T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 8 May 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Mr Charles Henderson, acting executive officer,

Ms Sarah Lord, program manager, pharmacotherapy advice and mediation service,

Ms Jane Dicka, health promotion team leader specialising in drug overdose prevention education, and

Ms Stephanie Tzanetis, program coordinator, DanceWize, Harm Reduction Victoria.

Necessary corrections to be notified to executive officer of committee

The CHAIR — While you are sitting down I will do the introductions. Obviously we have had a good, long day with many contributions from some pretty amazing groups, but certainly we are keen to hear from Harm Reduction Victoria. We are pleased that Harm Reduction Victoria put in a submission to us. You have got a bit of time to briefly give us an overview of that, and then we would be pleased to follow up with some questions and so on. Are we starting with Charles and then going from there?

Mr HENDERSON — We are. Thank you so much. Thank you for having a read through our extensive submission. We worked hard on it and we tried to cover as many of the options as we could, and we think we did a pretty good job. We are going to start with me with a written comment or two, and then after that we are just going to have a brief comment from each of our specialised workers who are working in various areas. They will explain that as they go. I will just kick it off, so thanks a lot for your time.

We represent the voice for and of Victorian drug users. We provide invaluable expertise not necessarily available from the range of professionals you have seen today and will continue to see as the verbal submissions continue. Our voices' expertise is formed from lived experience. Our added strength of knowledge — real knowledge — and direct contact with drug users as they are, not as research participants or parts of a focus group, make us a vital source of information for this committee. We are proud to be that voice, so often neglected and misconstrued or more often ignored. Today we encourage this committee to make a difference in the lives of drug users in Victoria — to discover a path enlightened, more compassionate and more inclusive than any other efforts in Victoria or Australia to date and to build on these efforts to benefit drug users and the wider community.

Harm Reduction Victoria is a state-based drug user organisation, and it has long advocated that minimising the harm associated with the use of drugs requires the amendment of policy and laws associated with the control of these drugs. Harm Reduction Victoria is not in the business of promoting drug use. As a harm reduction organisation, our philosophy and actions look to reduce the harmful effects of drug use regardless of their illegal status. We neither condemn nor condone. We understand that drug use will continue to occur despite legal prohibition.

Harm reduction itself receives less than 2 per cent of funding allocated under the harm minimisation strategy. Return on investment data on the Australian NSP over the 10-year period of government investment showed that for $1 invested there was around $4 return in downstream health costs saved. During this period over 32 000 HIV infections and over 96 000 hepatitis C cases were averted — what an outstanding return on that overall investment. This and other research states it is the most successful public health intervention bar none, yet year after year Harm Reduction Victoria continues to struggle in our capacity, our reach and the range of services we offer.

Looking at the NSP data from the Kirby Institute shows that the rate of injecting drug use by age has not changed in 20 years or more. Young people continue to become injectors as older people retire. The age of initiation into injecting remains at about 19 to 20 years old. Nationally 50 million needles and syringes are distributed as of the 2015–16 year, and this is an increase of around 50 per cent over the 10-year period from 2006–07 to 2015–16. More than 10 million needles and syringes are distributed in Victoria and over 80 per cent of the newly acquired hepatitis C notifications annually are attributed to injection drug use as a risk factor. Three out of four NSP attendees in Victoria test positive for hepatitis C. Even at rates of 100 per cent of needles and syringes going out to injectors, still secondary distribution remains illegal. We need to get more needles and syringes out there, not less.

Most needles and syringes are distributed from public sector NSPs, at 87 per cent, and these services are in contact with the majority of injecting drug users. This contact is brief and fleeting but with a large potential to do a great deal in respect of opportunistic interactions or brief interventions. Over three-quarters of attendees have had an associated injection-related injury or disease. Often these take the form of abscesses, vein degradation and bacterial infections, which are entirely treatable if contact is maintained.

Injection drug use is not going away. Regular people who inject drugs — those who have injected in the last week or more — have increased 10 per cent over the last 10 years. Drug use over time is cyclical, as are the types of drugs consumed and by what methods they are consumed. This in turn is related to wider economic and social conditions. The current Victorian drug user profile is a user that is polydrug. Even with those who choose to inject amphetamines, any range of drugs can be and are consumed.

The current levels of hysteria and misinformation associated with just about any media reporting or public discussion in relation to the use of methamphetamines is leading to extreme levels of harm and stigma for a group of people already highly marginalised within our community. Ultimately, responding to methamphetamine use is not rocket science. It should be based on the very same principles that we advocate for effective responses to other illicit drugs, including the provision of peer-driven, harm reduction approaches for all methamphetamine users and for those who wish to access treatment — the provision of appropriate pharmacotherapy-based treatment and other evidence-based treatment services.

Heroin figures in almost one in two overdoses in Victoria over the last year and pharmaceutical opioids figure in about three in four of those overdoses. This is not a one or other dichotomy; it is a reflection of polydrug use and that relative to heroin, as indicated in the IDRS 2016 data, low-frequency patterns of use and cheaper prices suggest that pharmaceutical opioids are used opportunistically by PWID, or people who inject drugs, in Victoria as a substitute for heroin. In reality it has never been easier to get heroin. Police data indicates that the purity is low, but we are all aware of the horrendous overdoses statistics. Each statistic represents someone who has died. Each death is someone's loved one — a parent, a child — all profoundly sad and unnecessary. These are entirely avoidable.

Annual overdose numbers continue to climb. Non-fatal ambulance attendances has increased by 20 per cent more since 2014–15, and conversely this connects with increasing knowledge around naloxone, but importantly without the means of accessing this life-saving medication easily. Our health promotion team leader, Jane Dicka, specialises in naloxone overdose training and we will inform the committee of her efforts to reverse these appalling events for Victorian citizens.

Universal hep C DAA regimen access, regardless of acquisition, is a remarkable event that Australia should rightly be proud to state as a global first. The fact remains that despite the availability of the new treatments in Australia, and the subsequent increases in the numbers of people being treated, the majority of people with hepatitis C are still largely hidden and disconnected from the health system and are likely to remain so without targeted education and support to engage them. A peer-based approach is therefore key. Now the hard work begins, engaging the many people who inject drugs with chronic hep C who are disenfranchised and disengaged from the health system and HCV treatment.

Despite the improvements in treatment medications, for many individuals HCV treatment remains a major undertaking that cannot just be separated from other aspects of their lives and experience. For HCV-positive PWID this includes the negative impact of ongoing stigma, discrimination and criminalisation of people's life circumstances, their health and their interactions with the health system. An effective response to the HCV epidemic therefore will require an approach that not only provides access to appropriate models of care in the community for the priority population but must also focus on preventing ongoing transmission of hepatitis C.

This means that it must have a priority focus on current users and providing expanding resourcing and support for locally driven, peer-based approaches to hepatitis C prevention and testing. In short, people who inject drugs need access to a comprehensive hepatitis C cascade of care that not only focuses on the delivery of treatment but has HCV prevention and peer-based approaches at its centre, not its edges. These peer-based approaches and supports could be viewed as essential to effectively supporting people across the HCV treatment journey and beyond.

The CHAIR — I see you have got another full page of notes there, Charles. I am aware of the time, and I am keen that we have some opportunity for a bit of dialogue, so could you as much as possible cut to the chase or try and simplify the key points that you want to make?

Mr HENDERSON — All right. There is clear evidence to support the urgent need to address the increasing rate of bloodborne viruses in our prisons. As a community we know that half the people in Australian prisons have a history of injecting drug use prior to imprisonment, and the authorities themselves say it is impossible to keep illicit drugs out of prisons. We think that we need to provide access to sterile injecting equipment in prisons in Victoria and elsewhere, and there is ample evidence from other countries on the effectiveness of the NSP in prisons. Harm Reduction Victoria believes this is a fundamental human rights issue for Victoria and must be addressed as part of this inquiry.

Opioid replacement therapies, methadone, buprenorphine and buprenorphine/naloxone, are life savers for many, and they provide a genuine therapeutic alliance with health providers, but cost is a barrier and regulatory red tape can create insurmountable obstacles. Sarah will discuss this more.

What does the law do? It maintains a barrier for those PWID in need. Often the NSP contact is not maximised and the peer-based approach such as ours is not invested to a level to make vital differences to more and more people who want it. The evidence piles up. A classic example is the push to trial a medically supervised safe injecting centre in Richmond, the centre of Melbourne's street-based heroin trade and a place where dozens of people have died needlessly.

Sydney's injecting centre has been running for more than a decade. It has saved many lives and managed thousands of overdoses without a single fatality, and crucially at least three out of four people who use it have accepted referrals to other health services and other health experts to deal with other issues to do with their lives. Along with the Victorian coroner, we are calling for a supervised injecting facility to be established in the North Richmond area as soon as humanly possible.

Drug checking services is another vital harm reduction initiative that would save lives and build bridges instead of our current mistrust and fear, particularly amongst our younger citizens. Our DanceWize coordinator, Steph, will talk more about this, including the novel psychoactive substances unregulated markets as further need for law reform. Evidence suggests that harm is least when drug use is taken away from the black market: purity is known, toxic unknown adulterants are removed, the cost and access is via health-based environments and effective education and knowledge-based solutions are readily available.

Please remove the use of illicit drugs from the back rooms, alleyways and places in the dark. As the committee represents a broad range of political parties based in Victoria, you should take this opportunity, be the ones that are brave and forever be associated with the starting point to where a road to humanity, justice and working towards positive change is the norm. That is the basis for where we all belong and the platform from where we act. This has been shown to work in Portugal. This policy was introduced 15 years ago, resulting in a decrease in drug use, drug-related crime, disease and overdoses. It has caused many other nations to adopt similar policies, and they have a broad appeal for a whole raft of reasons. But most of all for Harm Reduction Victoria it is the result of adhering to evidence-based policy.

Our work is simple but by no means easy. It is about being practical, pragmatic and realistic. People will always seek to take drugs. Drug use within a human societal context is ancient and profound, and drug use is intrinsic to us as human beings. A solution to the drug problem lies in changing the law, and we owe it to ourselves and to everyone to come. Let's start.

The CHAIR — Thanks, Charles.

Ms TZANETIS — Hi. My name is Stephanie. I coordinate Harm Reduction Victoria's DanceWize program, which does outreach, harm reduction education and support at music events and festivals. We also visit universities, orientation weeks and things like that for harm reduction education and support, along with a range of other special projects. In the HRV submission recommendations 19 through 22 strictly relate to the DanceWize program's work, and number 25 as well, which is promoting the Portugal model. That supports everyone; that supports all harm reduction work. I would just like to start with that.

The CHAIR — How many workers do you have in DanceWize?

Ms TZANETIS — I am the only staff member. We have had 1.5 employees at most, and that has been between 3 people, but we have a team of more than 100 volunteers. We are very grateful for the DHHS funding we receive, but that is dwarfed by the community effort — the volunteer hours.

I would just like to start with an anecdote about ice. I do despise puns so forgive me for this, but when I was a child I remember a television show called *Beakman's World*, which was basic introductions to science. Something has stuck with me since then, and that is that when you boil water and add it to an ice tray and put it in the freezer, it becomes ice faster than water from the tap. It is the only visual aid I have today, but there is a diagram of what it does.

What I would like to point out about that anecdote is that sometimes we have to think creatively and laterally to find the best evidence-based solution to a problem. We also have to be willing to trial strategies that may provoke some resistance in us and which seem counterintuitive, especially if the status quo is failing, because right now the status quo is failing and we are seeing people die. In my past year of work I have witnessed one person in their 20s receiving CPR unsuccessfully, and that was avoidable through drug-related education, and I have supported the friends of someone who died at a festival. This was not in the media. At that festival there were sniffer dogs at the front; there were police drones over the top, and a pharmacist in her 20s still died. So this is something that needs to be addressed because I do not want to be a shoulder for people to cry on when it is unnecessary. It might provoke resistance; it might seem counterintuitive, but when the status quo is failing and when our people are dying and in other parts of the world there are strategies — they have an evidence base that shows they are effective — we have to consider them.

I am going to talk about sniffer dogs and how they are used in Victoria at the moment and I am going to comment on pill testing and the potential for a collaborative early warning system which would increase police intel and encourage people to discard a substance or substances that are suspected to be more high risk.

Sniffer dogs are used at times in front of festivals. They can sometimes detect illicit substances, but the way they are used in these settings, in festivals, is that there is too much stimulus. We know that people still get drugs in or they modify their drug-taking behaviour and preload before going in. All up we end up damaging our economy because at these events, these arts and culture events, it becomes harder and harder. You need more security, more police, user-based policing, so people are more likely to avoid going to these places of public entertainment and party at home, which is a more high-risk setting. Sniffer dogs sometimes prompt people who have substances on them to panic and consume them all. I know of at least two anecdotal situations where people died because of that. So all the people who are intoxicated at festivals with sniffer dogs at the front shows that they are ineffective at detecting all of the drugs. Believe me, for festivals where sniffer dogs are there, there are still people who are intoxicated.

The thing I am also very concerned about is the false detections, where people do not have substances on them but they get strip-searched. Approximately 80 per cent of detections are false detections and that can be the first encounter that people ever have with police. I know it was not popular, but the Police Schools Involvement Program has been defunded. It was not very popular, but that is how I learned about the role of police officers in the community. I learned how to be a law-abiding pedestrian and ride my bicycle from those encounters with police visiting schools. Now, the first encounter most young people are going to have with police is being screened by sniffer dogs and then possibly strip searched when they have not done anything wrong. That is worrying, especially if people get inside and they are doing something which might be high risk, like using drugs — and unfortunately that is something that does happen; that is a reality — people are less likely to put their hand up and ask police for help when something is going wrong. So that is sniffer dogs. It is ineffective and it is potentially more dangerous as well.

In regard to pill testing, we are not suggesting that you just have an odd pill testing set up at festivals. It would be a mixed model, where you could go to your GP as well and get samples tested. If there were supervised injecting spaces, they could be drop-ins to do pill testing as well. You could have mobile testing facilities in entertainment hotspots as well as pill testing at festivals. And all of that data gets shared and is triangulated against police seizure data so we have a much better idea of the illicit drug market. Because irrespective of how much experience you have in this industry, the game has changed radically since 2005 with the advent of internet shopping and the rise of its popularity. The dark web is a place where you can get almost anything at low cost and millions of packages are sent into Australia. So our narco-trafficking network in Australia and globally is so complex that conventional policing mechanisms cannot keep up. There were 750 novel substances recorded in the EU last year. We want that type of intel here so we can have an early warning system and save lives.

Ms DICKA — On naloxone, I do not have heaps of notes, so I will be sharing this one.

Ms PATTEN — Good, because we will ask heaps of questions.

Ms DICKA — Basically naloxone reverses the effects of heroin. Are we all aware of naloxone?

Ms PATTEN — Yes.

Ms DICKA — It is fantastic that they finally made it available to drug users, and I train drug users in how to administer it. I refuse to train someone unless I can actually put it in their hand at the end of the training. That is the barrier: putting it in their hand at the end of the training. It is a prescription drug so we need a doctor to write a prescription. I cannot get a doctor willing to follow me around wherever I go. They said, 'We made it dual listing. We made it S3 and S4 so now you can buy it over the counter', but to buy it over the counter it is not covered by the PBS so the cost is just not affordable. And think about it, at the end of the day you are asking people to pay for something they might need or they might not need, and really they do not need it for themselves. They are not going to use it on themselves. They are going to use it on someone else, and perhaps a total stranger. It is a fantastic thing. It should just be freely available. We have defibrillators in public places. You should in cases of emergency be able to break glass with a naloxone dose there. It should be in everybody's first aid kit. It is just crazy that there is still so many barriers for people to be able to access it when we know that it is worth its weight in gold.

Mr HENDERSON — And our capacity is so low. We have got one worker that does the whole state. We need to be given a greater ability. The Canberra model that Margaret mentioned in her submission is a great model. We can connect and do those sorts of interventions.

Ms DICKA — It is the peer-to-peer training that kicks goals. These other agencies do not have peers doing it, and if you look at what our peer program in Victoria has done, well, the rest of Australia combined has not matched our totals because we are all peer based. Drug users listen to other drug users. It is not rocket science.

Mr HENDERSON — Anecdotally, how many overdoses have you seen, Jane?

Ms DICKA — Over 150 reversals I have had reported. That is not to say that 150 people would have died, but 150 instances of overdoses were made a lot easier to manage and a lot less stressful and avoided an ambulance call-out. I do not know how much it cost for an ambulance these days — quite a bit of money.

Ms PATTEN — A thousand dollars.

The CHAIR — That is what we were told earlier on.

Ms DICKA — It is not best practice to tell people not to call an ambulance, but that is what people are doing. They are not calling an ambulance. They are saving their mates and going on about their lives.

Ms LORD — Hi. I am Sarah and I run the PAMS program. PAMS stands for the very long named Pharmacotherapy Advocacy Mediation and Support. Essentially we are a very small program. There is me full time and I have a co-worker three days a week. We cover the whole state. I guess our overall goal is to keep people on methadone and suboxone — buprenorphine/naxolone and the buprenorphine program — and also to increase access to these programs, particularly for anybody who is struggling. I am sure you all know quite a bit about pharmacotherapies. It is an essential medicine declared by the World Health Organisation.

The CHAIR — I guess we are really interested to know what are the restrictions? What are the problems that you are seeing out there in the field?

Ms LORD — Okay. Not a problem. The biggest problem for the consumer is the cost of the program. The drug is funded by the commonwealth government. In Victoria it is all dosing at a community pharmacy. The cost is around about $5 a day, but that equates to roughly $1500 to $1800 per year per person. This is a long-term treatment; it is not a six-month program. People are on methadone many, many, many years. It is also one of the most successful treatments and it is highly cost-effective, except for the cost to the client.

There are also particular special needs groups. For example, pregnant women are really encouraged to get onto methadone or buprenorphine when they are pregnant, and there are much better results in terms of the baby and unborn foetus. However, if for any reason they cannot get a dose or a number of doses of methadone or buprenorphine, which can quite often happen if they do not have the money to simply pay for a dose, then they are at great risk of miscarriage. It is particularly bad in the first and the third trimesters. That is a huge problem.

Some of the other groups are people who have just been released from prison. The department of justice pays for the first 30 days of their program post-release. A lot of the people who have been released from prison, particularly single males, have no accommodation option other than boarding houses, and they charge $200 a week. If you do the maths, there is very little money, if any, left to pay for the program. We often have people,

particularly single males, contacting us saying, 'I've just finished the 30 days of the funding. I don't know what I'm going to do'. They have been on the methadone program for a long time, often on high doses — 80, 90, 120 milligrams of methadone. You cannot just stop taking this medication. However, pharmacies are completely entitled to say, 'No, you don't have the money. I won't give you a dose'. Interestingly enough for Aboriginal and Torres Strait Islander people, Closing the Gap funds all medications, except for methadone and buprenorphine and buprenorphine/naloxone. That is a big problem.

The other thing is when people are trying to access a program for the first time, often they will contact PAMS because they have no money to pay for that first week. When people want to get on a program, they want to do it now. Access to prescribers is a huge problem, because although we have some prescribers and some particularly fantastic prescribers, we do have an ageing workforce of the prescribers in Victoria. Often people have to wait a week or more before they can get an appointment so that they can see the prescriber and get the first script, but then quite often after that they do not have the money to cover the first week. One of the things that we try and do at PAMS is to cover that first week, because once people are started on the program then they will get a feeling of what it is like, they do not have to get the money together every day to buy illicit drugs — all that sort of thing.

Victoria has a huge problem with a lack of prescribers, as I have just mentioned. The pharmacotherapy area-based networks have helped with that situation a bit. However, in terms of pharmacies it would be fantastic if every pharmacy was actually mandated to dispense methadone and buprenorphine and buprenorphine/naloxone. I think if that happened, then it would not matter where you lived. You would not have to travel up to an hour a day if you are living in a country area, because then you have got the cost of petrol or public transport on top of the cost of the program. I can assure you that if any pharmacies were not running a really good program, for the consumer group that would be their absolute last choice. One of the things is in terms of access to treatment providers there is very little choice, and that is because we do not have enough prescribers wanting to prescribe this sort of medication.

The other issue is the takeaway doses particularly for methadone were changed on 1 September 2016. People who are on methadone used to be able to get up to five take-home doses per week, particularly if they had been on the program for more than six months and were considered stable in treatment, which essentially means dosing every day, not missing doses — that sort of thing. That was reduced down to four and, although that might not sound very much, having to get into a pharmacy three days a week, particularly for people who are working full time, is really difficult, and if you are having to travel considerable distances, which a lot of people in the rural and regional areas are, then you have got that additional cost of the petrol and transport. That is most of the main points that I wanted to cover because I wanted to leave some time for questions.

The CHAIR — We might come back to you with some questions. We will see how we go. Thanks Sarah, and thanks all of you.

Mr TILLEY — All right, ladies and gentlemen. We can have academic papers and we can listen to them, we can read them and we can pull them apart. You are at the front line of drug users in the state of Victoria. You see this, you breathe this, you shit this every day, all right?

Ms LORD — In a manner of speaking!

Mr TILLEY — And I am coming from the law enforcement side. I am a long-time copper and saw a lot of this stuff on the streets. What I want to really get from you is if there is anything you want to say and you want to say in camera to this committee that is going to help it come up with findings and recommendations that are going to fix this mess up? Put it this way: if you were the government — you guys were the government making decisions on public policy — what is it that you want?

Now, we heard from the coroner earlier today about the methadone program. Let me tell you, in country Victoria we have got pharmacists all over Wodonga. You know, the methadone program, there is not a problem. So I do not wear the issue in relation to travelling and the cost of petrol and all that sort of stuff.

Ms LORD — We do not have prescribers though in Wodonga. I can guarantee you that.

Mr TILLEY — Yes, you do, don't worry. There are plenty of them. I guarantee you. Oh, no, we don't. That is the other side — — **Ms LORD** — Yes.

Mr TILLEY — But there is plenty of methadone around town, don't worry about that.

Ms LORD — I will send you a few clients to place with prescribers in Wodonga.

Mr TILLEY — You make a very good point on that. So if you understand where I am coming from, we just want to get straight to the point, you know? Sniffer dogs, I know about them. I have spent hundreds of hours working with sniffer dogs.

The CHAIR — What is your question, Bill?

Mr TILLEY — The point is what I want from these people is straight up, none of this academic staff. If it needs to be said in camera, please ask for that and we can turn around and suspend that part, because we need to know this warts and all and mud and all.

Ms LORD — Thank you. That is a wonderful opportunity.

Mr TILLEY — So go hard.

The CHAIR — But if we do that, then we do change the nature of the meeting because we have to ask — —

Mr TILLEY — We can have a conversation around the table, which is going to be helpful.

The CHAIR — No. If we go in camera, we have to ask the audience to leave. So if we need to, then we will.

Ms PATTEN — I would not have thought any of you would need to go into camera, knowing you all.

Ms LORD — No.

Mr TILLEY — I do not want anybody compromised, that is all.

The CHAIR — If we do not need to, that is good.

Ms TZANETIS — I think recommendation 25, which is decriminalisation, sometimes makes people have a kneejerk reaction. It is not condoning drug use. It is not normalising it. It is decriminalising specifically use, which is just a summary offence and many people do not realise it is even an offence, and possession of a smaller quantity for personal use only. So that would be, I would assume, under the threshold where trafficking is inferred. Those two offences should just vanish off the face of the earth because they waste police resources, they clog up the court system, and they do add a lot of issues for people on a personal level because they limit employment opportunities and promote stigma and discrimination. So it is those two.

Mr HENDERSON — That is right. It creates a career of narrowing options and those options tend to be mental institutions, prisons and unemployment. Treating it as a health issue is just a vital cog to the whole drug policy question. If you do not treat it as a health issue, you will continue to be addressing these things at the edges. As Portugal did in 2001, they took that hard step even in respect of the UN conventions. They decided to decriminalise, and 15 years later all of those indicators are now on the downward trend.

The CHAIR — It is fair to say that as the committee we will be going to Portugal and looking at the issues in Portugal. We will be going to Sydney to look at their supervised injecting facility in a few weeks time, so we will clearly be looking at all of those.

Mr HENDERSON — Yes — for instance, the needle and syringe program in 1985 was really perhaps an issue to do with HIV and the epidemic that that was. I think that perhaps the needles and syringes program itself got implemented as a slight fear factor of the fact that HIV could have got into the wider population through sexual transmission. Perhaps with hepatitis C that might not be as apparent and so therefore not so much of a worry to the wider population. But I think we need to treat all citizens fairly in terms of what sort of drugs they want to use, and we need to treat all drug use as a health issue. Anything else, guys?

Ms LORD — We desperately need to look at heroin prescription. Pharmacotherapy is fantastic and it works very well for a hell of a lot of people, but it does not work for everybody. There is a certain number — albeit, a small minority, I believe — of people who do continue to use heroin and other opiates on top of methadone, and

I guess it is a treatment-resistant group. We do not have time to discuss all the issues with heroin prescription today, but I do believe it is possible. There have been a huge number of trials done recently in other parts of the world — for example, England and Canada — and I think we really need to look at that research and go back to that. We nearly got there. Canberra nearly implemented a diamorphine trial

The CHAIR — That point was made by the Turning Point people earlier on today.

Ms LORD — Yes. Yet again I think buprenorphine is fantastic, but it is not everything and it is certainly not everything to all people who are opioid dependent.

Mr HENDERSON — Drug use itself is powerful. Five per cent of the people who become dependent on a lot of the drugs we talk about that are now currently illicit are the ones we often deal with in the treatment sector, and the vast majority use drugs quite safely, as they would any other drug — alcohol, coffee, sugar.

Ms TZANETIS — I think drug knowledge, moving harm reduction education across the board, is something that we need, so harm reduction education in schools and universities. Also among other stakeholders like Victoria Police — I think that would be great. I see them as a critical ally. I find that my interactions with Victoria Police are quite diverse. They are some of my staunchest allies and the community-based focused officers inside a festival are awesome, but then sometimes some of the specialised operations can be a bit more militaristic and some police are just completely unaware of what harm reduction is. I think also we would benefit from harm reduction education, and just more drug knowledge, within health care and even the medical curriculum.

The CHAIR — Again, that point has been made several times today, so it is good to hear it again.

Ms PATTEN — We have been hearing a lot about naloxone, and I was pleased to read that it was rescheduled as schedule 3 so there was the over the counter, but I appreciate the price difference and the fact that it is not supported by the PBS. But I liked your comment about every first-aid kit having some; it is an interesting one, and using the defibrillator analogy was an interesting one. I know a lot of people will go to *Pulp Fiction* to think about

Ms TZANETIS — Yes, that has got a lot of attention, that Tarantino movie.

Ms PATTEN — That is right. We are going to see the EpiPen going straight through the chest cavity. Jane actually trained me so I know that is not the case. But in getting that widespread use of naloxone, do you think we also need that 30-minute training session with every single person?

Ms DICKA — It does not need to be 30 minutes, seriously; it can be just an exchange of — I mean, if somebody is going to try and do the heartstarter needle and they can actually get a needle through someone's sternum, good luck to them. They are just doing a lot of damage and chipping away at it. But if little Johnny eats peanuts and goes into anaphylactic shock, there is that pen in the cupboard with some instructions. You can do more damage with one of them than you can with naloxone, and they are just everywhere.

Ms PATTEN — Because I think this leads to the talks about how we need to be updating our NSPs — needle and syringe programs — and obviously there is a perfect place for naloxone.

Ms DICKA — It is, Fiona, but if those workers cannot actually put it in the person's hand, it is useless.

Ms PATTEN — I appreciate that. Have you done any costing on how much naloxone we would need to get out there and how much it would cost us?

Ms DICKA — We have not done that. However — —

Ms PATTEN — I have been doing my calculation on subsidising methadone, and that was — —

Ms DICKA — When it got rescheduled to have the dual listing and that, even still one of the DanceWize volunteers happens to be a pharmacist, and she sent me the guidelines that pharmacies get to be able to hand it out. A schedule 3 has to come from an actual pharmacist, there has to be a conversation and it is for one ampoule, or one mini-jet.

The CHAIR — Charles, how much does one dose of naloxone cost?

Ms PATTEN — Thirty eight dollars.

Ms DICKA — When it is covered by PBS.

Mr HENDERSON — But with a concession card, cheaper.

Ms DICKA — Over the counter it is more expensive, yes.

Ms LORD — But at the same time, if people cannot afford to buy one dose of methadone, which is about $5, how is this same client group going to be able to go and fill scripts on a PBS of naloxone?

Ms DICKA — That they are not going to use on themselves?

Ms LORD — Exactly. We have got people missing doses because they do not have enough money to pay for that one dose.

Ms PATTEN — Yes. I just did a back of the envelope, so we would be looking at $23 million a year to subsidise 13 000 users at $5 a shot. That is $35 a week for 13 000 users, and it comes in at about 23 or 24 million. I suspect that there is a cheaper option where we subsidise the dispenser and we start incentivising the dispenser so you have got more dispensers and prescribers.

Ms LORD — Yes. So you are talking about pharmacotherapy now, are you?

Ms PATTEN — Yes, sorry. Over to you now.

Ms LORD — Yes. We do have just over 13 000 people on the program in Victoria. I mean, it is crazy. People would just never have got the money to start on the program, and that is if they can get a doctor at the time when they need it. People do not sort of say, 'Oh, I'm thinking about going onto methadone in maybe two or three weeks. It is like, 'No, now — today'. Pharmacotherapy is a drug that has to be dispensed every 24 hours. The other thing is people cannot say, 'Look, I don't like the service I'm receiving in this pharmacy. Just give me my script back. I'm not prepared to wait 45 minutes to get my dose for today. Give me my script back. I'll go to another pharmacy'. It cannot happen because you have to dose at the pharmacy where the script is.

Mr DIXON — You mentioned earlier what was in your submission. It was about the mobile injecting facility. How does that work? What would it look like? Does it go to where there might be a hotspot as distinct from a static one?

Ms DICKA — The mobile, yes, could go to hotspots, but the idea behind a mobile service is not so much that it is mobile but — let us say North Richmond, for example. We put it there. The drug market changes. The police come. Everyone goes over to Fitzroy to score. This facility has got the ability to put the wheels up and drive itself over there where the drug market is. I guess I think along that line because I think it would be awful if they made this beautiful building that was purpose built and fantastic, and then the drug market shifted three or four suburbs. People are not going to travel all the way back to there to use that facility.

Mr HENDERSON — That has happened in Victoria now. There have been five hotspots only eight years ago, and now there is one.

Mr DIXON — In New South Wales you have got this facility in Kings Cross — —

Ms DICKA — It is a fixed site in Sydney, but Kings Cross is a little bit different, I think, because it is Kings Cross, and it has been that way forever. However, with us really only having one really visible street drug market, being North Richmond, and police activity, people just move on. That is what police activity does.

Mr HENDERSON — It is like a Winnebago. It is about as big as that, and so people can walk in and walk out. It is a smaller, more compact supervising facility.

Ms DICKA — And it also helps with that thing about nobody wanting that building next door to them.

Ms TZANETIS — The mobile facility is most effective when it is part of a mixed model, so you have fixed sites and a mobile option.

Ms DICKA — There are really good models in Barcelona.

The CHAIR — It is a matter of having backup support.

Mr HENDERSON — Again, a lot of this is a broad range of interventions that are all health based, not criminally sanctioned.

Ms PATTEN — I have just got one other question that has been tugging at me. As we say, the peer-dispensing of needles and syringes is technically illegal — —

Ms DICKA — No, they are legal, the ones we have got, the program we have.

Ms PATTEN — Sorry, but when you give it to David to then go and hand out to John, Roger and — —

Mr HENDERSON — Secondary distribution.

Ms PATTEN — Yes, the secondary distribution is technically — —

Ms DICKA — Illegal.

Ms PATTEN — Illegal.

The CHAIR — But has anybody been charged?

Ms PATTEN — That was the question.

Ms DICKA — I am not aware of it, but that does not mean that it does not happen.

Mr HENDERSON — Well, it does happen.

Ms PATTEN — That people are prosecuted?

Mr HENDERSON — No, no — —

Ms PATTEN — I know people — —

The CHAIR — But maybe less people do it if they are concerned, but the feedback seems to be that it is not enforced.

Ms DICKA — When you go to an NSP to get your equipment, they ask you how many other people you are picking up for — so, you know, entrapment!

Mr HENDERSON — It is an easy law to fix, really — just change the wording to acquirer and supplier.

Ms SULEYMAN — I just had a question about the pill testing, in particular with concerts that you raised, Steph. You made note in relation to testing perhaps in pharmacies, mobile sites and GPs. Can you explain to me how that would in reality work?

Ms TZANETIS — Yes, at a festival? Based on the Check!n and CheckIt model, in the EU there is collaboration between a range of jurisdictions that provide pill testing services at events. They actually have a guide, and it is one of the footnotes in our submission. It is the best practice for pill testing. You could have a mobile facility, like what we were just mentioning for a mobile-supervised injecting space, or you could have it as a tent structure, and it would be a technician or a medical professional who would be using lab quality equipment, so something like a GCMS (gas chromatography mass spectrometry).

Ms SULEYMAN — So who would that be?

Ms TZANETIS — I can name a couple of experts who advocate for it at the moment. Monica Barratt, who is connected with NDARC at the University of New South Wales. What does the acronym stand for? The

national drug and research centre, or something like that. Also there is the drug observatory, which is Dr David Caldicott, based in the ACT. But what they do in the EU is that people can be trained relatively quickly to use this equipment. The sample is destroyed in the process, so it is not like you have to worry about any illicit substances being left over. It would be a collaboration, as it is in Europe, between a peer-based organisation like DanceWize that can engage and deliver brief interventions with the peer community, and the actual sampling would be done by researchers or medical professionals that have undergone the technical training to run the equipment — that is, like a mass spectrometer.

It would all depend on the festival, just like in the same way our set-up changes festival to festival, but you would want something like six by six metres-plus, then it would just be work health and safety with queues and managing a queue of people. You would want, sort of like how NSPs have a no-go zone, like an easement where law enforcement would not approach anyone that presents to it, because people could be presenting just because they want to get sunscreen too, like they do with DanceWize.

Mr HENDERSON — Did you mean, Natalie, in the GP setting or in the pharmacy setting?

Ms SULEYMAN — I am trying to just understand who would actually be pill testing and how it would be working in a pharmacy setting or in a mobile setting.

Ms TZANETIS — That is why Victoria Police are a critical stakeholder in this. There would need to be cooperation so that people can present at either a pharmacy or a GP.

Mr HENDERSON — Broadening the settings. Effectively we are broadening the settings where pill testing can occur and drug checking can occur. We would still have a level of drug checking that is of an appropriate standard to know what is in the pills, but it would be just broadening the area.

Ms SULEYMAN — I am just trying to understand with the changing markets, and we have heard today that all these drugs are changing and every month there is a different drug on the market — —

Ms TZANETIS — Daily, yes.

Ms SULEYMAN — Daily, there you go. So how would you possibly be able to monitor and be responsible for the testing of these pills?

Ms TZANETIS — There seems to be a lot of media commentary and some experts as well sharing blatant lies that lab quality testing does not produce really comprehensive results. They can produce comprehensive results within an hour and remotely.

Ms SULEYMAN — That is your opinion.

Ms TZANETIS — No, it is not my opinion; it is based on Check!n. It is evidence-based — I swear on my life and the life of my peers that it is evidence-based. The other thing is — —

The CHAIR — We can get technical advice on that score too.

Ms TZANETIS — Yes. The Check!n best practice — it is essential that you look it up. If you are attending European jurisdictions, you will be able to see it in practice. The other thing is that when you get results that you do not expect, when there is some novel substance, that is what you are telling someone — 'You've provided us with a sample. You think it's MDMA. I'm telling you it's not. I can't tell you exactly what it is right now; with these novel substances, there is not enough research to show what the long-term effects would be anyway.' So you are saying to someone, 'This is an unknown substance. You can choose to discard it', so they can.

Mr HENDERSON — And to be honest, the new substances are a function of the black market. Really, the traditional drugs that one knows a lot about, including the traditional hallucinogens that have been around since time immemorial — we know what they do. But with these new substances, we do not know what they do. It is a direct function of the black market and trying to escape those functions of illegality.

Ms LORD — Across the board that is where the harm comes from.

Mr HENDERSON — But you would be well aware of that.

The CHAIR — Are there any further questions?

Ms PATTEN — I have got thousands, but I am going to stop there because I have got to go.

The CHAIR — We have gone over time again today, but thank you very much for your contributions.

Ms PATTEN — Absolutely, guys. Great submission.

The CHAIR — It is good that you have come in and shared that with us.

Mr HENDERSON — Thank you. I will pass that on to Tamara.

Ms PATTEN — Please do.

Ms LORD — If you have any other questions, feel free to contact us.

Ms PATTEN — Yes, thank you. And if you have some thoughts about the costings of some of the recommendations that you have made, why not?

Mr HENDERSON — Okay, great. We would love to do that. I have noted the naloxone that Fiona said, absolutely. Thanks for the back-of-the-envelope calculation. It is good stuff.

Ms PATTEN — That was for methadone.

The CHAIR — Thank you so much. That concludes the hearing for today.

Committee adjourned.