offences (e.g., possession, use, acquisitive crime), regardless of repeat offences. Supports for people on community orders must also be adequately resourced, as must programs beyond those related to drug dependence treatment (e.g., housing and employment support). Resourcing of such programs should take account of the considerable cost savings that would occur through a reduction in the prison population.

Monitoring processes for individuals on community orders and responses related to breaches of community orders also need reform. Relapse characterises typical trajectories for drug users, whether or not individuals are involved with the justice system (Kimber et al., 2010; Nambiar, Agius, Stoove, Hickman, & Dietze, 2015), and such relapses should be expected among people with community orders. Responses to relapse, which currently typically involve punitive responses such as reincarceration, should instead focus on reasons for relapse and provide effective responses to minimise their recurrence. In this regard, changes to Victoria's parole system over recent years in response to high-profile cases have had a major impact on drug-using populations. Changes have resulted in many individuals being reincarcerated for relatively minor breaches (unlikely to result in any community harm) that have not previously attracted such a punitive approach.

Parole reform has led to increasing rates of rejected parole applications in prison, and therefore more prisoners being released at the completion of their sentences. These prisoners re-enter the community without the reporting requirements and controls that apply to those on parole and without access to support to broker access to community services. Already, most prisoners incarcerated on drug-related offences are released with their offending behaviour only partially addressed or neglected completely due to short sentences and the increased demands on prison programs. The existing parole system must change to take account of the post-release challenges of people with significant drug use histories. Similarly, individuals on community-based corrections orders for drug-related offences should not be subject to punitive actions, such as reincarceration, for breaches related to ongoing drug use.

Few effective injecting drug harm reduction programs are available in Victorian prisons. Crucially, Victorian prisons lack needle and syringe programs (NSPs) and take-home naloxone on release (see below: *4. Take-home naloxone and overdose responses*). Community NSPs are effective and, given the overrepresentation of people dependent upon injectable drugs in prison and consequent very high prevalence of hepatitis C, and the acknowledged availability of drugs in prison, the absence of prison NSPs is inconsistent with international law that ascribes prisoners the right to health care standards equivalent to those in the community (United Nations General Assembly, 1990). Prison NSPs are endorsed by Australian health and medical peak bodies, including the Australian Medical

Association, Australasian Society for HIV Medicine, the Public Health Association Australia, the Royal Australasian College of Physicians, and the Australian Ministerial Advisory Committee on Blood-Borne Viruses. Prison NSPs are also endorsed by major global bodies like the United Nations General Assembly, the World Health Organization, UNAIDS and the United Nations Office on Drugs and Crime. Contrary to concerns expressed by some, across nearly 25 years of international experience, prison NSPs have not increased attacks on prison staff or other prisoners or been associated with safety problems related to syringe disposal (United Nations Office on Drugs and Crime, 2014). Prison NSP should be trialled in Victorian prisons, with careful consideration of prison operational environments and appropriate systems to control and monitor the location of injecting equipment to ensure the safety of prisoners and prison staff.

3. Supervised injecting facilities

Supervised Injecting Facilities (SIFs) enable PWID to consume drugs acquired from illegal sources in an environment that minimises risks of harm. SIFs reduce fatal and non-fatal overdoses (Marshall, Milloy, Wood, Montaner, & Kerr, 2011; Salmon, van Beek, Amin, Kaldor, & Maher, 2010), improve linkages to other services (MSIC Evaluation Committee, 2003; Tyndall et al., 2006) and improve public amenity by regulating public injecting (MSIC Evaluation Committee, 2003; Wood et al., 2004). SIFs are acknowledged as an evidence-informed intervention in the National Drug Strategy (Intergovernmental Committee on Drugs, 2015). We have previously shown that available evidence supports the establishment of SIFs in selected locations in Melbourne (Dwyer, Power, Denham, & Dietze, 2016; Power, Winter, Papanastasiou, & Kirwan, 2011).

SIF implementation requires regulatory change to allow the legal consumption of illegal drugs. The Sydney Medically Supervised Injecting Centre (MSIC) is covered by Part 2A of the NSW Drug Misuse and Trafficking Act 1985 that was enacted specifically to create the operating conditions of the service. These conditions include specifications of the basic operational environment of the MSIC (including the requirements for supervision and medical training of staff) as well as allowing illicit drug possession and consumption, and allowing police to exercise discretion around charging people with drug offences if the person is travelling to or from the MSIC. Equivalent legislative provision for Vancouver's Insite SIF was required at a federal level in Canada, but such provision is not required under Australian law. Establishment of any SIF in Melbourne requires only amendment of the Victorian Drugs, Poisons and Controlled Substances Act 1981, with the Part 2 A of the NSW Drug Misuse and Trafficking Act 1985 serving as an appropriate model.

4. Take-home naloxone and overdose responses

Naloxone is a powerful opioid overdose reversal drug. Take-home naloxone programs, which train peers, family or friends of people at risk of overdose in overdose recognition and response, including the provision and use of naloxone, have been shown to reduce overdose deaths (McDonald & Strang, 2016). The idea of widening access to naloxone was first suggested at a conference in Melbourne in the early 1990s, but such programs only became operational in Victoria in 2013, and the provision of take-home naloxone remains outside of normal clinical practice with at-risk populations.

The Victorian Government's support for take-home naloxone has been welcomed. However, improving the current meagre uptake of this potentially life-saving intervention needs further work. International experience shows that uptake can be improved by issuing clear standing orders so that appropriately credentialled non-medically trained persons can train people in take-home naloxone, as is the case in parts of the USA (Walley et al., 2013). Similarly, although current 'Good Samaritan' provisions under the Victorian Wrongs Act 1958 cover people engaging in overdose response in good faith, specific amendment to the Wrongs Act providing specific exemption from liability in the case of naloxone administration in good faith, as in many US jurisdictions, would clarify the legal status of overdose response for program participants (Davis, Webb, & Burris, 2013). Further, in parts of the USA a range of first responders, including police and fire personnel, have been trained in overdose response and naloxone administration (Fisher, O'Donnell, Ray, & Rusyniak, 2016). Finally, evidence from rigorous evaluation of the Scottish take-home naloxone program, in which prisoners with a history of injecting drug use are provided take-home naloxone on release, shows that the program reduces mortality in this key period of overdose mortality risk (Bird, McAuley, Perry, & Hunter, 2016). These options for take-home naloxone, particularly connected to prison release, and opioid overdose response more broadly should be examined and implemented in Victoria.

5. *A real-time drug monitoring system through a public-facing forensic testing service*

Drugs sold as ecstasy (3,4-methylenedioxy-methamphetamine – MDMA) that contain other chemicals can cause injury and death. In the Netherlands, civilians can submit illicit substances for chemical analysis to find out what they contain (Brunt & Niesink, 2011). However, Victoria does not have such a real-time illicit drug monitoring system. Moreover, it does not have an adequate warning system to rapidly disseminate information when police forensic laboratories test illegal substances for prosecution purposes. We have very limited data on health harms from new/novel psychoactive substances (NPS) in Australia because it is likely that most NPS use here is unintentional, and likely to be incorrectly associated with MDMA, LSD or even heroin. As a result we continue to guess the extent to which newer and lesser known substances are contributing to hospitalisations and deaths. However, this kind of information is crucial for developing evidence-informed responses to prevent NPS-related harms among young Victorians.

Victoria has recently created a blanket ban on all psychoactive substances. While this ban is likely to push the supply of NPS from shopfronts to websites, and this change may be desirable to reduce open access, especially to under-age purchasers, such bans do not address the problem described above. We know that some manufacturers are seeing financial opportunities in on-selling NPS bought cheaply as better-known drugs that are more acceptable to consumers. Therefore, in addition to traditional police work that targets such suppliers, a real-time drug monitoring system can help to rapidly identify and remove harmful drug combinations and preparations from the drug market before consumption, thereby deaths and hospitalisations following the unintentional consumption of some NPS. These monitoring systems cannot prevent all deaths/hospitalisations (as some are caused by the expected substance at a 'normal' dose), but will lead to a reduction

of consumption-associated hospitalisations and deaths, consistent with the harm minimisation framework, and augment police drug intelligence systems.

We recommend that Victoria trials a fixed-site public-facing laboratory service. A fixed-site health-focused service will invite people to surrender some drugs for content and purity testing with laboratory-grade equipment. Drugs will be analysed rapidly to identify misrepresentations and mixtures of particular danger, and issue public warnings as needed. This data would feed into Victoria Police's existing forensic databases. The project requires legislation to exempt individuals operating within the designated site from offences under the Drugs, Poisons and Controlled Substances Act 1981 (Vic). This legislative change is similar to the legislation that enables Sydney's SIF to operate legally, as mentioned above. Any such service should be rigorously evaluated to determine its effectiveness at reducing drug-related harms.

Much of the debate about 'pill testing' in Australia has focused on the unreliability of reagent test kits used in field testing. The real-time drug monitoring service proposed here avoids that problem through the use of laboratory-grade tests conducted outside of the party or festival environment. This model will remove the most dangerous substances from drug markets, notify the public swiftly about particularly dangerous preparations or combinations, and provide a much-needed connection between partygoers in Australia and health services, so that if they begin to experience problematic drug use, they will have knowledge about where to get help.

We also recommend that Victoria Police make their forensic data available more quickly to the public. One barrier is the lack of suitable personnel to interpret and collate the information in digestible alerts aimed at a public audience. We have previously shown the value of working alongside the Victoria Police Forensic Services Department in providing data synthesis that improves understanding of drug markets and systems (Scott, Caulkins, Ritter, Quinn, & Dietze, 2015). This type of outcome could be facilitated by funding a health promotion expert to work with the Victoria Police Forensic Services Department to open up these existing data sources for the original purposes for which they were intended under previous government strategy. Timely alerts on the state of Victoria's drug markets have the potential to become a credible source of information that illustrates the variability, the misrepresentations, and average purity levels of drugs of concern.

6. Opioid substitution therapy take-away guidelines

The opioid substitution therapy (OST) system in Victoria currently works with approximately 14,000 consumers (Aitken, Lloyd, & Dietze, 2017). The policy for pharmacotherapy (for prescribers and dispensers) was revised in September 2016, with increased restrictions on the availability of take-away doses.

A recent review of the Victorian OST system (King, Ritter, & Berends, 2011) found that keeping people in OST improves social, health and economic outcomes. The authors argued for a policy on unsupervised dosing and that this be developed independent of the current take-away dosing policy.

We recommend the development of guidelines and policy on unsupervised dosing that will facilitate OST use and retain more people in OST. We recommend that future iterations of the current OST take-away policy ensure that the policy supports consumers to receive evidence-based clinical care and support, meaning that providing suitable storage mechanisms to program participants should be explored.

7. Peer distribution of sterile needles and syringes

Access to sterile injecting equipment is a cornerstone of Australia's drug policy. Publicly funded NSPs have been integral in preventing the spread of HIV and HCV infections, with evidence suggesting they are highly cost-effective (Kwon et al., 2012).

Currently, pharmacists and NSP workers who distribute sterile needles and syringes are able to operate due to special exemption laws allowing them to distribute sterile needles and syringes without risk of criminal conviction. Peer distribution of needles and syringes is currently unlawful in Victoria. Peer distribution is defined as 'the giving or receiving of new sterile needles and syringes to/from another individual that were originally obtained from formal or "safe" sources' (Bryant & Hopwood, 2009). Peer distribution of needles and syringes is also commonly referred to as 'secondary supply' or 'secondary exchange'.

Peer distribution of needles and syringes is common in Australia, with over one third of nationally surveyed NSP clients reporting that they have distributed needles and syringes (National Centre in HIV Epidemiology and Clinical Research, 2010). Participants in a study of the secondary exchange of needles and syringes in NSW commonly reported distributing sterile needles and syringes to a range of peers to help avoid them acquiring blood-borne viruses (Bryant & Hopwood, 2009).

Decriminalising peer distribution of needles and syringes aligns with the policy frameworks of the National Drug Strategy 2010–2015, the Fourth National Hepatitis C Strategy 2014–2017, the Seventh National HIV Strategy 2014–2017 and the Victorian Hepatitis C Strategy 2016–2020.

Improved access to sterile needles and syringes, through peer distribution, may help increase personal coverage of sterile needles and syringes to ≥100%. A recent Victorian study found that between 22% and 36% of respondents experienced <100% personal coverage of sterile needles and syringes (O'Keefe, Scott, Aitken, & Dietze, 2016). Personal coverage of ≥100% will help to reduce new blood-borne viral infections among PWID.

Recent changes to laws in Tasmania, ACT and NT have allowed for the decriminalisation of peer distribution of needles and syringes (see, for example, http://www.legislation.act.gov.au/b/db_53829/). Similar law reforms should be considered in Victoria.

8. Roadside drug testing

Driving under the influence of intoxicating substances such as alcohol and other drugs poses significant risks to all road users. Victoria has been a world leader in relation to roadside drug testing for alcohol through breath screening and introduced a world-first screening system for illicit drugs in 2004. The system is designed to detect drug-affected drivers and deter those who would otherwise consider driving under the influence of a selected range of drugs from driving. The system has not been thoroughly studied, with no published evaluation of its effects on road crashes, injuries or deaths and minimal evidence of cost-effectiveness in relation to deterrent effects. Nevertheless, the program has recently been expanded.

Under the current Victorian system, outlined in the Road Safety Act 1986, the detection of any of the illicit drugs that are screened for during a roadside test is deemed an offence. This process does not align with any impairment or elevated crash risk, unlike the limits set for alcohol that accord with elevated risk of road crashes (Walker, 2000). We suggest that the Inquiry consider relevant recent work that stipulated the establishment of detection thresholds to correspond with impaired driving (Wolff et al., 2013). We would also suggest that the range of drugs screened be widened to include other drugs known to produce significant impairment, such as benzodiazepines. Such change would, at a minimum, make Victorian drug-driving law and regulation (including alcohol) appropriately consistent. Where impairment levels have not been adequately determined, we recommend that the Inquiry advise of the need to commission research from appropriate agencies involved in road safety research to determine impairment levels.

9. Recurrent presentations of warrants

Having an outstanding warrant for arrest is commonly reported by people with a history of drug use (including injecting drug use) (Kerr et al., 2009). In our experience working with people who use drugs, it is not unusual for people to have these warrants issued for multiple reasons. These warrants will ultimately cause many to be imprisoned for short periods of time, only to find that on release another warrant ‘appears’ because it was not presented at the same time as the others. The harms to individuals and their families of incarceration are well documented, especially for younger people with drug injecting histories (Graffam & Shinkfield, 2011). Therefore, administrative systems need strengthening and streamlining to ensure that all outstanding warrants are presented simultaneously and managed concurrently so that the people affected receive a fair and appropriate response from the criminal justice system.

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