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

Hansard, 22 February 2017

Dr CARLING-JENKINS (Western Metropolitan) — I rise this afternoon to speak on the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017. I will say right from the beginning that I will be opposing the bill.

The proposer of the bill, Ms Patten, refers to the medically supervised injecting centre at Kings Cross as the model for the injecting centre her bill would allow to be set up and operate as a pilot for 18 months here in Victoria. She refers to 10 years of data and reviews of the Kings Cross injecting centre, claiming that this data demonstrates the merits of such an injecting centre for Victoria. I propose to examine her claims carefully, but first I wish to address the coroner's findings that were handed down this week.

I have read the findings of Coroner Hawkins into the death of Ms A in December 2016, which were released on 20 February 2017, and I do wish to extend my sympathy to Ms A's family. I note that the coroner's report states that the family was working towards funding a naltrexone implant for Ms A. Curiously, the coroner does not address the issue of funding for such implants, which may indeed save lives. Reading the findings, both Ms A's tragic personal history and the broader evidence about the current high levels of illicit drug use in North Richmond strengthened my conviction that Victoria needs to seriously consider models such as a compulsory residential rehabilitation program for illicit drug users based on the successful Swedish model.

Coroner Hawkins asserts that Dr Jauncey's evidence led to the conclusion that the injecting centre in Sydney has helped save many lives. However, the only evidence from the doctor that is cited to this effect is a broad assertion that everybody agrees that the injecting centre saves lives. This is simply not a fact, and I will examine this claim in greater detail shortly. However, I note specifically the data in the findings that 70 000 needles per month are distributed in North Richmond and the injecting centre in Sydney averages only 150 injections per day. Translated to North Richmond, this would mean that only 4500 out of 70 000 injections per month would be likely to take place in the centre, with 93.6 per cent still occurring elsewhere. I am disappointed with the coroner's lack of thoroughness and believe her findings to be inadequate at best and misleading at worst.

So now I return to the specifics of the bill presented for debate this afternoon, and I will try and be as quick as possible as I go through this. I note that KPMG conducted a review of the injecting centre for NSW Health and published it in September 2010 under the title *NSW Health: Further Evaluation of the Medically Supervised Injecting Centre During its Extended Trial Period (2007–2011) — Final Report — 14 September 2010 v 1.1*. I will analyse this review and the claims made by Ms Patten when she presented this bill to the house to demonstrate that this proposal is flawed.

The first claim that I wish to look at is the referrals. Ms Patten stated that 10 years of data and reviews demonstrated that the injecting centre had generated more than 9500 referrals to health and social welfare services. The KPMG report states that from 2001–02 to 2009–10 there were 8508 client referrals. It is instructive to examine this data for 2009–10, the most recent year covered by this final evaluation. Mrs Peulich, if you like stats, I have got some stats for you. In that year there were 648 clients referred, meaning that less than 1 per cent of all visits to the injecting centre resulted in a referral of any kind. Of these referrals only 322 were for drug dependence treatment, representing less than 0.5 per cent of all visits. That is on table 8-13 on page 123. Of these, the majority — 189, or 59 per cent — were referrals to the maintenance programs such as methadone. There were only 22 referrals, or 7 per cent, to drug-free treatment programs, such as residential rehabilitation programs or Narcotics Anonymous.

Curiously this report does not specify the percentage of individual clients who received referrals. However, a March 2007 report by the National Centre in HIV Epidemiology and Clinical Research indicated that as of 2007 only 17 per cent of clients had received a referral of any kind and only 11 per cent of clients had received a drug treatment referral. In other words, 89 per cent of clients using the injecting centre had never received a referral for drug treatment.

A second claim made is in regard to ambulance call-outs. Ms Patten stated that 10 years of data and reviews demonstrated that the injecting centre had decreased ambulance call-outs to Kings Cross by 80 per cent. The figure of 80 per cent appears to have been taken from a June 2007 evaluation report by the National Centre in HIV Epidemiology and Clinical Research, which indeed found — as indicated on page 27 — an 80 per cent decline in ambulance call-outs for suspected opioid overdoses in the Kings Cross area, or postcode 2011, during injecting centre opening hours from an average of 17 per month from May 1998 to April 2001, before the injecting centre opened, to an average of four per month from May 2001 to April 2006.

The more recent 2010 KPMG report used different data ranges and concluded that there had been a 64 per cent decline in ambulance call-outs for suspected overdoses in the Kings Cross area — same postcode — during injecting centre hours from an average of 10.2 per month from May 1995, before the injecting centre opened, to April 2010 to an average of 3.6 per month from May 2001 to March 2010.

It is relevant to compare this decline with the decline in three other areas of New South Wales overall — except for the postcode that I have already mentioned of Kings Cross — the neighbouring areas of Darlinghurst, Surry Hills, postcode 2010, and Cabramatta.

The June 2007 evaluation report found a 60 per cent decline in ambulance call-outs for New South Wales as a whole, exclusive of postcodes 2011, but only a 45 per cent decline in ambulance call-outs in the Darlinghurst-Surry Hills area.

Interestingly there was a decline of 83 per cent in ambulance call-outs for suspected opioid overdoses in Cabramatta, with a sudden decline from a high of 70 in December 2000 to less than 10 per month through 2001. This decline is reasonably attributed to the introduction of a sniffer dog policy in the area. The similar decline in the Kings Cross area may well be attributed to a similar sniffer dog program introduced there six months after the injecting centre opened. The comparatively lower rate of decline in ambulance call-outs in the Darlinghurst-Surry Hills area may well reflect a displacement effect of injecting drug use from Kings Cross due again to the sniffer dog program.

We need to be careful not to make wide, sweeping statements when we come to such serious issues. Another claim was made in regard to discarded syringes. The claim has been made that 10 years of data reviews demonstrated that the injecting centre had halved the number of publicly discarded syringes in the area, and the KPMG report does indeed note that the number of needles collected in the Kings Cross area more than halved during the reported period. However, it is quite without foundation to attribute this halving of collected needles to the establishment of the injecting centre alone. The KPMG report itself states:

It should be noted however, that in the absence of comparison data for the period prior to the MSIC commencement, it is not possible to infer a correlation between the reduction observed and the operation of the MSIC.

It is not possible to infer a correlation. Further, the KPMG report notes that the City of Sydney also collects needles and syringes via community sharps bins located in public places. KPMG were unable to source data for collections of needles and syringes collected by the City of Sydney community sharps bins during the period of the evaluation. An increase in the number of needles and syringes being disposed of in these bins may explain the decrease in the number of needles and syringes collected in public areas.

Another claim has been made regarding drug overdose deaths. It has been claimed that 10 years of data and reviews demonstrated the injecting centre had successfully managed more than 4400 drug overdoses within the centre without a single fatality. The KPMG report refers to 3426 drug overdoses in the period of 6 May 2001 to 30 April 2010. Ms Patten has gone on to claim that the Sydney injecting centre:

…saved lives, and continues to do so. Over 4000 overdoses successfully managed within the injecting centre is over 4000 potential community overdose deaths prevented …

This claim of 4000 community overdose deaths prevented is without any foundation in the data and is quite simply indefensible. Interestingly the KPMG report from 2010 is reluctant to attribute any reduction in overdose deaths in Kings Cross directly to the injecting centre. It stated this, and I will quote:

The circumstances leading to overdose (and subsequent involvement of ambulance, emergency department and deaths) are complex. There is a level of caution needed when drawing conclusions from interpretation of this data. These events are impacted by a range of factors, such as changes to the availability, purity and price of drugs. While external data can be useful … indicators for the environment that the MSIC operates within, it is not possible to ascribe causality of any one factor to changes in these figures.

The morbidity rate for heroin overdoses calculated by the National Drug and Alcohol Research Centre is 1 in 25, or 4 per cent. This means that the most that Ms Patten could defensively claim is that the injecting centre has prevented up to 160 overdose deaths from 4000 overdoses. However, this conclusion would again only be valid if the negative effect of the injecting centre in increasing risky behaviour and leading to a higher overdose rate is ignored.

In 2009–10 the overdose rate for heroin injections in the Sydney injecting centre was 14.6 per 1000. The overdose rate at the injecting centre from 2001–02 to 2009–10 was 3426 overdoses from 604 022 injections, or 5.67 per 1000. By comparison the prior overdose rate for clients registering at the injecting centre can be calculated to be 0.228 per 1000. This suggests that injecting heroin at the medically supervised injecting centre in 2009–10 increased the risk of overdose by a factor of 64. That is 6400 per cent. And overall injecting at the centre in its first nine years of operation increased the risk of overdose by a factor of nearly 25.

If clients at the injecting centre had the same rate of overdoses at the centre that they do when they do not use the centre, there would only have been 137 overdoses instead of 3427. Applying a mortality ratio of 4 per cent, this means the injecting centre could be, at best, attributed in preventing a net of 5.48 deaths in nine years or roughly 0.6 deaths per year. So according to my calculations, Ms Patten has exaggerated the number of deaths prevented by 59 233 per cent.

More concerning than these exaggerations, though, is the underlying reality that a so-called medically supervised injecting room simply serves to increase the rate and intensity of inherently risky drug use by its clients and therefore to increase the profits of drug dealers. This is the last thing that I believe the people of North Richmond need, and for that reason alone I would oppose this bill. However, I further note that the whole notion of a supervised injecting room has been soundly condemned by the International Narcotics Control Board, which monitors the international conventions on narcotics, to which Australia is a signatory.

In paragraph 559 of its annual report for 2001 the International Narcotics Control Board states this:

The board regrets that local authorities in the Australian state of New South Wales have permitted the establishment of a drug injection room, setting aside the concerns expressed by the board that the operation of such facilities, where addicts inject themselves with illicit substances, condones illicit drug use and drug trafficking and runs counter to the provisions of the international drug control treaties. The board notes that the national policy in Australia does not support the establishment of drug injection rooms. The board urges the government to ensure that all of its states comply fully with the provisions of the international drug control treaties, to which Australia is a party.

I would also like to draw on the expertise of Mr Shane Varcoe, speaking for the Dalgarno Institute here in Melbourne, who has said:

Any enterprise that inadvertently enables, empowers or equips ongoing illicit drug use has already breached best healthcare practice. Harm reduction can never be about the support of ongoing, health diminishing substance use. Caring, responsible and civic-minded clinicians and policymakers will always be focused on movement toward exit from, and cessation of drug use. Mechanisms that enable any government agency to send a message to the community that we are not only supporting, but enabling taxpayer-funded illicit drug use, not only breaches care for the illegal drug user, but breaches international conventions. It also demonstrates a lack of concern for the wider majority of the non-drug using community.

I do agree with the assessment of both the international narcotics board and the sound views expressed by Mr Varcoe. This bill quite simply is flawed. It fails academically. The evidence does not stack up. It fails vulnerable people, who are encouraged and indeed enabled to continue their risk-taking behaviour, and it fails the community as a whole. We must turn to

best practice, and it is clear to me that injecting rooms are far from being a best practice model. So quite simply in summary, I will not be supporting this bill.