Parliament of New South Wales

JOINT SELECT COMMITTEE INTO SAFE INJECTING ROOMS

REPORT ON THE ESTABLISHMENT OR TRIAL OF SAFE INJECTING ROOMS

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COMMITTEE MEMBERSHIP

The Hon Ann Symonds, MLC, Chair, from 23 September, 1997

The Hon Patricia J Staunton, AM, MLC, Chair, to 2 September 1997

The Hon Ian Cohen, MLC

The Hon John Jobling, MLC

Mr Malcolm Kerr, MP

Ms Reba Meagher, MP

Mr John Mills, MP

Ms Clover Moore, MP

Mr Bill Rixon, MP

Mr George Thompson, MP

The Hon Dorothy Isaksen, MLC, from 18 September, 1997

Ms Marie Swain, Research Officer - Parliamentary Library, from 17 October 1997

Dr Kate Dolan, Senior Project Officer, to 5 December 1997

Ms Susan Want, Clerk to Committee

Mr Paul Adams, Research Assistant, to 5 December 1997

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CHAIR=S FOREWORD

This Inquiry began with the election of the Hon. Patricia Staunton as Chair of the Committee on 8 July 1997. As Chair the Hon Patricia Staunton established the research outline for the Report and arranged for expert briefings and community consultations as well as a study tour to examine the operation of injecting rooms in Europe. On 2 September 1997 the Hon. Patricia Staunton accepted an appointment to the Magistracy and therefore resigned as a Member of the Legislative Council and as Chair of the Select Committee. On behalf of the Committee I would like to acknowledge her valuable contribution to the Inquiry and, in particular the manner in which she established a comprehensive research plan for the collection of information and evidence. The Committee elected me to replace the Hon. Patricia Staunton as Chair on 23 September 1997.

This Inquiry required the Select Committee to advise government on the costs and benefits to the public of the establishment or trial of safe injecting rooms and of amendment to the *Drug Misuse and Trafficking Act 1985* which would be needed to ensure that an injecting room could be conducted legally. The Reference is a direct result of the recommendation made at the Royal Commission into the New South Wales Police Service which was conducted at a cost of over $70 million to the citizens of New South Wales. Emerging from the examination of issues of illegal drugs and police corruption in this State, Commissioner James Wood concluded that the Commission favoured the establishment of safe, sanitary injecting rooms approved for this purpose. He said

> *At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances, to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short-sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour.*
>
> *For these reasons, the Commission favours the establishment of premises approved for this purpose and invites consideration of an amendment of the Drug Misuse and Trafficking Act to provide for the same (Final Report, Vol II: Reform, 1997:226).*

I agree with Commissioner Wood that there are good reasons for the existence of safe and sanitary injecting rooms, particularly in high risk locations, and I concur with his conclusions.

However, the majority of the Committee ultimately did not recommend trialing safe injecting rooms. The division of the Committee on this issue was not a surprise as the diversity of opinion on this Reference was evident in the debate which proceeded on the matter in both the Legislative Assembly and the Legislative Council. This was acknowledged even in the Terms of Reference of the Committee which provided for dissenting reports, a departure from the usual Standing Orders.

My personal belief is that there would be value in a trial to test the *real* benefits and

costs to both injecting drug users and the community. Support for a trial in New South Wales came from public health officials, the NSW Law Society, the Australian Medical Association, the Bar Association, and parents who have suffered the death of a child, but there is understandable apprehension in some sections of the community.

I would like to acknowledge the commitment of all members of the Committee in seeking to address this Reference in a manner which identified community benefit as a priority. I wish to express my particular appreciation for Ms Marie Swain of the Research Staff of the Parliamentary Library for the compilation of the Report. Ms Swain provided a balanced, objective and impartial presentation of the evidence. The quality of the Report reflects the procedural advice and attention to detail given by the then Legislative Assembly Clerk-Assistant (Committees), Ms Ronda Miller. I also recognise the work prepared by Dr Kate Dolan, Senior Project Officer and the ongoing, reliable and thorough support given by Ms Sue Want, Clerk to the Committee who was assisted by Mr Paul Adams. Once again my personal assistant Ms Julie Langsworth has provided valuable assistance.

I believe the Report provides important information and relevant opinion which will be of considerable benefit to policy makers who are interested in the development of health approaches to illegal drug use in New South Wales.

I commend this Report to the Parliament and the community.

The Hon. Ann Symonds, MLC
Committee Chair

EXECUTIVE SUMMARY

This Inquiry has its genesis in a recommendation made by Commissioner Wood in the Final Report on the Royal Commission into the New South Wales Police Service. Evidence had been presented to the Royal Commission that illegal shooting galleries, that is, places where drug users go to buy injecting equipment and rent a room for a short period of time to inject drugs, were operating in Kings Cross often with the approval of the police. Given that such a situation could give rise to corrupt practices, and that illegal drug use is an ongoing phenomenon in our society, Commissioner Wood recommended that 'consideration be given to the establishment of safe, sanitary injecting rooms under the licence or supervision of the Department of Health, and to amendment of the Drug Misuse and Trafficking Act 1985 accordingly' (*Final Report, Vol II: Reform*, p226). The New South Wales Parliament acted in response to Commissioner Wood's recommendation and the establishment of a Joint Select Committee Upon Injecting Rooms was agreed to in June 1997.

A Subcommittee of the Joint Select Committee visited five injecting rooms and held discussion with key stakeholders in Europe. The Committee also visited several Sydney suburbs, Wollongong, Newcastle, and a number of rural areas in New South Wales in order to speak to concerned members of the community, health workers, and drug users. In addition to its own research, the Committee received 103 submissions and took formal evidence from 89 witnesses.

Chapter Two attempts to canvas a number of aspects related to the injecting drug problem despite well acknowledged difficulties associated with the presentation of an accurate profile of injecting drug use. It would appear from various studies that: injecting drug use appears to be undertaken by a very small percentage of the Australian community (1% - 2%), but approximately half the injecting drug user population is located in New South Wales. Injecting drug users are not a homogeneous group: they use drugs for different reasons; they do not all use the same drugs; they do not all have the same level of drug use; the vast majority do not inject their drugs in a public place; there is no certain way to determine who will and who will not become an injecting drug user; they can be found all over the State although there is a greater prevalence in certain areas such as Sydney than others; and approximately 66% have had at least one (non-fatal) heroin-related overdose, and 90% have been present when someone else has overdosed.

The overall health of regular injecting drug users is often compromised, particularly in relation to the presence of blood-borne viral infections contracted through the injecting drug process. While the rate of HIV amongst injecting drug users has remained relatively low since the introduction of harm reduction measures such as the Needle and Syringe Exchange Programs, hepatitis B and hepatitis C infection have not been able to be contained in the same way. Both these diseases pose significant concerns not only for the individual but also for the community at large, given the ease with which they can be transmitted.

While it is understood that for many people injecting drug use is experimental, there are a number of people who become dependent, and as such a number and range of services and treatment programs should continue to be provided as a positive public policy response to injecting drug use. Not all options will be of equal benefit to each drug user. When considering illicit drug use, it should always be kept in mind that any one

injection could be fatal, and therefore the question of harm reduction is ever present. The recommendation of Commissioner Wood to consider the establishment of safe, sanitary injecting rooms was made in the context of the harm reduction approach, specifically as an extension of the Needle and Syringe Exchange Program. He said:

> *At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour. For these reasons the Commission favours the establishment of premises approved for this purpose and invites consideration of an amendment of the Drug Misuse and Trafficking Act 1985 to provide for the same* (Final Report, Vol II: Reform, p226).

Chapter Three contains details of a number of overseas injecting rooms visited by the Subcommittee to gain a first hand impression of how these facilities were run. These centres were located in Rotterdam and Arnhem, the Netherlands; in Berne and in Basel, Switzerland; and in Frankfurt, Germany.

The overseas experience of injecting rooms provided the Committee with important data on the possible costs and benefits of legal injecting rooms, as well as the problems encountered in establishing and operating them. While the philosophies of the injecting rooms varied in the detail, the commonality in approaching the injecting drug problem from a harm reduction perspective was evident in all the European centres visited. The Committee is cognisant of the fact that the establishment of injecting rooms in particular cities in the Netherlands, Switzerland and Germany, needs to be viewed in terms of their specific cultural and legal context, and that this feature needs to be taken into account when considering whether such facilities would translate to an Australian setting.

The question of costs and benefits associated with the establishment or trial of injecting rooms is examined in Chapter Four. It should be stated at the outset that while the general costs and benefits of establishing or trialing injecting rooms can be identified, a mathematically precise cost-benefit analysis cannot be provided. Those accustomed to working in the area of costing aspects of the illicit drug problem list a number of reasons, most of which are linked to limitations of, and gaps in, data collection for why this is the case. With this in mind, the Committee has looked at the arguments for and against the establishment or trial under the broad headings of health implications; social implications; economic implications and legal implications. At the end of the day which arguments are seen as compelling, are to a certain extent, a matter of individual value judgement. As was articulated in one submission to the Committee:

> *There is no simple or objective basis on which to decide whether legal injecting rooms should be established. Considerable uncertainty exists in predicting what their effects would ultimately be, and there is significant concern about potential and perceived problems; while at the same time a decision not to establish or allow them would be equally difficult because it would leave unaddressed the serious problems associated with public injecting* (Reid, Submission 101).

The **arguments for** the establishment or trial of injecting rooms from a **health perspective** are: the potential to reduce fatal overdoses and to reduce the transmission of blood-borne viral infections; such facilities may provide injecting drug users with better access to primary medical care and improve the likelihood of them accessing drug treatment programs; and injecting rooms may improve the occupational health and safety conditions of health workers and emergency service personnel. The **arguments against** are that injecting rooms could lead to an increase in drug use or in the number of injecting drug users; they may delay injecting drug users from seeking rehabilitation; and there are potential health and safety implications for both those using and those working in the injecting room.

The **arguments for** the establishment or trial of injecting rooms from a **social perspective** are that they may: lead to a reduction in the public nuisance aspects of injecting drug use; reduce the opportunities for police corruption; reduce the incidence of certain criminal activities; improve the likelihood of re-integration of injecting drug users into mainstream society; and they may provide a valuable point of contact with the most marginalised of injecting drug users. The **arguments against** are that injecting rooms may: lead to the assumption that drug use is condoned; lead to the congregation of injecting drug users; cause areas where injecting rooms are located to become labelled as drug centres or to feel as if they are ›social experiments=; and lead to an increase in drug dealing and in opportunistic street and property crime; Some rely on moral grounds to object to the establishment or trial of injecting rooms.

The **arguments for** the establishment or trial of injecting rooms from an **economic perspective** are that they may: reduce the cost to the community associated with the treatment of overdoses and the treatment of people who contract blood-borne viral infections; if modelled along the lines of a more general health facility, reduce the social and economic costs to the community of injecting drug use; mean less time and consequently less money, will need to be spent by councils on removing discarded syringes from public areas; and the return for money spent on increased law enforcement does not appear to date to have been cost effective. The **arguments against** are that: spending money on injecting drug users is a waste of money; injecting rooms would have a negative impact on businesses and on property values in the nearby vicinity; and money spent on injecting rooms would be better spent on alternative drug treatment and rehabilitation programs or law enforcement.

The **arguments for** the establishment or trial of injecting rooms from a **legal perspective** are: that it would clarify the role to be adopted by police in relation to both those using and those running such establishments; and eliminating the need to pursue self-administration offences in the courts would save police and court time. The **arguments against** are that: making a distinction between behaviour which is legal in an approved injecting room but illegal elsewhere will lead to the creation of ›fuzzy= law; and there are a number of potential issues surrounding incidents occurring in an injecting room.

Chapter Five examines the current legal position in New South Wales in relation to injecting rooms, and presents a number of options, both legislative and non-legislative, for reform if the establishment or trial of injecting rooms is recommended. While it would appear technically feasible to achieve the establishment and/or trial of injecting

rooms through administrative means such as the amendment of the Police Commissioner=s Instructions, or possibly through amendment to the Drug Misuse and Trafficking Regulation 1994, the Committee is of the view if this were to go ahead, legislative amendment to the *Drug Misuse and Trafficking Act 1985* would be more appropriate. While the form of amendment would ultimately be a question for the Parliamentary Counsel=s Office, the insertion of a new Part into the *Drug Misuse and Trafficking Act 1985*, exempting those activities taking place in an injecting room which would otherwise be an offence, would be a useful way to proceed. If a trial, as opposed to establishment of injecting rooms were recommended, these exemptions would only apply for the time specified for the trial. It would remain the case that all other drug-related activities occurring in a non-injecting room context would remain offences, and would be vigorously pursued by law enforcement officials. Legal issues of a general nature, particularly those related to liability, would also need to addressed. It would appear that while Australia=s international treaty obligations do not prevent the trial of injecting rooms, the position as regards their actual establishment is less clear, with expert opinion divided as to the possibility.

Chapter Six examines many of the operational aspects which would be involved in the establishment or trial of an injecting room, and those assessed as being minimum mandatory requirements are outlined. In deliberating on the issues surrounding the establishment or trial of such facilities, the Committee was mindful of the fact that it must consider both the needs of the potential user group and those who may be affected by the operation of the injecting room.

The minimum mandatory requirements identified are:

- only those over the age of 18 with a history of injecting drug use would be able to gain access to the injecting room;

- the full range of sterile injecting equipment should be available in the injecting room as should a means to ensure appropriate and safe disposal of used equipment;

- the injecting room should be adequately staffed by trained health workers;

- a registration system and strict entry criteria should be in place;

- an injecting room should be located in an area where public injecting is currently a problem, and the area chosen must be on an accessible public transport route;
- the hours of operation of the injecting room need to have minimal impact on the local community;

- all services offered by an injecting room need to be provided free of charge;

- an expert advisory group consisting of key stakeholders needs to be set up to oversee the establishment and running of any injecting room. The Committee is of the opinion that the success of any innovative program in injecting drug use is reliant on the co-operation and support of police, health workers and the community;

The issues integral to both the short-term and long-term monitoring and evaluation of

injecting rooms are canvassed.

Three possible injecting room models are presented, and their advantages and disadvantages discussed. The first model is a new service or facility managed by the NSW Health Department or contracted out by the Department to a suitable non-government organisation; the second model is an injecting room incorporated into an existing health or drug treatment service; and the third model is the licensing and regulating of an existing commercial premises.

If the trial or establishment of injecting rooms is to proceed, the expert advisory group would be best placed to determine on a case by case basis the operating details of any particular injecting room which may be created. This would be done in close consultation with the local community.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE INQUIRY

The impetus for this Inquiry lies in the findings of Commissioner Wood in his *Final Report on the Royal Commission into the New South Wales Police Service* that:

> *Much of the corruption identified in this Inquiry was connected to drug law enforcement. The huge sums of cash associated with the drug trade, and the apparent inability of conventional policing to make any impact on the illegal market in narcotics creates cynicism among police working in the field. It also creates an environment in which corrupt conduct flourishes: of the conventional kind, involving protection and bribery; of the kind that involves direct criminal activity, such as theft and supply of drugs; and in the various forms of process corruption earlier identified (Royal Commission into the New South Wales Police Service*, *Final Report, Vol II: Reform,* May 1997, p223).

One example of corrupt conduct of the conventional kind about which the Royal Commission heard evidence was that of the corrupt relationship between police and owners and operators of ›shooting-galleries= in Kings Cross. ›Shooting-galleries= are defined in the *Royal Commission into the New South Wales Police Service Final Report* as ›places where drug users can go to buy a syringe kit and rent a room for a short period of time to inject drugs= (*Vol I: Corruption*, May 1997, p16). According to Commissioner Wood the ›shooting-galleries= in operation were:

> *unsanitary premises where prohibited drugs were supplied and injected ... The action of the [Police] Service in closing down these premises was appropriate in the light of the evidence, as those connected with them were not in any way suitable for any form of imprimatur, official or otherwise, to operate such a facility. Their interest was purely commercial and counter-productive to rehabilitation* (*Final Report, Vol II: Reform, p225).*

At the same time the Commissioner recognised that in keeping with the National Drugs Strategy objective of harm reduction, approved injecting rooms may have a role to play. He said:

> *There are, however, good reasons for the existence of approved injecting rooms in high risk locations, as:*
>
> - *it is fanciful to think that drug addicts can be prevented from obtaining and using prohibited drugs;*
> - *the risk of the spread of infectious diseases demands that sterile syringes and needles be made readily available to the population of injecting drug users;*

- *used syringes and needles need to be disposed of safely;*

- *such an environment reduces the incidence of theft and violent assaults on drug users;*

- *injecting drug users, very many of whom want help, can be targeted for education and encouraged to seek treatment for their addiction and associated medical problems; and*

- *in the event of an overdose, staff are available to contact the Ambulance Service and, if suitably trained, to administer preliminary first aid* (*Final Report, Vol II: Reform, p226).*

Commissioner Wood referred to the amendments made to the *Drug Misuse and Trafficking Act 1985* in 1994, which created a legislative foundation for the Needle and Syringe Exchange Program (NSEP), as an acknowledgement of the medical and social dimensions surrounding injecting drug use. He added:

> *At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour. For these reasons the Commission favours the establishment of premises approved for this purpose and invites consideration of an amendment of the Drug Misuse and Trafficking Act 1985 to provide for the same* (*Final Report, Vol II: Reform, p226)*.

In this context Commissioner Wood went on to recommend that:

- *consideration be given to the establishment of safe, sanitary injecting rooms, under the licence or supervision of the Department of Health and to amendment of the Drug Misuse and Trafficking Act 1985 accordingly* ; *and*

- *guidelines be published by the Police Service in conjunction with the Department of Health, setting out the basis on which the policing of Needle Syringe and Exchange Programs and Methadone Maintenance Programs and similar public health initiatives should occur* (*Final Report, Vol II: Reform, p226)*.

The New South Wales Parliament acted in response to Commissioner Wood=s recommendation and the establishment of a Joint Select Committee Upon Injecting Rooms was agreed to in June 1997 (*NSWPD*, 19 June 1997, pp10702-10703).

THE TERMS OF REFERENCE OF THE COMMITTEE

The Terms of Reference of the Committee are:

(1) That in the light of the Royal Commission into the New South Wales Police Service recommendation concerning safe and sanitary injecting rooms a Joint Select Committee be appointed to:

  (1) advise the Parliament of the costs and benefits to the public of the establishment or trial of safe, sanitary injecting rooms under the licence or supervision of the Department of Health and of amendment of the Drug Misuse and Trafficking Act 1985 accordingly; and

  (2) make a recommendation to the Parliament as to whether or not such establishment or trial should proceed.

(2) That the Legislative Assembly Members comprise:

  (1) Government Members nominated in writing to the Clerk of the House by the Leader of the House;

  (2) 2 Opposition Members nominated in writing to the Clerk of the House by the Leader of the Opposition; and

  (3) 1 Independent Member nominated in writing to the Clerk of the House by the Independent Members.

(3) That notwithstanding anything to the contrary in the Standing Orders of either House:

  (1) the Committee is to elect as Chairman a Government Member;

  (2) the Chairman of the Committee have a deliberative vote and, in the event of an equality of votes, a casting vote;

  (3) at any meeting of the Committee 4 members constitute a quorum, provided that the Committee meet as a Joint Committee at all times; and

  (4) dissenting reports shall be permitted to be tabled.

(4) That the Committee have leave to sit during any adjournment of either or both Houses; to adjourn from place to place; to make visits of inspection within the State of New South Wales and Australia; and have powers to take evidence and to send for persons, records and things; and to report from time to time.

(5) That the Committee report by 30 November 1997. [Extended to 27 February 1998 by resolution of the Parliament.] (V&P 8.12.97, M.of P. 4.12.97)

(6) That should either or both the Houses stand adjourned and the Committee agree to any report before the Houses resume sitting:

(1) the Committee have leave to send any such report, minutes and evidence taken before it to the Clerks of the respective Houses;

(2) the documents be printed and published and the Clerks forthwith take such action as is necessary to give effect to the order of the House; and

(3) the documents be laid on the Table of the Houses at their next sittings.

(7) The Legislative Assembly requests the Legislative Council to appoint 4 of its Members (being 2 Government and 2 Non-Government) to serve on the Committee and to nominate the time and place for the first meeting of the Committee.

1.2 THE INQUIRY PROCESS

Advertisements detailing the Committee=s Terms of Reference and calling for written submissions were placed in 14 metropolitan and regional newspapers in addition to *Drum Media*, an inner city music magazine (see **Appendix 1** for a copy of the advertisement.)

Throughout this Inquiry, the Committee has gathered information from a range of sources. A total of 103 submissions was received (see **Appendix 2** for a list of submissions). In addition, evidence was taken from 89 witnesses including representatives from relevant government and non-government agencies, academics, researchers in the drug and alcohol field, parents and interested members of the public (see **Appendix 3** for a list of witnesses).

Site visits were made to Nimbin, Byron Bay, Cabramatta, Newcastle, Wollongong and Redfern where meetings were held with key stakeholders and users. The Committee also visited the New South Wales Users and AIDS Association (NUAA), the Kirketon Road Centre, >the Buttery= in Binna Burra, and premises in Kings Cross which rents cubicles that are used for drug injecting (see **Appendix 4** for a list of site visits).

From 22 August to 2 September 1997, three members of the Committee, then Chair, the Hon Patricia Staunton, MLC, the Hon John Jobling, MLC and the Hon Ian Cohen, MLC along with the Senior Project Officer, Dr Kate Dolan, conducted a study tour of injecting rooms in Europe. There they met with law enforcement officials, public prosecutors, health workers, researchers in the drug and alcohol field, and injecting drug users in the Netherlands, Switzerland, Germany and England. The Hon Ann Symonds, MLC, accompanied the official delegation while it was in Europe. The Hon John Jobling, MLC went to Sweden on a private study tour and Mr Bill Rixon, MP visited Israel and was able to join the delegation for a day in Switzerland (see **Appendix 5** for details of the study tour).

1.3 SCOPE OF THE INQUIRY

By the nature of its Terms of Reference, this Inquiry has a very narrow focus. It is not concerned with general issues related to drug law reform but specifically with the costs and benefits of safe injecting rooms; the necessary amendments to the *Drug Misuse and Trafficking Act 1985* to permit their establishment or trial, and making recommendations to the Parliament as to whether or not such establishment or trial should proceed. During the course of the Inquiry process a number of broader issues pertaining to drug use, such as methods of prevention and alternative treatments, were raised. As these issues were outside the scope of the Inquiry they have not been pursued to any great extent in this Report. The Committee acknowledges, however, that an integrated drug strategy should contain appropriate prevention and education measures and a broad range of treatment options.

At the time of this Inquiry, there was quite coincidently, considerable debate on the controlled-availability of heroin trial proposed to be run in the Australian Capital Territory. This led to a degree of confusion as evidenced by some submissions which expressed concern that heroin would be made available to those attending an injecting room. Prescription of heroin or other illicit drugs in an injecting room or elsewhere is not being considered by the Committee. Furthermore, the establishment or trial of an injecting room would not be part of a heroin trial and is not intended to lead to the legalisation of illicit drugs.

1.3.1 DEFINITION OF INJECTING ROOM

For the purposes of this Inquiry, the term ›injecting room= has been defined as a legally sanctioned indoor facility where injecting drug use would occur under the supervision of appropriately trained personnel, who could provide access to medical equipment in the event of an overdose. The Committee notes that the terms ›injecting room= and ›shooting gallery= are frequently used interchangeably by the media. For the purposes of this Report, the Committee differentiates between legal injecting rooms and ›shooting-galleries= which are illegal. As a harm reduction strategy, sterile injecting equipment would be supplied and provision would be made for the safe disposal of used injecting equipment. Education and information on safe drug use would be provided and injecting drug users attending such facilities would have the opportunity to consider treatment and rehabilitation. Some primary health care services would also be made available as would referral to other appropriate services.

The main aims of a legal injecting room would be:

- to reduce deaths from drug overdose;
- to reduce the spread of infectious diseases from the shared use of injecting equipment;
- to reduce the public nuisance associated with drug injecting in streets and parks;
- to reduce inappropriate disposal of used injecting equipment; and
- to provide a gateway for injecting drug users to treatment and rehabilitation.

The issues of public nuisance, health and safety risks for health professionals, the police, the general community and drug users themselves which arise from illicit drug use will be addressed in this Report in relation to the possible establishment or trial of injecting rooms. It is not uncommon for injecting drug users to resort to injecting in public places such as lane ways, stairwells and public toilets in conditions less than hygienic. The used injecting paraphernalia may then be discarded causing alarm and potential health risks for the general community. Injecting drug users often inject on their own which places them at increased risk of death if they overdose. Injecting rooms have been established in response to these problems in some European cities.
Injecting rooms are one option for drug dependent individuals to inject drugs in a safe and sanitary setting, thereby minimising the risks both to themselves and to the wider community. This Inquiry examines: (i) the potential advantages and disadvantages of injecting rooms if they were to be established, or a trial to be run; and (ii) the necessary legislative changes which would be required to facilitate their establishment or trial.

1.4 CONTEXT OF THE INQUIRY

The establishment or trial of safe injecting rooms as one approach to the issue of injecting drug use needs to be examined in the context of the current National and New South Wales Drug Strategies. The historical development of these strategies was outlined in the NSW Health Department submission to the Committee:

> *Government policy ... in relation to drug use, both legal and illegal, has undergone significant change in recent years. Prior to 1980, drug strategies were largely limited to law enforcement to deter supply and use, treatment aimed at achieving abstinence and education to prevent and reduce drug use. In common with most countries, there was little attempt to articulate a national approach to drug policy.*
>
> *With the establishment of the National Campaign Against Drug Abuse (NCADA) in 1985, now known as the National Drug Strategy (NDS), health, legal and enforcement policies on drugs were brought together with a national approach. The aim of a national drug policy was defined as being 'to minimise the harmful effects of drugs and drug use in Australian society'.*
>
> *The emergence of the concept of harm minimisation was significant in at least three ways. It provided, for a range of disparate programs and activities, a single unifying principle which was rational and had broad appeal; it provided a basis for bringing policy on legal and illegal drugs much closer together; and it had a stimulating effect on innovation and research.*
>
> *In the mid eighties it became clear that the epidemic of HIV/AIDS had profound implications for drug policy and services. The new policy framework based on harm minimisation, which was being developed in the context of NCADA, proved to be extremely useful in developing the innovative public health measures needed for HIV. In particular, it facilitated the establishment of needle and syringe exchange programs*

and brought significant changes in the nature and accessibility of methadone treatment.

The new services and other developments which accompanied the adoption of harm minimisation as the basis of drug policy had a dramatic effect on the drug and alcohol field and provoked significant misunderstanding, opposition and controversy.

However, it is important to recognise that these changes were essentially evolutionary in nature. In general, previous strategies and services were added to, and in some cases significantly strengthened, rather than replaced:

- *The legal policy within which health services operated continued to be one in which the possession and use of certain substances were subject to the criminal law.*

- *Previous strategies of supply reduction through law enforcement, and demand reduction through education and treatment, were maintained or expanded.*

- *Resources provided to these strategies were in most cases increased, and in the case of law enforcement, substantially increased.*

- *Traditional drug and alcohol treatment services based on an abstinence goal continued to operate, and receive substantial Government funding, at the same time that syringe programs were introduced and methadone maintenance was expanded.*

Harm minimisation as the national aim of drug policy was not intended to, and did not, weaken support for long established treatment programs based on an abstinence goal or education programs designed to discourage the commencement of drug use. Rather it defined a common purpose between these and the more recently introduced programs and even more importantly, between health programs, legal policy and law enforcement. In the current National Drug Strategy this is expressed as follows:

> *Harm minimisation is consistent with a comprehensive approach to drug related problems using a balance of supply control, demand reduction and problem prevention. A comprehensive approach must take into account three interacting components: the people involved, their social, physical and economic environment, and the drug itself. Harm minimisation involves a range of approaches to prevent and reduce drug-related harm, including prevention, early intervention, specialist treatment, supply control, safer drug use and abstinence (National Drug Strategic Plan 1993-97).*

> *The common operational principle of the new 'harm reduction' services, such as needle and syringe programs and more accessible methadone treatment, is to facilitate the replacement of more harmful practices with less harmful ones. When applied successfully, this approach can significantly reduce harmful effects while not necessarily eliminating them ... Harm reduction services are not philosophically opposed to abstinence programs, since achieving abstinence is clearly one form of replacing a more harmful practice with a less harmful one. The difference is one of degree, in that harm reduction programs tend to offer clients alternative behaviours that are more achievable and a wider range of alternatives from which they can choose.*
>
> *A second difference ... is that harm reduction services are distinguished by the extent to which they are involved with, and address the needs of, people who continue to actively use drugs. Prior to the HIV epidemic, it was generally considered either not feasible or not desirable for services to have such extensive involvement with this population. While attitudes on this issue are still changing, this aspect of harm reduction continues to give rise to the common misunderstanding that services such as syringe programs condone or even encourage drug use and other criminal behaviour.*
>
> *The current range of services related to injecting drug use can be understood as forming a continuum of strategies which complement each other and cater to a complex variety of situations and needs* (Reid, Submission 101).

Harm reduction was just one of three approaches put forward in the *National Drug Strategic Plan 1993-1997* as a means by which the drug problem in Australia could be addressed. The three overarching strategies are:

- to reduce demand through education and prevention;
- to control supply through legislation and regulation; and
- to reduce harm in order to limit the risks of drug use to the users themselves, to their immediate environment and to society in general (Commonwealth of Australia, The Drug Offensive, 1993).

The Harm Reduction Subcommittee of the Ministerial Advisory Council on Alcohol and Drugs met several times from late 1994 until August 1995 to develop a definition of harm reduction for use by government and non-government organisations working in the alcohol and drugs field. It recommended that the Ministerial Council accept the following definition of harm reduction: 'A policy or programme directed towards reducing the adverse health, social and economic consequences of drug use, even though the user continues to use psychoactive drugs at this time'. (D Burrows, 'What is harm reduction ?' *National Aids Bulletin*, Vol 10 No 1, Jan/Feb 1996, p11).

The Subcommittee went further and developed a more precise definition of harm reduction. It recommended that:

- harm reduction refer specifically to those policies and programmes which attempt to reduce harm while accepting that some drug users are currently using drugs, and that some will continue to use drugs;

- the Council accept that reform of current drug laws is a legitimate option for harm reduction;

- the Council note that harm reduction policies and programmes must be part of a public health approach, as protecting the health of the community must include protecting the health of drug users; and

- the Council recognise that a wide variety of individual and social harms can be caused by drug use, so that a broad range of interventions is needed to address these harms (D Burrows, ibid).

In its submission to this Inquiry, the AIDS Council Of New South Wales (ACON) suggested that some key aspects of harm reduction are as follows:

> - *while we may not approve a person=s decision to use drugs we must accept as a fact that people are using drugs and that some will not stop using drugs in the immediate future.*
>
> - *harm reduction is not opposed to abstinence ie harm reduction activities can be carried out that assist people who use drugs to stay alive and as healthy as possible until they are ready to stop using drugs. However, a harm reduction model does not prioritise abstinence above more immediate and realisable goals.*
>
> - *people who use drugs are treated with dignity and as normal human beings who are responsible for their own behaviour* (ACON, Submission 92).

At both the federal and state and territory levels of government there has been a history of bipartisan support for harm reduction strategies in areas concerning public health, including that of illicit drugs, as evidenced by measures such as the introduction of Methadone Maintenance Treatment (MMT) programs and Needle and Syringe Exchange Programs (NSEP).

In 1987 the New South Wales Parliament amended the *Drug Misuse and Trafficking Act 1985* to repeal the provision making it an offence for a person to have in their possession a needle and syringe. This change was made in line with a resolution unanimously endorsed by both the Australian Health Ministers= conference and the Ministerial Council on Drug Strategy, as a necessary step in the containment of the HIV/AIDS epidemic. In recognition of the fact that it is not possible to prevent the transmission of this disease by placing an outright prohibition or ban on high risk activities such as intravenous drug use or unsafe sexual practices, the Health Ministers and the Ministerial Council adopted a harm reduction or harm minimisation approach. Such an approach acknowledges that a particular activity or behaviour exists, which cannot be eradicated by legislative action and which in the interests of public health calls for measures which will reduce or minimise the risk to the individual and to the community. As Drucker puts it:

> *harm reduction consists of a set of governmental, professional and community drug control strategies based on public health goals and principles. These strategies, rather than focusing solely on the individual outcome of achieving abstinence ... seek to limit many of the destructive health and social consequences associated with the use of illicit drugs.* (E Drucker, 'Drug Prohibition and Public Health: It's a Crime', *The Australian and New Zealand Journal of Criminology*, (1995) Special Issue, pp67-73 at 70.)

In introducing the Drug Misuse and Trafficking (Amendment) Bill in 1987, the Minister for Health and Minister for the Drug Offensive made the following comments:

> *The clean needles and syringe distribution programs are of crucial importance in stopping the spread of AIDS and there should be no impediment to users participating in the scheme. It is proposed therefore to exempt needles and syringes from the operation of section 11 of the Drug Misuse and Trafficking Act 1985, so that possession of these items will not be an offence even if the person intends to use them to administer illegal drugs. Usually such charges are only laid where the equipment is found on a person, together with prohibited drugs. Of course, possession and use of prohibited drugs will continue to be an offence* (Hon P Anderson MP, *NSWPD*, LA, 14 May 1987, p12223).

The Bill was passed by the Labor Government with the support of the Liberal Party and the National Party. In reply the Deputy Leader of the Opposition said that:

> *The spread of AIDS by intravenous drug users has become such a serious problem that some drastic and unpalatable action is needed, including a scheme to provide free needle and syringe exchanges to intravenous drug users. When the scheme was first announced by the Federal Minister for Health last year, I spoke against it because it might have been seen to make heroin addiction easier and safer. I emphasized the enormous moral dilemma facing the community when there are laws prohibiting the use and possession of needles and syringes for illegal purposes, while at the same time recognising the vital need to reduce AIDS transmission by heroin addicts using contaminated needles. The Royal Australian College of General Practitioners and the Royal Australasian College of Physicians supported the pilot needle exchange program.*
>
> *The Bill before the House embodies a provision unanimously endorsed by the Australian Health Ministers' Conference in April 1987. Needle exchange schemes are supported by the widest cross section of experts in the AIDS field. In light of all that expert evidence I conceded on 18 March that needle exchange programs are a necessary weapon in the war against AIDS. As this Bill will resolve the moral dilemma I mentioned a moment ago and referred to in my initial objection to the proposed scheme. Government sponsorship of a needle exchange scheme is justified. I make that statement cognizant of the fact that several Members on this side of the House, who have agonized over the decision,*

> *see very real moral difficulties in accepting this proposal. But I believe now, and the Opposition believes, that the decision is inevitable in the interests of public health as a suitable mechanism to reduce the incidence of AIDS in our community* (Hon P Collins MP, *NSWPD*, Legislative Assembly, 14 May 1987, p13058).

Ms W Machin MP speaking for the National Party said that:

> *The National Party also supports the proposed legislation, recognizing it as an attempt to take some realistic steps in the prevention of AIDS ... it is not a decision to come to lightly, particularly in view of the major step it takes in permitting a more liberal distribution of needles to addicts ... Obviously if AIDS did not exist it would not be necessary to consider this matter. Certainly such a proposal would not be contemplated in view of the drug problem. However, we must be mindful of the reality and of the rapid increase in the incidence of AIDS brought about by the use of dirty needles. We must weigh up which is the lesser of the two evils: to refuse the distribution of clean needles and therefore risk the further rapid spread of AIDS, initially within the drug community and among prostitutes and then through them to the community at large; or to endeavour to protect the health of the addicts ... by trying to ensure that they are not injecting AIDS antibodies into their bloodstreams along with other substances ... We must consider also which of these evils has the potential to kill more Australians* (*NSWPD*, Legislative Assembly, 14 May 1987, pp13060 - 13061).

A decade on, educating the public as to the very real risks posed by HIV/AIDS and the need to adopt certain precautions has been a successful strategy. However, complacency would undermine the good work to date, especially in light of the fact that other diseases such as hepatitis B and hepatitis C are now recognised as being similarly problematic. In its submission to the Committee the Hepatitis C Council of New South Wales provided the following figures:

> *In Australia it is reliably estimated that there are already between 150,000 to 200,000 people who have been exposed to the hepatitis C virus and an estimated 8,000 to 10,000 new infections are occurring in Australia each year. Of those already infected we estimate at least 50,000 to 70,000 live in New South Wales ... It is thought that of all people who are already infected about 80% to 85% contracted it through sharing injecting drug equipment ... hepatitis C is not classified as a sexually transmitted disease and sexual transmission of hepatitis C is thought to be extremely low risk. Of the 8,000 to 10,000 people being newly infected in 1997, its known that the vast majority contact hepatitis C through blood to blood contact from sharing drug injecting equipment* (Loveday, Submission 47).

Details on hepatitis B were provided to the Committee by Professor Kaldor from the National Centre in HIV Epidemiology and Clinical Research:

> *Hepatitis B of the three viruses ... has probably been around the longest ... but is the least well monitored. Our information is the poorest on hepatitis B compared to the other two ... so I can only quote from a*

> *reasonably limited number of studies ... among drug users anything between 30% to 60%, depending on which survey you read, have had some exposure and have antibodies, but a very much smaller percentage, probably about between 3% and 5% are actually carriers, are currently infectious, are at risk of transmitting the virus ... if you come into contact with hepatitis B as an adult you will get sick. That you will get hepatitis B with an acute illness is quite a high likelihood but there is only a very small chance that you will actually become a long term carrier, a chronic carrier ... the proportions are about 3% to 5% of injecting drug users are carriers or infected with hepatitis B. Once again that proportion is higher than the population proportion in Australia which is probably of the order of 0.5%* (Kaldor, Evidence 7 October 1997).

The emphasis on harm reduction continues given the potential public health problems posed by blood-borne viral diseases such as hepatitis B and hepatitis C. The need for an ongoing bipartisan approach to the illicit drugs problem was called for by a number of witnesses who appeared before the Committee. Councillor Vic Smith, Mayor of South Sydney City Council said:

> *There are two important points that I would like to make before proceeding. The first is my view, and the view of the majority of councillors, that the only real and lasting solution to this problem will come through bipartisan support from the State Parliament. The urgency of this situation places it above politics. Bipartisan support must be the cornerstone of any robust public debate on this matter; otherwise a serious health issue affecting the lives of thousands of young Australians will become subject to cheap political tactics and sensational but ill-informed media coverage.*
>
> *An example of the constructive power of consensus has been on the issue of needle exchange. Until recently there has been wide recognition of the health benefits of this program as part of the New South Wales HIV prevention program. That consensus prevented an HIV epidemic amongst intravenous drug users in South Sydney and the spread of other diseases ... So I urge you to strive to develop a sensible, realistic policy that recognises the unfortunate reality of drug use and has bipartisan support* (Smith, Evidence 1 October 1997).

Mr Chris Gration, President of the AIDS Council of New South Wales (ACON) also commented that:

> *ACON makes a submission to the Committee based on its experience of 12 years fighting the HIV/AIDS epidemic in New South Wales ... In that time evaluations of the national HIV/AIDS strategy show that 3,000 new infections are being prevented each year by the harm minimisation approaches within the HIV/AIDS strategy and specifically to the programs associated with injecting drug users under that strategy ... We are, therefore, deeply concerned that withdrawal of bipartisan support, as appears to be happening in New South Wales, may put Australia's HIV/AIDS response at risk by putting at risk measures like needle and syringe exchange programs and the necessary extension of them in the*

case of safe injecting rooms (Gration, Evidence 1 October 1997).

Similar sentiments were expressed by other witnesses appearing before the Committee.

The Committee supports the harm reduction principles of education, prevention, treatment and rehabilitation, and recognizes that any consideration of the establishment or trial of safe injecting rooms must be made in accordance with these, and that the economic and social costs related to the establishment or trial of injecting rooms will also need to be taken into account. In recent times, however, the usefulness of the harm reduction approach has been questioned in some quarters and the Committee is very aware that the ongoing national debate about how best to tackle the problems associated with illicit drug use may have an impact on the direction and outcomes of this Report.

1.5 PRINCIPLES UNDERLYING THE REPORT

In examining the issues surrounding the establishment or trial of injecting rooms the Committee recognises that the use of illicit drugs is not just a matter for the criminal law, but that there are also significant health and welfare considerations to be taken into account. The growing community concern about the impact of illegal drug use on individuals, families, and the wider community is considered. It is in the interests of the community that solutions for the problems associated with illicit drug use are found. It is imperative that we reduce the crime, corruption, disease and death associated with the personal use of illicit drugs. This Report does not seek radical changes to our drug laws. Cautious responsible changes that are consistent with the principles of harm reduction as recommended by Commissioner Wood will be considered by the Committee.

1.6 STRUCTURE OF THE REPORT

Chapter Two provides a profile of injecting drug use in New South Wales.

Chapter Three describes models of injecting rooms observed by the Subcommittee during its overseas study tour.

Chapter Four examines the arguments for and against the establishment or trial of injecting rooms in New South Wales.

Chapter Five considers the legal position in relation to the establishment or trial of injecting rooms in New South Wales. Australia=s international obligations are also addressed.

Chapter Six contains possible models for legal injecting rooms, if a decision to establish or trial such facilities in New South Wales is supported by the Parliament. Issues relating to the monitoring and evaluation of injecting rooms are also canvassed.

The **final Chapter** presents the Committee=s conclusions and recommendations.

CHAPTER TWO

INJECTING DRUG USE IN NEW SOUTH WALES

This Chapter profiles injecting drug use in New South Wales: the extent and location of the activity; the health status of injecting drug users; the available treatment programs and services, such as Methadone Maintenance Treatment (MMT) and the Needle and Syringe Exchange Program (NSEP). The problems associated with injecting drug use and the responses to it are considered. This overview provides the context in which recommendations such as the possible trial or establishment of safe injecting rooms can be considered.

2.1 A PROFILE OF INJECTING DRUG USE

It is difficult to ascertain with any precision the size of the injecting drug using population in New South Wales. Given that injecting drug use is an illegal and highly stigmatised activity in our community, people are likely to be reluctant to identify themselves as injecting drug users. Therefore, arriving at an accurate and reliable figure is difficult.

Dr Andrew Penman, Director of the Centre for Disease Prevention and Health Promotion and Director of the Drug and Alcohol Directorate, told the Committee:

> *One of the problems in this whole area is that the quality of information available on the distribution and patterns of heroin use is notoriously unreliable, but in fact we believe that the number of heroin users is increasing in this country and not decreasing* (Penman, Evidence 24 October 1997).

Dr Lisa Maher, Research Fellow in the School of Community Medicine, University of New South Wales said:

> *It is really difficult because we do not know the size of the population. It is a hidden population and I do not think any studies of illicit drug users would ever claim to have a representative sample* (Maher, Evidence 8 October 1997).

Dr Don Weatherburn, Director of the New South Wales Bureau of Crime Statistics and Research also commented on the lack of reliable information in this area:

> *... given the size of the sample used to carry out the [national drug use] survey you could not realistically get reliable estimates of the extent of regular heroin use. Only 2% of people in the survey indicate that they have ever injected any drug. The percentage of people who regularly inject heroin would be smaller than that, albeit numerically quite large. But as a percentage of the Australian people it would be quite small ... we do not have information on trends. Each year or every couple of years someone puts together an assumption of what they think is the number of illegal drug users based on needle exchanges, re-arrests or something like that. But the ranges are quite broad and they go up to 100,000 or*

> *even in excess of 100,000 [nationally]. We lack any indicator that could be used to assess the effectiveness of treatment or law enforcement. We need some reliable indication month by month ... of the number of people injecting illegal drugs of one form or another. If we had that information we could assess the strategies, and make a judgement about whether they are effective. We do not have it, so what tends to happen is that we have a public debate that is in no way conditioned by facts about the effects of public policy* (Weatherburn, Evidence 1 October 1997).

Despite the inherent difficulties relating to the collection of data on illicit drug use, a number of reports have been prepared in recent years which give an indication of some of the more salient aspects. These reports are:

- *In the Same Vein: First Report of the Australian Study of HIV and Injecting Drug Use (ASHIDU)* by W Loxley, S Carruthers and J Bevan, Curtin University of Technology, National Centre for Research into the Prevention of Drug Abuse, 1995 (referred to hereafter as ›the ASHIDU Report=).

This report presented the findings of the entire study on HIV and injecting drug use undertaken in Sydney, Melbourne, Adelaide and Perth in 1994.

- *Drugs and Our Community*, by the Victorian Premier=s Drug Advisory Council, April 1996 (referred to hereafter as ›the Penington Report=).

In December 1995 the Premier of Victoria established the Premier=s Drug Advisory Council, to inquire into, and report on, illicit drugs and how to tackle the illicit drug market in Victoria. This body was headed up by Professor Penington and had a diverse and representative membership. The Report=s recommendations were unanimous and it took the view that: ›we should not lessen efforts to control trafficking, but rather that we should look afresh at strategies that might curb demand and reduce the harm caused in society by the use of illicit drugs=.

- *National Drug Strategy Household Survey: Survey Report*, Commonwealth Department of Health and Family Services,1996 (referred to hereafter as ›the Household Survey=).

This survey is the fifth in a series of household surveys undertaken to monitor and evaluate issues relevant to the National Drug Strategy, concerning both licit and illicit drugs (previous surveys were conducted in 1985, 1988, 1991 and 1993). A total of 3,850 face to face interviews were conducted with people fourteen years and over, Australia-wide during the period May to June 1995.

- *Drug Trends: Findings from the Illicit Drugs Reporting System (IDRS)* by S O=Brien, S Darke and J Hando, National Drug and Alcohol Research Centre (NDARC), Technical Report No 38, July 1996 (referred to hereafter as ›the NDARC Drug Trends Report=).

This study was part of a trial for a revised Illicit Drug Reporting System first implemented in Australia in 1989. It was intended that the revised system provide a co-ordinated approach to the monitoring of data associated with the use of opiates, cocaine, amphetamines and cannabis and that this information act as an early warning indicator

of the availability and use of the main drug categories. During the trial, information was collected through: a survey of 152 injecting drug users from inner and south-western Sydney suburbs; extensive interviews with 44 key informants (injecting drug users; health and law enforcement professionals and researchers) about trends they were perceiving; ethnographic research among heroin users in south-west Sydney; and an analysis of existing early warning indicator sources.

- *Sex, drugs and viruses in Sin City Sydney 1994: Report of the Australian Study of HIV and Injecting Drug Use (ASHIDU)* by S Rutter, K Dolan and A Wodak, July 1996 referred to above.

This report discusses the findings for the Sydney component of the larger *Australian Study of HIV and Injecting Drug Use*.

- *The Fitpack Study: A survey of 'hidden' drug injectors with minimal drug treatment experience* by S Lenton and A Tan-Quigley, Curtin University of Technology, National Centre for Research into the Prevention of Drug Abuse, January 1997 (referred to hereafter as 'the Fitpack study').

The National Centre for Research into the Prevention of Drug Abuse at Curtin University of Technology in Western Australia surveyed people buying 'Fitpacks' (a hard disposal container which contains needles and syringes) at pharmacies in an attempt to establish trends amongst 'hidden' injecting drug users or people who do not access treatment and needle exchange programs. Over 66% of needles and syringes provided to injecting drug users in Western Australia are sold in 'Fitpacks' by community pharmacies. A similar scheme was established in New South Wales in 1986 by the NSW Branch of the Pharmacy Guild of Australia, operating initially as a supply (sale) scheme only. It was relaunched as the Pharmacy Fitpack Scheme in 1990 with funding from the NSW Health Department. The major change was that the scheme now operated on a partial exchange model, using the Fitpack. Clients have the option of free exchange of used syringes for new ones, or simple purchase as before. There are approximately 530 retail pharmacies in all parts of New South Wales participating in the scheme (Reid, Submission 101).

- *A Background Report on Heroin Use in Australia* by D Crosbie from the Alcohol and Other Drugs Council of Australia (ADCA) for the National Community Drug Action Conference Stage 1, October 1997.

This document contains: (i) details on the extent of heroin use and heroin-related problems; (ii) a brief discussion of key issues associated with heroin use; and (iii) a listing of current government responses to heroin problems.

General profile

People use drugs, both legal and illegal, for a number of reasons including the following: to obtain relief from physical or psychological pain; for social reasons; for relaxation; for the pleasurable effects; to control stress; because of loneliness or social isolation; social rebellion; and cultural reasons. The way that people use illegal drugs has been described as similar to usage patterns for drugs like tobacco and alcohol, and falls into five major categories:

- **experimental use**: single or short-term use which is motivated by curiosity or a desire to experience new feelings or moods;

- **social or recreational use**: well controlled use in a social setting by experienced users who know what drug suits them and in what circumstances. If they like the effects and the group, they will use, despite illegality. These people may not necessarily identify with the term ›user=;

- **situational use**: drugs are used for a specific purpose in situations where particular tasks have to be performed or freedom from pain is sought or where temporary relief is needed, for example, study, stress, and bereavement;

- **intensive or binge use**: major doses are taken daily and while similar to the previous category, it borders on dependence; and

- **compulsive or dependent use**: where use is persistent, frequent and involves high doses, producing psychological and physiological dependence such that the user cannot discontinue without experiencing significant mental or physical distress (R Schafer, *Drug Use in America: Second Report of the National Commission on Marijuana and Drug Use*, US Government Printing Office, Washington DC, 1979).

These categories overlap to a certain extent and no-one will fit exactly into each description.

One finding in the Penington Report was that the majority of drug users do not progress from one group of use to another. However, of those that do, progression is generally related to the route of administration (people who administer drugs by intravenous injection are more likely to progress than oral users) and an individual=s characteristics (for example, those who commence drug use at a younger age or have a history of psychiatric problems are more likely to progress). (The Penington Report, op cit, p18). Further, the Premier=s Drug Advisory Council stated that:

> *Most drug use is neither abusive nor problematic to the individual or the community and falls within the experimental and recreational patterns of use. The drug-using careers of these people is relatively short. Drug users in the intensive and compulsive categories are the least numerous, but on an individual basis, have the longest drug-use careers. Episodic abstinences and decreases in drug use appear to moderate the drug-using career. Lifestyle changes, such as employment and stable relationships, are correlated with cessation of drug use* (The Penington Report, ibid).

Those that use drugs are as many and varied as the reasons for their use. Despite the stereotypical ›junkie= image, injecting drug use occurs across the community and there is no certain way to determine who will and who will not use drugs. As Drucker expressed it:

> *A wide range of individual, social and cultural factors determine patterns of drug use (from personal curiosity and peer pressure to social and economic deprivation, psychopathology and, possibly, genetic factors)* E

> Drucker, ›Harm Reduction: A Public Health Strategy=, *Current Issues in Public Health*, Vol 1, 1995, pp64-70).

An analysis of the demographic characteristics of those taking part in the Western Australian Fitpack study (511 respondents) were described by the authors as ›inconsistent with the stereotype of the drug injector held by many in the wider non-injecting community= (The Fitpack study, op cit, pxiii). Some of these were:

- The mean age of respondents was 26.2 years;
- Just over two fifths (43.4%) were women, a similar proportion (44.3%) were married or living with their sexual partner, and 41.7% had at least one child, 33.6% having a child in their care;
- Just under one quarter (23.8%) listed senior high school as their highest level of education completed, 22.4% listed trade or technical school and 6.8% had completed a university or college course;
- 46.4% of respondents were employed and of these 66.4% were in full time employment; 30.3% were unemployed; and
- Whilst the majority of respondents (59.6%) lived in rental accommodation, just over one in six (16.8%) owned or were buying their place of residence, and just under one in six (15.4%) lived in their parent=s home.

While acknowledging that their sample may not be representative of all drug injectors but rather of those who buy their needles through pharmacies, the authors nonetheless conclude that:

> *this study demonstrates that there are many injecting drug users who do not fit the negative stereotype held by some in the community who do not inject drugs. The data presented here challenge the ›them and us= view which marginalises and stigmatises drug injectors. Challenging stereotypes and stigma is likely to be important in further supporting efforts to prevent the spread of blood-borne viruses such as HIV, hepatitis B and hepatitis C* (The Fitpack study, ibid, pxvi).

Similar results have been found in New South Wales. Dr Alex Wodak, Director of the Alcohol and Drug Service at St Vincent=s Hospital told the Committee:

> *We did work looking at drug users who go to pharmacies to buy their needles and syringes and compared them with drug users who go to needle exchanges and, even in New South Wales, they are quite different populations. The drug users who go to needle exchanges are the stereotypical drug users. The drug users who go to pharmacies are people who are more likely to be employed, have a stable residence, and are less likely to be known to be drug users* (Wodak, Evidence 9 October 1997).

Illustrations of injecting drug use occurring across the wider community were provided to the Committee. Dr Fulde, the Director of the Emergency Department at St Vincent=s

Hospital said:

> *My perspective is one from the Emergency Department of a major inner city hospital. Around St Vincent=s we drain not only the inner city socially disadvantaged, we drain the rich suburbs, we drain the city, we drain where people come to have a cup of coffee or to get drugs or to have dinner on any night of the week ... It is not just the stereotype injecting drug user who comes to my Department. It cuts across every part of our society from the rich and famous to the spoilt children, to those who are at university, from the suburbs, to lots and lots of young people who drift in from all over New South Wales, and probably Australia, because the Cross is where it is at* (Fulde, Evidence 7 October 1997).

Dr Wodak told the Committee that:

> *There are at least as many middle class conventional functional drug users as there are drug users who are known to legal services/health services. There was a study done in the State of New York ... about five years ago ... they estimated that there were more functional drug users who were employed, who were in stable residence and were not known to be drug users generally than there were people who were known to the health system and to the criminal justice system because of their drug use* (Wodak, Evidence 9 October 1997).

2.1.1 Proportion and number of injecting drug users

Based on the figures obtained in the *National Drug Strategy Household Survey* it would appear that a very small proportion of the Australian population (1% to 2%) inject drugs. The report stated that of those 3,850 people over the age of 14 across Australia who were interviewed over the period from May to June 1995, 1.3% said they had ever injected a drug (compared with 1.8% of 3,500 people in 1993), and 0.6% had recently (in the past year) injected an illegal drug compared with 0.5% in 1993.

The need to view these results with a certain degree of caution has been pointed out by Griffin, amongst others. He writes that ›because so few respondents have either used or tried illicit drugs other than cannabis, standard error margins are high on data regarding the use of illicits=. Nevertheless he goes on to add ›while the usefulness of the information on illicit drug use suffers somewhat because of the small number of respondents who use these drugs, there is no doubt the information is still of use= (M Griffin, ›Snapshots of drug use=, *Connexions*, 16(5), Oct/Nov 1996, pp5-8).

Other key findings of the Household Survey were:

- 39% of the population aged 14 or more said they have tried at least one illicit drug, and 17% have used one in the past year. Marijuana accounts for the major part of these rates;

- most illicit drug use has remained steady since 1993, with no significant increases or decreases in either the ›ever-tried= or the ›recent-use= rates. This is despite an apparent halving in the availability of nearly every illicit drug as

measured by the number of people reporting being offered or having the opportunity to take each illicit drug;

- behind marijuana, non-medical use of analgesics is the next most frequently tried and used drug, with 12% having ever tried it and 3% recently using. Hallucinogens (especially LSD) and amphetamines come in next, at 6% - 7% ›ever-tried‹ and around 2% recent usage;

- the remaining drugs have each been tried by less than 3% of the population, and are currently used by less than 1%. Non-medical use of tranquillisers, cocaine, ecstasy, designer drugs and injecting drugs would appear to be more widespread than inhalants, heroin, steroids, or barbiturates although the very small sample sizes involved make inferences about current use tenuous;

- the small sample sizes in particular with needle users also make inferences difficult, but, based on the 62 respondents in the current survey who had ever tried injecting, about one third have shared needles and of these, nearly half have shared a needle within the past year. Even taking into account the large degree of sampling error on estimates based on so few respondents, this still indicates an area of concern;

- with regard to concurrent use of alcohol with other illicit drugs, nearly all users of amphetamines and cocaine, and more than half of the users of marijuana, barbiturates, inhalants, heroin, hallucinogens and ecstasy have all used alcohol with those drugs in the past year (*National Drug Strategy Household Survey: Survey Report*, Commonwealth Department of Health and Family Services,1996).

Professor Wayne Hall estimated that in the period 1988 to 1993, there were 49,000 to 150,000 dependent heroin users Australia wide, with the most probable estimate placed at 59,000 (W Hall, *The Demand for Methadone Maintenance Treatment in Australia*, Technical Report No 28, NDARC, 1995).

Dr Shane Darke, Senior Lecturer at the National Drug and Alcohol Research Centre, told the Committee of his estimates of the number of regular heroin users:

> *I am dealing with best guesses, of course. Australia-wide my best guess for regular users would be in the order of 80,000 to 100,000. That best guess is based on previous studies and on data such as data for overdose deaths. Follow-up studies tell us that overdose deaths represent about 1% of heroin users a year. On rough calculations, that is about 600 deaths nationally for overdoses, and probably another 200 for various other causes. If that represents 1%, we are talking about 80,000 to 100,000 regular heroin users ... The question of casual users is much more difficult to answer. Casual users do not turn up in the overdose fatalities ... Casual users rarely turn up in prison and rarely turn up in treatment. They are very much a hidden population. I suspect it is a population that is greatly exaggerated. There would be a proportion of recreational users, but I think that it would form a small proportion compared to regular users because people give up rather than continue with recreational use* (Darke, Evidence, 30 September 1997).

Dr Roger Garsia, Chair of the Ministerial Advisory Committee on AIDS Strategy said:

> *I think the number of injecting drug users in New South Wales is put at something in the vicinity of 60,000, of whom about a third are regular injecting drug users. So we are probably talking about a regular injecting drug user population of about 20,000* (Garsia, Evidence 8 October 1997).

2.1.2 Geographic distribution

Estimates provided by the NSW Health Department on the number of injecting drug users in each of the State=s 17 Area Health Services are illustrated in the Table below. The following notes have been provided to assist in the interpretation of this data:

- ›Opioid deaths= is based on Coroner=s Reports over the period 1987 to 1995. It consists predominantly of accidental overdose deaths involving opiates (eg heroin and morphine) and opioids (eg methadone). Suicides are not included.
- ›Hep C notifications= shows the cumulative number of positive hepatitis C antibody tests notified to the Health Department since testing commenced in 1991.
- ›Emergency Department data= shows drug related presentations to hospital Emergency Departments based on the Emergency Department Information System.
- ›Residents in MMT= refers to numbers of persons enrolled in methadone treatment programs by place of residence.
- For the Wentworth and Mid Western Areas, the ›IDU Score= in Column K was calculated as: (opioid deaths + hep C notifications + residents in MMT) ÷ 3 as no ›Emergency Department data= was available.
- For all other Area Health Services, the IDU Score in Column K was calculated as: (opioid deaths + hep C notifications + emergency dept data + residents in MMT) ÷ 4
- It has been estimated that injecting drug users constitute approximately 1% of the population. The figures in this Table are based on that assumption. 1% of the current population of NSW (6264970 Total Column A) is approximately 62650 (Total Column L). The estimated number of injecting drug users in each Area Health has been calculated by determining the percentage (expressed in Column K which indicates the IDU Score of each area) of the overall State total of 62650. For example, the South Eastern Sydney Area has an IDU Score of 21.6%. 21.6% of 62650 = 13654 (Column L). Figures have been rounded up or down as appropriate so exact numbers may differ.

Number of Injecting Drug Users per NSW Area Health Service

Area Health Service *	Population 1997		Opioid deaths 1987-1995		Hep C notifications Cumulative to 1997		Emergency Dept data 1996		Residents in MMT 1997		IDU Score	Est no of IDU
	No	% NSW	No	% NSW	No	% NSW	No	% NSW	No	% NSW	% NSW	
South Eastern Sydney	722579	11.5	356	26.3	8190	18.0	343	22.6	2320	20.4	21.6	13654
Western Sydney	647705	10.3	160	11.8	4646	10.2	120	7.9	1738	15.3	11.3	7072

South Western Sydney	729364	11.6	165	12.2	5349	11.7	263	17.3	1645	14.4	13.9	8717
Central Sydney	457702	7.3	261	19.3	6088	13.4	199	13.1	1722	15.1	15.2	9527
Northern Sydney	746973	11.9	113	8.3	3416	7.5	116	7.6	711	6.2	7.4	4653
Central coast	279475	4.5	40	3.0	1852	4.1	17	1.1	425	3.7	3.0	1858
Hunter	540242	8.6	33	2.4	3044	6.7	87	5.7	454	4.0	4.7	2948
Wentworth	307369	4.9	58	4.3	1458	3.2	n/a	n/a	414	3.6	3.7	2321
Illawarra	342190	5.5	47	3.5	2226	4.9	69	4.5	508	4.5	4.3	2718
Northern Rivers	263238	4.2	31	2.3	3314	7.3	79	5.2	360	3.2	4.5	2806
Mid North Coast	256634	4.1	24	1.8	1410	3.1	48	3.2	325	2.9	2.7	1703
Mid Western	171366	2.7	23	1.7	1259	2.8	n/a	n/a	294	2.6	2.3	1470
Southern	167252	3.0	16	1.2	1113	2.4	3	0.2	226	2.0	1.5	909
New England	189168	3.0	6	0.4	808	1.8	20	1.3	70	0.6	1.0	649
Greater Murray	264083	4.2	10	0.7	963	2.1	54	3.6	105	0.9	1.8	1147
Macquarie	107033	1.7	10	0.7	328	0.7	6	0.4	59	0.5	0.6	371
Far West	52596	0.8	2	0.1	105	0.2	5	0.3	19	0.2	0.2	137
NSW	626497 0 A	100.0 B	1355 C	100.0 D	45569 E	100.0 F	1429 G	94.0 H	11395 I	100.0 J	100.0 K	62650 L

***** See **Appendix 6** for map illustrating the boundaries of each Area Health Service in New South Wales

In correspondence provided to the Committee by the NSW Health Department, it is pointed out that:

> *These estimates were made to assist in the planning of the State=s Needle and Syringe Program and other drug related health services. They are based on a number of data sets, each of which can be used as an indicator of injecting drug use. It should be noted that these estimates have a wide margin of error, and due caution should be exercised in their interpretation or application. They are preliminary in nature and are subject to ongoing revision and amendment as additional information becomes available, and the methodology used is still at an early stage in its development* (Correspondence 8 January 1998).

In *A Background Report on Heroin Use in Australia*, Crosbie estimated that ›based on the number of heroin related deaths and the number of people in methadone programs, it is possible that up to 50% of Australia=s dependent heroin users reside in New South

Wales: (*A Background Report on Heroin Use in Australia* by D Crosbie from the Alcohol and Other Drugs Council of Australia (ADCA) for the National Community Drug Action Conference Stage 1, October 1997, p7).

2.1.3 Age of injecting drug users

According to the 1995 Household Survey the median age for first trying heroin was 20. This compares with the 1993 Household Survey where the median age was 19.1. The age at which each drug has been first tried appears to be remaining fairly stable, as indicated by the following Table taken from page 33 of the 1995 Household Survey:

Age at which first tried illicit drugs

	Age at which first tried: 1993			Age at which first tried: 1995		
	Base *	Median Age	Proportion before 16	Base *	Median Age	Proportion before 16
Marijuana	1185	17.8	20%	1331	17.5	24%
Analgesics	107	15.2	50%	446	16.2	46%
Tranquillisers	117	18.4	22%	139	19.8	22%
Steroids	10	16.9	9%	21	18.6	22%
Barbiturates	51	17.6	44%	55	17.7	23%
Inhalants	119	16.0	44%	117	14.9	58%
Heroin	56	19.1	2%	61	20.0	14%
Amphetamines	197	18.4	18%	242	19.6	7%
Cocaine	88	20.4	14%	126	20.4	13%
Natural Hallucinogens	Single category - see LSD			210	18.6	12%
LSD	274	18.6	11%	246	18.4	12%
Ecstasy / Designer Drugs	85	20.6	15%	99	21.4	1%

* Base - All who have ever tried each drug

Respondents to the *Australian Study of HIV and Injecting Drug Use* reported first injecting at an average age of 18 and the Sydney component showed that respondents in this city were more likely to have begun injecting earlier than their counterparts in other cities: 37% of the 219 people surveyed first injected at less than 15 years; 46% at 16-20 years, 11% at 21-25 years and 6% at more than 25 years. (Sex, drugs and viruses in Sin City Sydney, 1994, op cit, p13).

The NDARC Drug Trends Report found: that there was a perceived reduction in the average age of those using heroin to the early to mid-twenties, which was consistent with the findings of their survey, where the average age of both the inner-city and the south-western sample was lower than reported in previous studies; and that there had been an increase in the number of people in their late teens/early twenties making a transition from injecting amphetamines to injecting heroin, which may explain the source of new, younger heroin users.

While the Committee accepts that instances of young people in their early teens injecting drugs certainly do occur, it would appear from the body of research that injecting drug use at such an early age is not the norm.

The following points were made in the Penington Report about young people and the use of drugs:

> *Youth are a heterogeneous group most of whom will experiment with licit and illicit substances, most notably tobacco, alcohol, and cannabis. Drug dependency is usually a long term and damaging process. Preventing young people commencing use or reducing the levels of misuse is one of the potentially most significant intitiatives that could emerge from this investigation. The vast majority of young people who try illicit drugs are simply experimenting, primarily with cannabis, and will not develop a dependency on this or other illicit substances ...*
>
> *With respect to substance abuse it is possible to conceptualise young people as belonging to the following categories:*
>
> - *at 12-14, people who may begin with some experimental use of drugs;*
> - *at 15-17, experimental use continues but becomes interspersed with ›binge‹ use;*
> - *at 18-20, any problematic use of substances begins to become integrated into the young persons life; and*
> - *at 21-24, problematic use of substances becomes entrenched.*
>
> *The risk of young people developing serious problems with drug use is more likely if other areas of their lives have been disrupted. Disordered family relationships, social disadvantage and early and prolonged periods of homelessness are predictive of serious problems with substance abuse as a young person and in later adult life ...*

Polydrug use (particularly amphetamines, alcohol, Ecstasy, inhalants and abuse of prescription drugs) is also a feature of problematic adolescent drug use (The Penington Report, op cit, p94).

2.1.4 Type of drugs used

Injecting drug users inject a range of substances including heroin, amphetamines, cocaine, benzodiazepines and steroids.

The National Drug Strategy Household Survey conducted in 1995 estimated that just over 10% of the population have tried at least one of the hard drugs, (that is, amphetamines, heroin, hallucinogens, cocaine, designer drugs, or illegal drugs which are injected), and about 4% of those who have ever tried a hard drug have done so in the past year. Amphetamines have been tried by 6% of the population and used in the past 12 months by 2%. More than twice as many males than females have tried or recently used this drug, and use is highest among those aged 20 - 34 (among whom 6% have used in the past 12 months). Again, nearly all recent users are aged less than 35 (The Household Survey, op cit, p2).

According to the Household Survey, needle-use levels have remained constant, although there may be changes in the types of drugs being injected, particularly with a decrease in the proportion of needle-users in the last 12 months injecting amphetamines, which was injected by 91% of the needle-users in the 1993 survey, but only 54% of the needle-users in the current survey. Heroin, however, appears to have increased from 20% of needle-users in 1993, to 53% in 1995. It must be emphasised, however, that these trends are based on only 21 respondents who used needles in the past 12 months prior to the 1993 survey, and 22 in the current survey and so these patterns may simply be sampling variations (The Household Survey, op cit, pp30-34).

The NDARC Drug Trends Report reveals the following information from a study of 152 regular injecting drug users in Sydney in late 1995 and early 1996 (76 respondents from inner-city suburbs and 76 respondents from south-western suburbs were interviewed):

- Of the inner-city injecting drug users: 47% were male and 53% were female; their average age was 27; 65% had completed Year 12 schooling; 59% were unemployed; and 22% were on methadone at the time of the survey.

- In the south-western Sydney injecting drug user group: 62% were male and 38% female; their average age was 25; only 11% had completed Year 12 schooling; 87% were unemployed; and only 11% were on methadone at the time of the survey.

- Most injecting drug users in both groups reported heroin as their drug of choice, followed by amphetamines. Whereas almost all the south-western Sydney respondents were primary heroin users (95%), a significant proportion of the inner-city injecting drug users (22%) reported amphetamines as their drug of choice. Heroin was the drug of choice of 66% of inner-city respondents.

- The respondents in both the inner-city and south-western groups were generally younger than users reported in previous Sydney studies, and there were more

women in the inner-city group than had previously been recorded (traditionally samples of injecting drug users have been approximately two thirds males).

- A substantial proportion of both groups had moved from injecting amphetamines to injecting heroin, and this may well be the source of new and younger heroin users. Injection of methadone syrup (20% of the inner-city group and 21% of the south-western group) and the use of benzodiazepines (75% of the inner-city group and 66% of the south-western group) was also notable.

- The user perception of trends was for the inner-city group that: heroin was becoming more common, more fashionable, and more appealing to younger users and females. The south-western group believed that: the police presence and activity in Cabramatta had increased; more users coming into Cabramatta to buy heroin; heroin use was becoming more common; and users were becoming younger. Incidence of street trafficking in Cabramatta has declined since Operation Puccini has been carried out by the police.

Some of the trends in illicit drug use identified by key informants in this study were:

- the average age of heroin users had decreased;
- the availability of heroin had increased in south-west Sydney;
- more people were travelling to Cabramatta to purchase heroin ;
- there had been an increase in heroin smoking in south-western Sydney among both Asian and non-Asian populations;
- methadone clients and heroin injectors throughout Sydney were using increasing amounts of benzodiazepines, and inner city populations were using more cocaine;
- there was an increased risk of overdose among heroin injectors from concurrent alcohol and other drug use;
- an increase in methadone and amphetamine injection had occurred;
- the purity and price of amphetamine had decreased and its availability increased;
- there was an indication that some primary amphetamine users were making a transition to regular heroin use;
- there was an increased risk of hepatitis C transmission; and
- there had been an increase in cocaine injection among some inner-city injectors, and intra-nasal use had increased among inner-city professionals; the price of cocaine had decreased and its availability had increased; and there were more cocaine-related problems including health problems and violence (NDARC Drug Trends Report, op cit, pvii).

2.1.5 Place of injection

Most injecting drug use occurs privately in the home of the user or that of the dealer or a friend. It is thought that such use constitutes 75% to 80% of all injecting incidents. The remaining 20% to 25% of injecting drug use occurs outside the home, either in a public place (such as a car, street, park or public toilet) or in commercial establishments such as ›shooting galleries= or in abandoned houses. A survey of 219 injecting drug users in Sydney in 1994 found that the majority of respondents (75%) had last injected in their own homes. A small proportion (10%) reported that they last injected in an illegal injecting room, and slightly more (15%) said they had last injected in a public place such as a street, park or public toilet (*Sex, drugs and viruses in Sin City*, op cit, p53).

A description of a ›shooting gallery= was given in camera to the Committee:

- Four rooms are available for injecting drug users who come in off the street, looking for somewhere to inject. Each room has somewhere to sit, a sharps bin (a secure receptacle for disposing of sharp implements such as hypodermic syringes) and a garbage bin;

- One worker is on duty at a time. None of the staff has any specific medical training. Staff advise customers not to use the rooms if they are drunk or young but this advice is often ignored;

- An average of 60 customers attend over a 24 hour period. Most of the heroin-using customers attend the establishment on a weekly basis, however, those using cocaine attend as often as four times in an hour. Most customers are in their early 20s and live locally, and 50% of customers are female;

- Customers pay $5 for use of the room for 10 minutes. A worker knocks on the door to signal to occupants when their time is almost up. This gives staff the opportunity to check whether an overdose has occurred.

- An ambulance is required to attend to 3 overdoses per week on average. On other occasions, customers require assistance from staff but an ambulance is not necessary. Over the last nine years 10 deaths have occurred on the premises;

- Staff try to encourage customers to stay if they are drug affected because, as the Committee heard, Ayou can=t put them out on the streets@.

- Police now visit the premises on a regular basis to ensure drug dealing is not occurring.

One witness gave evidence in camera that a number of brothels and parlours in Kings Cross also operate illegal injecting rooms. One of these rooms had Naloxone (Narcan) on the premises. Naloxone is a chemical derivative of opium, and when injected after a narcotic overdose it produces a rapid reversal of the symptoms of overdose. It belongs to the opioid antagonist category of drugs, which prevent access of neurotransmitters to receptor sites in the brain, resulting in the reduction in cravings for opiates and the blocking of the euphoric and other effects of opiates. It is an S4 drug and has to be administered by the person to whom it is prescribed, and is currently only available to medical practitioners and certain emergency personnel such as ambulance paramedics. Naloxone does not tend to be used in the overseas injecting rooms inspected by the

Subcommittee, given the likelihood that those being revived may react violently towards those administering the substance. In Europe, at least in the first instance, resuscitation is generally undertaken by taking a small bottle of oxygen to the client and administering it via a face mask and simple resuscitation bag until the client regains consciousness. If the client does not resume breathing within a certain amount of time, an ambulance is called.

Because of the illegal status of drugs a large proportion of injecting drug users spend time in prison, and various studies have shown that injecting drug use has not been able to be eliminated, even within the confines of a prison. According to a recent research report, almost two thirds (64%) of the sample of 102 inmates in New South Wales prisons in 1994 reported a history of drug injecting prior to entering gaol. Among those who identified themselves as injecting drug users, a majority (66%) reported injecting in prison at some time. Nearly all (91%) of these reported sharing syringes in prison (K Dolan, W Hall, and A Wodak, ›Bleach availability and risk behaviours in prison in New South Wales=, *Technical Report No 22*, NDARC,1994).

In its submission to the Committee, ACON quotes the following passage from the Third National HIV/AIDS Strategy:

> *The prevalence of HIV among prison inmates in Australia is about 0.5%, which is approximately 8 times higher than that in the non-prison community. At any time at least half the prison population in Australia is there for drug-related sentences ... the hepatitis C incidence among male prison entrants with a history of injecting drug use has been found to be extremely high* (*Partnerships in Practice: National HIV/AIDS Strategy 1996/97 to 1998/99*, The Third National HIV/AIDS Strategy, p11).

In this context ACON ›calls for the establishment or trial of safe injecting rooms in NSW prisons (both male and female)= (ACON, Submission 92). This view was also expressed by a number of witnesses appearing before the Committee.

Ms Jan Cregan, a Member of the Prisons and Blood-Borne Communicable Diseases Working Group, said:

> *I acknowledge the difficulty in proposing that a trial of a safe injecting room should be set up in a prison environment. The rationale for wanting to do so ... is that it is probably the highest risk environment or location for any injecting, because of the concentration of people who are positive with various viral diseases, the lack of clean injecting equipment and the availability of drugs* (Cregan, Evidence 1 October 1997).

Mr Stuart Loveday, the Executive Officer of the Hepatitis C Council of New South Wales, stated his organisation=s position on the subject:

> *We would recommend that this Committee makes a consideration that this particular kind of harm reduction facility, the enablement of safe injecting, is also trialled in New South Wales prisons* (Loveday, Evidence 7 October 1997).

2.1.6 Overdose incidents

The following Table appeared in *A Background Report on Heroin Use in Australia.* Crosbie states at page 3 that it:

> *represents the information currently available on the extent of heroin related overdoses in Australia. It should be noted that some of these figures may be disputed given both the difficulty of obtaining accurate information and the difficulty of defining a heroin-related death. Where the figures are unreliable they have not been included. The Table is based on NDARC reports, direct contact with Coroner=s offices, State and Territory government reports and figures collected ... for The Australian newspaper*.

Heroin Overdoses in Australia per State

State/Territory	1994	1995	1996	1997 (6 months)
NSW	124	281	321	n/a
Vic	83	140	167	67
Qld	60	43	69	n/a
WA	46	62	65	43
SA	29	27	14	n/a
Tas	4	6	Unreliable	n/a
ACT	3	15	6	2
NT	0	0	Unreliable	n/a
National Total	**349**	**574**	**642**	**112**

Further details on the nature of overdoses are provided in Crosbie=s paper:

- two thirds of users have had at least one heroin-related overdose (non-fatal) and 90% have been present when someone else has overdosed;
- almost 80% of heroin-related overdoses involve males;
- the average age at death among males increased from 24 in 1979 to just over 30 in 1995;
- most die in their usual place of residence in the company of others (not alone on the street);
- in only 10% of overdoses was medical intervention sought prior to death;
- 85% of deaths involve people who are not in treatment;
- most overdose deaths involve a combination of heroin and other drugs, particularly alcohol and benzodiazepines.

In the NDARC Drug Trends Report, overdose was common among both inner-city and south-western injecting drug users. Of the inner-city heroin users, 43% reported having experienced a heroin overdose, on a median of 3 occasions. Among the south- western users, 51% had experienced heroin overdose, also on a median of 3 occasions. Key informants identified the use of alcohol and heroin together as a major issue throughout Sydney as it increased the risk of overdose.

141 (65%) of the Sydney sample of the *Australian Study of HIV and Injecting Drug Use* reported having ever experienced an overdose compared with 50% of respondents from the other capital cities surveyed. The majority (90%) of those with overdose experience reported a heroin overdose. Approximately a third (32%) of those reporting ever experiencing an overdose reported the experience on five or more occasions *(Sex, drugs and viruses in Sin City Sydney 1994*, op cit, p56).

In a study which examined 197 overdose deaths in New South Wales in 1992, the following details emerged:

> *Heroin-caused deaths occurred mainly among males (82%) usually among a dependent population of users (80%), typically in the home environment (68%), and often in the vicinity of other persons (58%). There was time for intervention in the majority of cases (60%), although intervention was actually sought or administered prior to the subject=s death in only 21% of cases. A minority of cases were heroin-only deaths (26%) and in almost half of cases (45%) alcohol was detected at autopsy. The study found that the majority of subjects (72%) had never been in a methadone treatment program* (D Zador, S Sunjic, S Darke, *Toxicological findings and circumstances of heroin caused deaths in New South Wales*, NDARC Monograph No 22, 1992).

2.2 THE HEALTH STATUS OF INJECTING DRUG USERS

The overall health of regular injecting drug users is affected as much by the lifestyle as by the use of any particular substance. Factors such as sub-standard nutrition, poor personal hygiene, erratic sleep patterns and lack of compliance with medication contribute to a sub-standard level of health among many injecting drug users. A study by Webster and colleagues conducted in Sydney compared the physical and mental health of methadone clients with university students (mean ages about 24). Physical health conditions that were significantly higher among the methadone clients than the comparison group included: liver disease such as hepatitis, peptic or duodenal ulcer, high blood pressure, chronic bronchitis, emphysema, venereal disease, migraine, nervous breakdown, rectal bleeding, troublesome abdominal pain or indigestion, miscarriage and irregular periods. Psychological and social perception were more impaired among the client group, as indicated by their significantly higher rates of often experiencing sleep difficulty, feeling unhappy or depressed, wishing they were dead, nervous, experiencing worrying thoughts that keep recurring, and not getting on well with other people. Webster and colleagues noted that the poor health of the methadone clients was not so much the direct result of specific substances, but the result of years of a disordered lifestyle (I Webster, N Waddy, L Jenkins and L Lai, ›Health status of a group of narcotic addicts in a methadone treatment programme=, *Medical Journal of*

Australia, Vol 2 1977, pp 485-491 cited in C Spooner, R Mattick and J Howard, ›The nature and treatment of adolescent substance abuse=, *NDARC Monograph No 26*, 1996, p3-5 and 3-6).

The mode of administration itself can be hazardous to health, over and above any risk associated with the substance being used, and can give rise to varying health problems. For instance, the injection of substances is associated with communicable diseases such as HIV, hepatitis C, hepatitis B, septicaemia and bacterial endocarditis when injecting equipment is shared; abscesses, vein damage, and infections at, or around, the sites of injection because of incorrect injection techniques, non-sterile needles or repeated injections in the same spot; and blood vessels can become blocked by insoluble particles (C Spooner et al, ibid, p3-2).

An examination of the quarterly summaries of the Australian HIV Surveillance Report put out by the National Centre in HIV Epidemiology and Clinical Research indicates that less than 50 new cases of HIV relating to injecting drug use are reported in New South Wales each year. Other research suggests that the prevalence (that is, the number of cases of disease that exist, in a defined population, at some point in time) and incidence (that is, the number of specified new events occurring in a defined population over a specific time period) of hepatitis C and hepatitis B is higher than for HIV, particularly among injecting drug users (N Crofts, J Hopper, D Bowden, A Breshkin, R Milner and S Locarnini, ›Hepatitis C virus infection among a cohort of Victorian injecting drug users=, *Medical Journal of Australia*, Vol 159, 1993, pp237-241; and the Commonwealth Department of Human Services and Health, *Review of methadone treatment in Australia: Final Report*, AGPS, 1995).

In the Sydney component of the *Australian Study of HIV and Injecting Drug Use* the prevalence of HIV infection among female and heterosexual male respondents was found to be 3%. The authors state this figure is in line with numerous other studies in Sydney and elsewhere in Australia, and indicates that strategies to reduce risk behaviour have enabled tight control to be kept over HIV infection. However, more than two thirds of the Sydney respondents were found to be infected with hepatitis C, and almost one quarter had been exposed to hepatitis B. These figures were higher than those reported in other parts of Australia where this study was conducted. An explanation for this, according to the authors, may be that the Sydney sample was somewhat older and started injecting at a younger age.

The presence of these blood-borne viruses indicate that major reductions in risk taking practices by injecting drug users are required not just to keep HIV under control, but to substantially reduce, and possibly control, the spread of hepatitis C and hepatitis B amongst injecting drug users. Although some of the respondents in the Sydney sample correctly perceived that they were more at risk of hepatitis B and hepatitis C than HIV, the majority greatly underestimated their risk of becoming infected with any of these viruses. The study showed that the rate of hepatitis B vaccination in the injecting drug use population was still low, and given its high prevalence, substantial sexual transmission of this virus is inevitable (Sex, drugs and viruses in Sin City Sydney 1994, op cit, pp1-2).

2.2.1 HIV/AIDS

Since the HIV epidemic began in Australia, the prevalence of HIV infection among injecting drug users has remained relatively low compared to other countries. Research indicates that about 8% of Australians with HIV have reported injecting drug use (*New South Wales Needle and Syringe Exchange Workers- Training Manual*, Western Sydney Area Health Service, NSW Health Department, 1997, Chapter 5, p15) and surveys in most Australian capital cities have found HIV infection among only 2% to 3% of injecting drug users. Some of the reasons given for this low rate of HIV among injecting drug users include:

- the widespread availability of free needles and syringes which was implemented early in the epidemic;
- peer education and support provided by funded injecting drug user groups;
- user and consumer group contributions;
- widespread education and health promotion of safe practices; and
- expanded methadone treatment programs (*New South Wales Needle and Syringe Exchange Workers- Training Manual*, ibid).

In an independent evaluation of the Australian response to HIV/AIDS, Professor Richard Feachem concluded:

> *The evidence presented in this report shows that Australia has been successful in preventing a major epidemic of HIV among people who inject drugs. This is a remarkable achievement, in terms of the prevention of human suffering and in economic terms. The seroprevalence of HIV in this population is most probably below 5%, although it is higher among males who also describe themselves as homosexual or bisexual. The history of rapid epidemics among people who inject drugs in other parts of the world means, however, that there is no room for complacency.*
> *Needle and syringe exchange programs were established before the first Strategy and have continued in the second Strategy. A study of the cost effectiveness of these programs suggests that they have prevented approximately 3000 infections in 1991 and saved over $250 million through the avoidance of treatment costs associated with those infections.*
> *Needle and syringe exchange programs must be a foundation of Australia-s prevention efforts in a third Strategy and beyond. Peer education and community development are important adjuncts to the provision of needles and syringes and should also be integral to the long term response. These public health measures, which benefit the whole Australian population, must be given maximum support through whatever legislative action is necessary* (*Valuing The Past ... Investing In The Future: Evaluation of the National HIV/AIDS Strategy 1993-94 to 1995-96* Commonwealth of Australia, 1996, pp2-3*).*

As illustrated in the Table below, which provides details on the number of new diagnoses of HIV infection, only 20 cases of injecting drug users with HIV were reported in New South Wales for the 12 month period from 1 July 1996 to 30 June 1997.

New diagnoses of HIV infection per exposure category

Exposure category	1 Jul 95-30 Jun 96		1 Jul 96-30 Jun 97		Cumulative to 30 Jun 97			
	Male	Female	Male	Female	Male	Female	Total	%
INJECTING DRUG USE	**25**	**5**	**18**	**2**	**494**	**152**	**666**	**4.7**
Heterosexual	11	4	7	1	139	101	243	-
Not further specified	14	1	11	1	355	51	51	-
Total *	**695**	**55**	**608**	**52**	**13144**	**763**	**763**	**99.0**

* ›Total‹ refers to the total number of new diagnoses of HIV infection, including those in other exposure categories such as: male homosexual/bisexual contact; heterosexual contact; haemophilia/coagulation disorder, and receipt of blood/tissue.

Source:*The Australian HIV Surveillance Report*, National Centre in HIV Epidemiology and Clinical Research, Vol 13 No 4 October 1997, p17.

Professor Kaldor, the Deputy Director of the National Centre in HIV Epidemiology and Clinical Research, presented the Committee with the following overview of HIV and injecting drug users in Australia:

> *HIV in this population ... has remained at extremely low rates compared to almost every other country in the world. I would not say every other country, but most other countries ... When I say low rates for HIV, I am talking about prevalence, in other words the proportion of people who have had the infection, of the order of 1% to 1.5%, and if we compare that to other countries, particularly striking examples being some parts of the United States, most countries of southern Europe, a number of cities of South East Asia, the prevalence of HIV infection in people who are injecting drugs has been in the order of 40%, 50% or 60%, so 1% to 1.5% is a very low prevalence indeed in this population. This is something that we have confirmed through repeat monitoring over the last few years. It has been sustained since the beginning of the HIV epidemic in Australia ... When we talk about very low prevalence, I would like to make two qualifications to that. First of all, that is still a higher prevalence than the prevalence of HIV in our population as a whole, which is probably less than 1 in 1000, so we are talking about 1% or 1.5% for injecting drug users, but that is still substantially higher than the prevalence of people with HIV infection in the population as a whole, which is more than 10 times lower than that, so that is the first point we make. Injecting drug users, while they have a very low prevalence compared to other countries, have a higher prevalence than the general population.*
>
> *The second point to make about HIV in that population is that there is a sub-group of injecting drug users which is that sub-group of injecting drug users who are also gay men or men who have sexual contact with other men, who actually have a very high prevalence, so in that group of drug users there is probably about a 25% to 30% prevalence in the ones who*

> *are also having sex with other men. That strongly suggests that it is not the drug use that is causing transmission but the male to male sexual contact that is causing transmission. It is a much higher prevalence that you get among gay men in general and we can discuss reasons why that might be the case, but we have consistently found prevalence of the order of 20%, 25% or even 30% in the population of people who describe themselves as drug users but also are males who have sexual contact with other males* (Kaldor, Evidence 7 October 1997).

In relation to the incidence of HIV Professor Kaldor commented:

> *You also asked about the incidence of HIV. We have very little information directly on the incidence of HIV in the population, but we would say it is very low also, incidences being the number of new cases per year as opposed to the proportion of people who already have the infection in the population ... when we talk about incidence we mean a new occurring infection* (Kaldor, Evidence 7 October 1997).

2.2.2 Hepatitis C

It is estimated that between 150,000 and 200,000 Australians have hepatitis C. About 20% of whom are thought to have been infected through blood or blood products prior to 1990 when a screening test for the hepatitis C virus became available. Injecting drug use is the most commonly identified risk factor for hepatitis C infection in Australia, and occurs through sharing contaminated injecting equipment. According to the National Health and Medical Research Council ›the strongest single predictor of infection among users is duration of injecting‹ (*Strategy for the detection and management of hepatitis C in Australia,* National Health and Medical Research Council, March 1997, p5). About 20% of uninfected injecting drug users become infected with hepatitis C each year and the rate is even higher among younger users (*HIV/AIDS and Related Diseases in Australia: Annual Surveillance Report 1997*, edited by the National Centre in HIV Epidemiology and Clinical Research). In general, hepatitis C prevalence among injecting drug users in Australia ranges from 30% - 85% (National Health and Medical Research Council, op cit, p3). There is no vaccine for hepatitis C.

Professor Kaldor presented the Committee with the following overview of hepatitis C and injecting drug users in Australia:

> *... In terms of the actual incidence and prevalence, first of all, it is quite a different story from HIV. The prevalence of hepatitis C among people who have a current or past history of injecting drugs is very high, and Australia is one of the higher prevalence countries in that population, and surveys have revealed prevalence in the order of 40%, 50%, 60% or even 70%. It is strongly associated with one factor which is how long you have been injecting. The longer you have been injecting, or the longer ago you started injecting, the higher your prevalence is likely to be. That could be related to two factors.*
>
> *One is the longer you inject the more chance you have of coming into contact with the virus. But the other thing is, people who injected 10*

years ago, 15 years ago, were injecting in an era when the concept of safe injecting or non re-use of injecting equipment was not really widely promoted and particularly those people injecting in the 1970's before HIV came along ... If you started injecting 15 years ago, and maybe you have stopped now, there is a virtual certainty that at some point, you shared and came into contact with hepatitis C and acquired hepatitis C. So there is a very high prevalence among people who injected back in the 1970s or the 1980s, a lower prevalence than is more recent, but still of concern, even among people who injected only the last couple of years ... the prevalence is already of the order of 20% to 25%.

The incidence is commensurate with that. In other words, the incidence is high reflecting the fact that the prevalence is also high. Surveys that we have available suggest to us that the incidence, in other words the rate of new infections among people who are negative one year and then get tested the following year, the incidence is of the order of 15%. So for every 100 people who are negative for hepatitis C, who are injecting, 15 of them become positive by the following year (Kaldor, Evidence 7 October 1997).

2.2.3 Hepatitis B

Less than 1% of the Australian population has been exposed to hepatitis B, but the figure is much higher in some groups, one of which is injecting drug users. Although there is now a very effective vaccine for hepatitis B, studies such as the *Australian Study of HIV and Injecting Drug Use* show that vaccination among injecting drug users is still low. While a large number of drug users are infected with hepatitis C, the situation of hepatitis B is significantly different.

Professor Kaldor presented the Committee with the following overview of hepatitis B and injecting drug use

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Hepatitis B, of the three viruses that is the one we have known about for the longest. It has probably been around for the longest too. Hepatitis B is ironically the one that has been around the longest but is the least well monitored. Our information is the poorest on hepatitis B compared to the other two. It reflects to some degree the very strong focus that, first of all HIV and then more recently hepatitis C, have had in terms of policy, public and media interest. But there has not been strong hepatitis B monitoring, so I can only quote from a reasonably limited number of studies.

The overall finding of hepatitis B, we have to actually draw a contrast against HIV and hepatitis C. If you have the antibodies of HIV you are also infected; there is one-to-one correspondence of having antibodies and being infected. Hepatitis C, about between 60% to 80% of people who have the antibodies are also infected. In other words, most people who have the antibodies between 60% and 80% are actually infected, in other words infectious carriers and transmitters who are at risk of developing disease symptoms. With hepatitis B it is quite a different story. Among drug users anything between 30% to 60%, depending which survey you read, have had some exposure and have antibodies, but a very much smaller percentage, probably about between 3% and 5% are actually carriers, are currently infectious, are at risk of transmitting the virus.

This reflects the different biology of this virus which is, that if you come into contact with hepatitis B as an adult, you will get sick. That you will get hepatitis B with an acute illness is quite a high likelihood but there is only a very small chance that you will actually become a long term carrier, a chronic carrier. It is different if you get infected as a child, then there is a good chance of becoming a chronic carrier. But as an adult you become sick but you clear the illness after a few weeks or even months, and then you become immune, you are no longer at risk of getting it, but a small percentage of people who are exposed, do become infected infectious carriers. These are terms which are pretty interchangeable, 'infected' and 'carriers'. The proportions are about 3% to 5% of injecting drug users are carriers or infected with hepatitis B. Once again that proportion is higher than the population proportion in Australia which is probably of the order of 0.5%.

Hepatitis B is different to HIV and hepatitis C also in that it has probably got a higher prevalence in the population in general, because it is associated with people coming from certain backgrounds that have very high prevalences, such as South East Asia and the Mediterranean. There is only one study that I know of in Australia that has looked at the

> *incidence of hepatitis B in injecting drug users and that is a study that was done on Victorian prison entrants a couple of years ago. That study found that among the prison entrants who said they were injecting drug users (and not all of them would have revealed that) but among the entrants who said they were - and about half the prison entrants have some history of drug use - the incidence of new hepatitis B infection per year was about 20%. So it is of a similar rate to hepatitis C. That is striking for a further reason which is the fact that we have a good vaccine for hepatitis B, there is actually a known prevention strategy. Unlike HIV and hepatitis C we can actually vaccinate against hepatitis B. But the fact that of 100 prisoners coming into prison one year who were negative hepatitis B, 20 out of that 100 actually have become exposed to hepatitis B that following year, suggests that we are not looking at prevention through vaccine very well. This is Victoria, so maybe New South Wales is quite different* (Kaldor, Evidence 7 October 1997).

2.3 SERVICES FOR INJECTING DRUG USERS

There are a number of services and drug treatment options available for injecting drug users. However, as several witnesses appearing before the Committee pointed out the allocation of funds for drug-related programs, at both a Federal and a State level, is never sufficient.

Professor Webster told the Committee:

> *I would like to make the point that governments in general raise a huge amount of revenue from alcohol and tobacco and other taxes, but as a general issue they make a really small contribution back into that field as result of that. For example, in the figures, the Commonwealth Government raised $3,800 million per year from alcohol and tobacco, yet allocated approximately $36 million to the National Drug Strategy, about $2 per head of the population. In similar figures, in 1995 figures, New South Wales raised $894 million from taxes on alcohol and tobacco, that is about $148 per head of population and it allocated $47 million to drug and alcohol programs. That is about $7.83 per head of population. The point about those figures really is the amount of commitment specifically to the drug and alcohol treatment and prevention services, despite what Governments and the public state, is not high (*Webster, Evidence, 8 October 1997).

Similarly Dr Wodak said:

> *The major barrier to people entering treatment at the moment is lack of funding. New South Wales currently spends around about $50 million out of a health department budget of $8 billion on alcohol and drug treatment, whoever forms government that proportion is roughly maintained and in my opinion that is gross under funding* (Wodak, Evidence 9 October 1997).

The findings on the treatment history of injecting drug users as contained in the Report on the Sydney component of the *Australian Study of HIV and Injecting Drug Use*, are as

follows:

- 160 respondents (73%) reported their drug use had caused them problems and 198 respondents (90%) stated they wanted to change their drug use. The main reasons given were: health (31%), their children (18%) and for financial reasons (15%).

- 170 (86%) of those who wanted to change their drug use actually tried to do so on the last occasion they made the decision. Among those who tried to change, 39% tried by themselves or with friends or family help, 29% used methadone treatment (9% withdrawal and 20% maintenance), 22% underwent detoxification (10% home detoxification and 12% residential detoxification) . 135 respondents (80%) who tried to change felt the method they used helped them control their use. However, only 82 respondents (59%) were still using the same method.

- 201 respondents reported the various treatment methods they had tried in the past. The four most frequent methods reported were: changing by themselves (88%), methadone maintenance (68%), home detoxification (62%) and changing with friends or family help (53%).

- 124 (57%) stated they were currently in treatment, the majority of whom (90%) were in a methadone program for maintenance or withdrawal. The remaining respondents were in counselling (7%), Narcotics Anonymous (1%), or some other type of unspecified treatment (2%) (*Sex, drugs and viruses in Sin City Sydney 1994*, op cit, pp49-55).

It is clear from the above that no one treatment option suits everyone, and therefore it is important that a range of treatment options be available. Mr Trimingham, whose son died from a heroin overdose told the Committee:

> *We believe we need a wide range of options. We need to look at education, rehabilitation and treatment facilities. We need to trial new treatments. We need everything that is possible. We need to realise that what works for person A may not work for person B. I have had numbers of people ring me with a solution. For one person it is Jesus; for someone else it is discipline. For some people it is taking them away to camp and lashing them until they fear the word 'heroin'. For other people it is the body cleansing method. For others it is naltrexone. These are great if they work for those who want to get off drugs. The sad fact is that we are spending only about $2 per head of population on treatment, rehabilitation and education, and that is where we must put the emphasis. It should be across the board. People who stand up and claim to have a cure are deluding themselves* (Trimingham, 30 September 1997).

The view has been put that establishing safe injecting rooms would create another entry point for injecting drug users to go into treatment:

> *Whenever we have more entry points we have more people entering drug treatment and that is a good thing because although not everyone benefits from drug treatment, most people do benefit. The risk of death for a person using street heroin is something like 13 times higher for a*

> *person of the same age and sex who is not using any drugs. If they are in treatment that risk goes down from 13 times to about 3 times. So getting people into treatment is very important* (Wodak, Evidence 9 October 1997).

The importance of recognising that the needs of injecting drug users vary was referred to by the authors of the Fitpack study:

> *There needs to be more sophistication and refinement in prevention efforts in this area. Strategies need to be implemented which involve injecting drug users and address their wide diversity. These contrast with strategies which stereotype injectors and respond as if all injectors were the same. While some injectors are affluent others are financially poor. While many can afford the price of a 5 needle Fitpack, at times others may not and as a result may share. Whilst most will inject at home, others will in a car or a public toilet without access to swabs or sterile water. While some may not have problems accessing clean equipment, others may be less likely to share if Fitpacks are available in vending machines. Providing better blood-borne virus protection for the public, be they injectors, their children, or sexual partners, means providing a range of alternatives and choices which reflect the variety of life situations and needs of this varied community group of people who happen to inject drugs* (*The Fitpack Study: A survey of 'hidden' drug injectors with minimal drug treatment experience*, op cit, pxvi).

It is also important to understand that for some injecting drug users abandoning the process of injecting is harder than giving up the actual drug. Several witnesses described the phenomenon of needle fixation and the symbolism associated with drug use to the Committee. Dr Manderson, Senior Lecturer in the Law School at Macquarie University said:

> *The fact that drugs are not just substances, that they are symbols that are taken for symbolic reasons, is part of the reason that the drug problem is so intractable. It is not, at heart, the substance of a drug which leads to addiction but the symbolic meaning with which it becomes invested. The taking of a drug in some people becomes a kind of fetish ... something which originally is used to get some kind of pleasure or escape but which, in the mind of the user, becomes so associated with that pleasure that they cannot imagine having that pleasure without it, so rather than being an aid or an agent, it becomes the thing that is the pleasure ... my suggestion here is that it is the same in relation to the needle. The injection of drugs is taken for all sorts of reasons ... but it becomes so associated with it, that the user cannot imagine getting any of those things ... without the use of the drug and without the use of the needle.*
>
> *I think that is particularly so in relation to injectable drugs. Injection has its own symbolism, its own rituals and its own cultures. The way in which people inject, the situations in which they inject, who injects, whether they inject themselves or whether somebody else injects them, is all part of the meaning that is bound up in the drug using acts and we cannot just expect it to go away, we cannot just expect people to take different kinds of drugs*

in different ways (Manderson, Evidence 24 October 1997).

Dr Darke told the Committee:

> *We know that people who inject drugs, whether it be amphetamines, cocaine or heroin, have a heavier dependence. It is instant. People who inject a drug ... will use a drug more often, use more of the drug, and spend more money on the drug. It will play a bigger part in their lives. There is a strong association between the pleasure you get from the drug and from the needle ... there is a strong psychological component to that [needle] fixation. People like it ... that sort of fixation is a psychological thing; it takes on its own life. It becomes difficult for people not to inject* (Darke, Evidence 30 September 1997).

2.3.1 Needle and Syringe Exchange Program (NSEP)

The first National HIV/AIDS Strategy released by the Commonwealth Government in 1989, provided a framework for an integrated response to the HIV epidemic and a plan for action across a range of policy and program activities. The NSEP was part of the education and prevention strategy. The rationale behind the scheme is:

- despite drug education and treatment programs, many individuals will continue to inject illicit and licit drugs for varying periods of time;
- people must be provided with knowledge and skills necessary to make informed choices about risk behaviours; and
- the community as a whole faces a greater danger from widespread HIV infection than it does from the effects of drug use itself (*Needle and Syringe Exchange Policy and Procedures Manual*, NSW Department of Health, 1994, p4).

The NSEP is based on the concept of harm reduction and it aims to assist in the prevention of the spread of blood-borne viruses in the community. This is done by providing new needles to injecting drug users, thus reducing the need to share, and by also providing condoms and information and advice on safe sexual practices. NSEPs give health workers access to high risk sections of the community who would not normally use health services. This contact also offers an opportunity to establish communication and to stress the dangers of leaving used needles where they can potentially infect other individuals. Workers can use this contact to refer clients to other services, for example, legal or medical services (*NSWNSEP Training Manual*, op cit, Chapter 10 p7).

Details on the New South Wales NSEP was provided in the NSW Health Department=s submission to the Committee:

- The program commenced in 1988 after a trial scheme in 1987, and is based on a model of voluntary exchange in which achieving the return of used equipment to the program is an objective, rather than a requirement.
- The program=s policy is that supply of syringes is never denied on the grounds

that used equipment is not returned. Considerable emphasis is placed on educating clients about the importance of safe disposal. The program aims to ensure that the rate of return of equipment to the program is maximised and that equipment not returned is disposed of in other safe ways. Supply of equipment is always accompanied with a Fitpack or other approved disposal container.

- In addition to supplying sterile injection equipment, needle exchange staff provide clients with information and education about drug use, infection control, health care and safe disposal of syringes; and referral to drug treatment, and other health and associated services. This educational work is an essential component of the program and the key to much of the program=s proven effectiveness.

- *Public sector scheme*: The State=s 17 Area Health Services have operational responsibility for the NSEP, with policy direction and monitoring by the Central Office of NSW Health. It operates mostly through hospitals, community health services, drug and alcohol services and associated non government organisations. There are approximately 300 outlets located in all parts of the State. The NSEP uses a range of service modalities to maximise the program=s accessibility to the diverse range of people within the injecting drug user population. These include: conventional services conducted from a fixed premises; outreach and mobile services (both vehicle based and on foot); use of generalist and specialised agencies as secondary (additional) outlets.

- *Pharmacy Fitpack scheme:* Clients have the option of free exchange of used syringes for new ones, or simple purchase as before. There are approximately 530 retail pharmacies throughout NSW participating in this scheme (Reid, Submission 101).

The findings of numerous studies conducted both in Australia and overseas suggest that NSEPs have been effective in controlling the spread of HIV infection. Overseas studies have shown that the average annual HIV seroprevalence is 11% lower in cities with syringe exchange programs than cities without syringe exchange programs (SF Hurley, DJ Jolley, and JM Kaldor, ›The effectiveness of needle exchange programs for prevention of human immunodeficiency virus infection=, *Lancet*, Vol 349, 1997, pp1797-1800).

Professor Kaldor described both the effectiveness and cost effectiveness of the needle and syringe exchange program to the Committee:

> *First of all, in terms of effectiveness. Effectiveness for needle exchange is, at the bottom line, measured in terms of how many infections you actually prevent. Infection prevented: we are talking here about HIV, hepatitis B and hepatitis C. On a global basis there have been a number of attempts to try and measure the effectiveness in terms of preventing these viruses, and that work has resulted in a number of major reports, particularly in the US ... The overall conclusion from those reports ... has been that on the basis of material that has been accumulated ... people who are accessing needle exchange had lower rates, lower prevalence and incidence of both risk-behaviour related to injecting but also risk of transmission of HIV.*

> *... as part of the evaluation for the National HIV AIDS Strategy in Australia which took place in 1995 ... our Centre participated in a major analysis of effectiveness that looked at all countries in the world which had reported data on needle exchange and the prevalence of HIV among injecting drug users. The overall conclusions from those studies were ... were that in the cities where there had not been needle exchange put in place, there had been a steady increase in the HIV prevalence over time among injecting drug users. In other words an ongoing increase in proportion of drug users who had HIV infection. But among the cities where needle exchange had been implemented, the prevalence on the whole stayed relatively low and certainly was significantly lower than the prevalence in the cities that had not implemented needle exchange. That was a very clear demonstration on a global basis ... that needle exchange was associated with a much lower change in prevalence for HIV among injecting drug users. If you measure in terms of hepatitis C or hepatitis B there has been no corresponding analysis ... I would summarise that by saying there is clear and strong evidence of the effectiveness of needle exchange in preventing HIV transmission. On the same grounds you would also believe that it is effective [in preventing transmission of hepatitis C and hepatitis B]. In the sense of the basic principle of prevention, clean needles do prevent transmission, so effectiveness in a very fundamental sense is assured no matter which blood-borne virus you are talking about ...*
>
> *In terms of cost effectiveness, I think the best analysis of that issue for Australia has been presented in this document [the Feachem Report]. It was a commissioned report undertaken by the Commonwealth as part of what is known as the evaluation of the national HIV/AIDS strategies and it was found in this economic report that, in terms of per person years of life saved, depending on what assumptions are followed, needle exchange was a range of between $50 and $7,000 expenditure per person years of life saved ... as far as health intervention goes, that is actually a pretty cost effective health intervention. It shows quite clearly that needle exchange is, in comparison to a range of other health interventions, an extremely cost effective measure in its own right* (Kaldor, Evidence 7 October 1997).

Given that a person who intends to inject drugs will do so whether a new needle is provided or not, it is unlikely that NSEPs have led to an increase in drug usage. This assumption seems to be borne out by research done in the area. In the United States, Lurie and Reingold reviewed the existing literature and concluded that: ›there is no evidence that needle exchange programs increase the amount of drug use by needle exchange clients or change overall community levels of non-injecting or injecting drug use‹ (P Lurie and A Reingold (eds) *The Public Health Impact of Needle Exchange Programs in the United States and Abroad: Summary, Conclusions and Recommendations*, San Francisco Institute for Health Policy Studies, 1993). Similarly, a New South Wales study headed up by Dr Jael Wolk from the School of Health Services Management, University of New South Wales, appears to confirm this finding.
In November 1986, a pilot needle and syringe exchange was established in Sydney

adjacent to a methadone maintenance unit. A retrospective study was carried out by Dr Wolk and colleagues to determine the effect of increasing the availability of sterile needles and syringes on the treatment outcome of the methadone maintenance unit. In this study, an increase in availability of sterile needles and syringes was not found to be associated with an increase in the presence of illicit injectable drugs in the urine specimens of clients of the methadone programme compared to a control methadone unit where there was no known change in needle and syringe availability. According to the authors: ›this study suggests that an increase in the availability of sterile needles and syringes does not appear to lead to an increase in the frequency of intravenous drug use= (J Wolk, A Wodak, J Guinan, P Macaskill and J Simpson, ›The effect of a needles syringe exchange on a methadone maintenance unit=, *British Journal of Addiction*, Vol 85, 1990, pp1445-1450).

Two random telephone surveys have been conducted asking residents about their level of support for drug services in general, and NSEPs in particular. The first was conducted in 1990 and 90% of respondents in a sample of 300 residents chosen from four areas of New South Wales thought that the needle exchange program should continue. The majority (78%) agreed that teaching drug users how to inject more safely is important to help stop the spread of HIV and that this would also reduce the risk of overdoses (*Community Attitudes to Needle and Syringe Exchange and to Methadone Programs*, NSW Department of Health, Directorate of the Drug Offensive, December 1990). Another telephone survey was conducted in 1997, this time using a sample of 305 residents living in the 2011 postcode area (Potts Point, Elizabeth Bay, Kings Cross, Woolloomooloo and Rushcutters Bay). 82% believed that NSEP should continue *(K2 Community Centre Darlinghurst Road Kings Cross Baseline Evaluation: Survey of Community Attitudes to the Establishment of a Community Health Centre with Needle and Syringe Exchange Facilities*, Interim Draft Report, M MacDonald, National Centre in HIV Epidemiology and Clinical Research,1997).

2.3.2 Methadone Maintenance Treatment (MMT)

Maintenance approaches aim to stabilise a heroin dependent person by providing daily doses of a long acting, orally administered opioid drug, such as methadone, to replace heroin which is injected, illegal and shorter acting. It provides the person with an opportunity to disengage from illicit heroin use and the drug subculture and to use other rehabilitation services such as counselling. Methadone belongs to the ›agonist= category of drugs, that is, it acts at opiate receptor sites in the brain to induce a change in body function.

Associate Professor Mattick described substitution therapy which includes methadone treatment to the Committee as follows:

> *The evidence of methadone maintenance is quite consistent that it reduces drug use, that is, injecting opiates or use of opiates. It improves physical health, improves psychological well-being, and it reduces crime. It achieves reasonable goals set for it by the individuals who provide it, and by the organisations which sanction its provision. That has been demonstrated in a number of randomised controlled trials, clinical trials of methadone against some other comparative conditions, like the one I mentioned earlier where some patients were given methadone plus a lot*

> *of counselling and some were just given counselling. It has also been demonstrated from a large number of quite big cohort studies, studies of large groups of patients, particularly in North America but also elsewhere, that methadone achieves the reasonable goals set for it. There is some evidence that if it is delivered in certain ways its efficacy is less good and there are efforts, and have been efforts historically in Australia, to improve the quality of methadone treatment, but there is reasonable evidence that this intervention is effective.*
>
> *As far as other intervention using substitution therapy, apart from nicotine chewing gum which we may all be aware of as a substitution therapy, and nicotine patches, there is little evidence for other intervention. One area which has been of interest is what is called amphetamine substitution, where individuals who inject amphetamines on a regular basis and who appear to be dependent on amphetamines, are provided pharmaceutical amphetamines by a doctor under supervision with the view that that will help them stabilise their lives, reduce their injecting and gradually withdraw. There is no control trial demonstrating that this is effective. There is some evidence from the UK on this intervention and happily a group in Sydney are attempting to run such a trial, although it may not go ahead* (Mattick, Evidence 7 October 1997).

Research data suggests that methadone maintenance treatment results in a reduction of heroin use, crime and overdose deaths among treated heroin users (W Hall, ›Methadone Maintenance Treatment as a Crime Control Measure‹ in *Crime and Justice Bulletin*, No 29, NSW Bureau of Crime Statistics and Research, 1996). In a randomised control trial of methadone maintenance undertaken in the United States, only 25% of drug users who received treatment had returned to prison within a one year period. In contrast, all untreated subjects had returned to prison within the year (V Dole, J Robinson, J Orraca, E Towns, P Searcy and E Caine, ›Methadone Treatment of Randomly Selected Criminal Addicts‹, *New England Journal of Medicine*, Vol 280 1969, pp1372-1375).

In terms of cost effectiveness as a treatment option, Professor Hall told the Committee:

> *In terms of value for money, methadone comes out in front largely because more people are attracted into and are retained in it as a form of treatment. The average benefits that a methadone patient receives are probably not as good as the best outcomes from therapeutic communities, but a lot fewer people benefit from therapeutic communities than from methadone* (Hall, Evidence 24 October 1997).

The following points on the methadone program are made in the NSW Health Department submission to the Committee:

- Methadone maintenance is currently the most significant treatment program in NEW SOUTH WALES Methadone is a synthetic opioid which blocks and mimics the action of heroin and other opiates such as morphine and codeine. It is well researched and widely recognised as an effective method for managing opioid dependence and reducing individual and social harms associated with

dependence.

- Currently there are 11,400 people in methadone treatment in NSW or 4.1 per 1000 persons aged 15 to 44. Of these, approximately 30% are enrolled in public programs and 70% are treated by private prescribers. Details on private sector provision taken from the *NSW Methadone Program 1995/96 Annual Statistical Report* prepared by the Drug and Alcohol Directorate show that:

  - As at 30 June 1996, 32% of clients were being treated in public programs while 68% were in private programs. At 30 June 1987, however, there was a more equal spread of clients between both sectors with 51% being seen in the public and 49% in the private domain. As at 30 June 1987 the rate in the public sector was slightly higher than that in the private sector ... by June 1996, however, the sector trend had reversed with the rate in the private sector being more than double ... that in the public sector (NSW Health Department, In-House Report Series, March 1997, p3)

  - A breakdown of methadone pick up points as at 30 June 1996 shows that approximately two-thirds of clients in both public (61%) and private (63%) programs received their treatment in hospitals or clinics. A higher proportion of private sector clients (32%) used a pharmacy pick up as compared to public clients (18%) (Ibid, p7)

- A current trend is toward longer treatment duration. At 30 June 1996, 48% of clients had been enrolled in their current treatment episode for 2 years or more and only 20% of patients had been enrolled in their current treatment episode for less than 6 months (Reid, Submission 101).

The number of clients in MMT has continued to rise in recent years and there remains a substantial unmet demand (W Hall, *The Demand for Methadone Maintenance Treatment in Australia*, Technical Report No 28, NDARC, 1995). Given that private clinics charge about $6.50 to $7 per day and usually add an extra $1 for takeaway doses per dose, the question of cost to clients in obtaining methadone needs to be considered as this may act as a barrier to access or lead to a reduction in retention rates.

It would appear that a series of trials of alternative pharmacological agents for possible use in maintenance treatment are to be undertaken in several Australian States. According to Crosbie:

> *The trials of these agents will examine: the comparative effectiveness and cost - effectiveness of the new and existing agents; and the best way to deliver these treatments in general practice and specialist clinics. If successful, these agents would expand the range of options from which doctors and patients could choose, thereby increasing the chances of success ... LAAM is a long acting form of methadone (opioid agonist) that can be taken 3 times per week instead of daily. It reduces the need for daily attendance, enabling the person to lead a more normal life. Buprenorphine is safer than methadone in terms of overdose risk, it produces fewer withdrawal symptoms and like LAAM, it can be given 3*

> *times a week. Slow release morphine and tincture of opium may appeal to patient groups who find existing maintenance options unattractive. Oral morphine is widely used to manage chronic pain and may also be of use for heroin dependence. Tincture of opium is used in Asia for withdrawal and maintenance. It may appeal to heroin dependent persons from an Indo-Chinese background* (Crosbie, *A Background Report on Heroin Use in Australia*, op cit, p12).

2.3.3 Detoxification

Detoxification is another option for treating some injecting drug users. The process is described in *A Background Report on Heroin Use in Australia* as follows:

> *Withdrawal treatment (or 'detoxification') uses drugs to reduce the severity of these [withdrawal] symptoms by giving decreasing doses of methadone or other drugs over two weeks. Heroin dependent persons who abruptly stop using heroin experience distressing withdrawal symptoms. Withdrawal treatment does not produce enduring abstinence from heroin. Psychosocial interventions (eg support, counselling, crisis management, skills training) or maintenance drugs are usually necessary to assist a heroin dependent person to remain abstinent after withdrawal* (Crosbie, op cit, p11).

Associate Professor Mattick described detoxification to the Committee:

> *Detoxification, I view as a treatment to itself, that its goal is not abstinence from drug use thereafter but rather to give the individual an opportunity to withdraw in a safe and humane fashion, particularly for alcohol dependence where withdrawal can be life threatening, but also for opiate dependence and for other problems where withdrawal under supervision may assist the individual to successfully complete the process. The evidence is reasonably clear that people can be withdrawn safely and humanely if the resources are made available, but again the notion that withdrawal is or should be a precursor to long-term abstinence is not supported by the literature.*
>
> *It is quite clear that individuals, after they withdraw, are likely to relapse to drug use or to alcohol use. That does not mean that withdrawal as a treatment has failed, it just depends on the goals that you set for it ... The percentage that relapse is very high, it depends on the drug, but typically it would be of the order of 80% or 90%, quite promptly within a month or two, often within a shorter period ... It is very difficult for individuals to refrain because they are re-entering their usual social milieu. So it is unlikely that they are going to withstand the pressures that are there.*
>
> *In terms of particular factors, the factors which are usually and traditionally associated with drug or alcohol use ... is the issue of what is called stress; that unpleasant life events, untoward occurrences cause people distress and they will then use various psychoactive drugs and medications to relieve that stress* (Mattick, Evidence 7 October 1997).

Dr Wodak made the point to the Committee that detoxification was not a treatment as such but rather a prelude to it:

> *With regard to detoxification, I think the concept is often misunderstood. It is often considered a major treatment intervention. It is a very simple intervention and the idea is that through detoxification we provide a safe and comfortable environment for people to withdraw from drugs, and this is really better thought of as a prelude to drug treatment rather than treatment itself* (Wodak, Evidence 9 October 1997).

There has been recent media attention to alternative treatment options particularly ultra-rapid opiate detoxification (UROD) and the use of Naltrexone (which severely attenuates or completely blocks the effects of heroin or other opioids) as part of ultra -rapid opiate detoxification, where it is given with a general anaesthetic to achieve detoxification and then continued for 12 months. In a pamphlet produced by the Australian Professional Society on Alcohol and Other Drugs in July 1997 which describes naltrexone and its effects it is stated that: ›the precise details of this technique [administering naltrexone with a general anaesthetic] are somewhat unclear. It has not been independently evaluated and costs over $8,000.‹ Reports suggest that the costs may be lower if the treatment takes place in Australia.

The Committee notes that the New South Wales Government has recently announced that a clinical trial of naltrexone in rapid-opiate detoxification is to proceed and that the following strategies will be undertaken:

- A group of experts co-ordinated by the University of NSW's Dr George Rubin will oversee all trials sponsored by the Department of Health;
- The Department of Health is evaluating a number of proposals for trials including a proposal from a group of Westmead doctors co-ordinated by Dr John Currie to evaluate ultra-rapid opiate detoxification; and

- Other groups interested in trialing other approaches will be encouraged to participate to discuss a co-ordinated approach with the Department of Health (Media Release, Premier Carr, ›NSW Government to permit clinical trial of rapid-opiate de-tox - Naltrexone‹, 18 January 1998).

The Committee received a number of submissions in support of these treatment options particularly from those who had direct experience of injecting drug use within the family. Mrs Orr, whose daughter was a former injecting drug user wrote:

> *My daughter was the first Australian to have Dr Andre Waismann's medical procedure for heroin addiction in Israel. This treatment has cured her - and around 15 other Australians who have followed in her footsteps. Please, please put some of this money that is about to be spent on safe injecting rooms and free heroin trials into sending appropriate doctors overseas to assess this method of treatment and if it is as good as it appears to be, then set up trials here in Australia* (Orr, Submission 66).

Ms Slade, whose brother is an injecting drug user wrote:

> *I attended a meeting at Lismore recently at which Dr Waismann explained the procedure for curing heroin addicts ... I see the only hope of my brother surviving is to have what is known as Rapid Opiate Detoxification* (Slade, Submission 97).

Mrs McKay whose son died of an overdose thought that:

> *... to give in to shooting galleries is saying that we have lost the war against drugs and you keep them prisoners of their addiction; introduce Rapid Detoxification and Naltrexone and give them back their life before it is too late* (McKay, Submission 30).

Not all views on the alternative treatment options were as positive. Professor Hall told the Committee:

> *The newer treatments including the Waismann method ... and methods that Dr Colin Brewer has been pioneering are not really new. I have been quite concerned about what I see as the serious over-selling of those treatments. They may well have a role for a small proportion of heroin users, but to present them as an answer or a cure for heroin is extremely misleading. A component of the Waismann procedure, which is accelerated detoxification, has been around for well over a decade. The people who had been using it prior to him had never imagined that it was a treatment for heroin dependence and Dr Colin Brewer ... has been very critical of the claims made on behalf of this treatment by Dr Waismann. The second component of it, which is the naltrexone maintenance, has been around for twenty years. That has been trialled extensively. It does not stack up well against methadone in terms of retaining people in treatment, but there are clearly some people who will benefit from it and I think we ought to have, for that reason, naltrexone available as one of the treatment options that people who are opiate dependent can choose from* (Hall, Evidence 24 October 1997).

Associate Professor Mattick told the Committee:

> *The issue with Naltrexone is withdrawal using ultra-rapid detoxification or any other way of dealing with opiate dependence will not guarantee any long-lasting abstinence and should not be considered to do that. I think that the way in which recently the value of these interventions has been presented has been misleading in the sense that the proponents of these interventions have suggested that the use of Naltrexone will necessarily bring about a 100% cure and that is not true* (Mattick, Evidence 7 October 1997).

When asked for his views Dr Darke said:

> *To my knowledge the ultra-rapid detox has had no proper trial; there is no good evidence for it; it has not been properly researched. The only difference between ultra-rapid and the naltrexone maintenance is the anaesthetising of a person through withdrawal. It has not been properly tested. I advise the Committee to wait and see proper scientific evidence*

- just because someone says something does not mean it's true (Darke, Evidence 7 October 1997).

2.3.4 Other treatment options

Therapeutic communities (which provide a combination of psychosocial measures to their residents over a number of months to prevent relapse); rehabilitation; self-help and counselling are other approaches which may be beneficial for some injecting drug users who want to give up drugs.

Associate Professor Mattick expressed his view to the Committee on self-help and counselling as treatment options:

> *Self-help programs are not particularly well-researched. In fact part of the approach that these programs take is that the individuals are anonymous and therefore it is very difficult to track them across time. I think they are highly successful, however, for a number of people and I can think of no better self-supporting community based intervention than Alcoholics Anonymous, which runs very effectively through parts of Australia and through parts of the western world. NA, Narcotics Anonymous, is a similar kind of intervention. The adequacy of that intervention for drug users generally is rather unclear. It is very likely, as with all treatments, that the individuals who attend are self-selected. They are probably older; they have probably been involved in drug or alcohol use for a long period, but there is no reason to suggest that this should be considered a broad-based intervention for problems with drug use, particularly amongst young people where it is much less likely that these kinds of interventions would be acceptable.*
>
> *Similarly, the evidence for counselling is rather poor, that is, it is not particularly well-documented that counselling is a helpful intervention. There is some interesting evidence from some studies which were conducted of methadone treatment, particularly from Sweden, where individuals who were heroin dependent were given very intensive counselling, vocational rehabilitation and social work support, psychiatric care. They fared very poorly compared with individuals who were given the same care but also methadone maintenance treatment. All these individuals were heroin dependent. That was one of the most important studies of the effects of methadone treatment* (Mattick, Evidence 7 October 1997).

2.4 SUMMARY

This Chapter attempts to canvas a number of aspects related to the injecting drug problem despite well acknowledged difficulties associated with the presentation of an accurate profile of injecting drug use. Various studies have shown that: injecting drug use appears to be undertaken by a very small percentage of the Australian community (1% - 2%), but approximately half the injecting drug user population is located in New South Wales. Injecting drug users are not a homogeneous group: they use drugs for

different reasons; they do not all use the same drugs; they do not all have the same level of drug use; the vast majority do not inject their drugs in a public place; there is no certain way to determine who will and who will not become an injecting drug user; they are not in the same age group; they can be found all over the State although there is a greater prevalence in certain areas such as Sydney than others; and approximately 66% have had at least one (non-fatal) heroin-related overdose, and 90% have been present when someone else has overdosed.

The overall health of regular injecting drug users is often compromised, particularly in relation to the presence of blood-borne viral infections contracted through the injecting drug process. While the rate of HIV amongst injecting drug users has remained relatively low since the introduction of harm reduction measures such as the Needle and Syringe Exchange Programs, hepatitis B and hepatitis C infection have not been able to be contained in the same way. Both these diseases pose significant concerns not only for the individual but also for the community at large, given the ease with which they can be transmitted.

While it is understood that for many people injecting drug use is experimental, there are a number of people who become dependent, and as such a number and range of services and treatment programs are required to respond to their needs. Not all options will be of equal benefit to each drug user. When considering illicit drug use, it should always be kept in mind that any one injection could be fatal, and therefore the question of harm reduction is ever present. The recommendation of Commissioner Wood to consider the establishment of safe, sanitary injecting rooms was made in the context of the harm reduction approach, specifically as an extension of the Needle and Syringe Exchange Program. He said:

> *At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour. For these reasons the Commission favours the establishment of premises approved for this purpose and invites consideration of an amendment of the Drug Misuse and Trafficking Act 1985 to provide for the same* (Final Report, Vol II: Reform, p226).

Some members of the Committee hold a dissenting view which is appended to the Report.

CHAPTER THREE

OVERSEAS EXPERIENCE

Over the course of the last decade injecting room facilities have been established in several European cities and from 22 August until 2 September 1997, a Subcommittee of the Joint Select Committee on Injecting Rooms visited a number of these operating in the Netherlands, Switzerland and Germany. This Chapter reviews the different injecting rooms observed during the overseas study tour. The Committee notes that while various studies of these injecting rooms have been conducted and evaluation reports written, very little information is available in English. It should also be borne in mind that any costings provided for the overseas models in this Chapter reflect the social and financial context of providing such a service in the particular country concerned. They do not necessarily have any bearing on the costs of establishing or trialing an injecting room in New South Wales.

3.1 THE NETHERLANDS

Following on from an influential report produced in the 70s (the Baan Report), which recommended that both drug users and the community would be better served by pursuing a policy of drug information and prevention rather than prosecution, the Netherlands has adopted a ›low threshold= services approach to drug users. The term ›low threshold= is defined in a report on Swiss injecting rooms as ›describing any kind of program or service aimed at harm reduction, the general aim of which, is to stabilise and improve the drug user=s health. Achieving abstinence is considered a secondary issue= (R Geense, ›To have or to have not: that=s the question: A qualitative study of four low threshold needle exchange services for drug users in Switzerland=, Department of Health Education and Promotion, Maastricht University, April 1997). Such programs seek to improve the health status of drug users by maintaining contact with marginalised users and facilitating re-integration. They provide basic services such as needle exchange, counselling, food and they facilitate entry into drug treatment.

According to the Ministry of Health, Welfare and Sport for the Netherlands:

> *The protection of health of drug users is a major priority and a wide range of facilities are available. The Netherlands spends more than 300 million guilders a year on facilities for addicts. Over half of this amount is spent on the drug problem. There are 12 clinics for the treatment of addicts, and their capacity has been increased, from 500 places in 1980 to 961 in 1995. In the past ten years accessibility of care services has improved considerably. These services now reach an estimated 75% of all addicts. Their aim is to reach as many addicts as possible to assist them in efforts to rehabilitate, or to limit the risks caused by their drug habit. Social rehabilitation is an essential element. To achieve these aims, an extensive network of services has been established. Methadone programmes enable addicts to lead reasonably normal lives without causing nuisance to their immediate environment, while needle exchange programmes prevent the transmission of diseases such as AIDS and hepatitis B through infected needles. The services also provide*

> *counselling* (*Drugs Policy in the Netherlands*, Ministry of Health, Welfare and Sport for the Netherlands, April 1997, p1).

The declining prevalence of HIV infection among injecting drug users has been reported as one measure of success accepted by the local authorities in support of their approach to the illicit drug problem (C Hartgers, *HIV Risk Behavior Among Injecting Drug Users in Amsterdam*, Amsterdam, 1992). Information on the health status of injecting drug users is provided in *Drug Policy in the Netherlands: Continuity and Change*, a document prepared by the Ministry of Health, Welfare and Sport for the Netherlands:

> *The policy on drug addicts, which concentrates heavily on prevention and care, has helped achieve a situation where the health of addicts resident in the Netherlands also compares favourably with that in other countries. There is less widespread HIV infection among addicts and infection levels are falling. The mortality rate among addicts is low and is not increasing, as it is in many European countries. The government regards the results achieved to date as grounds for continuing the principal elements of the pragmatic policy pursued up to now, which has been geared to controlling the damage done to health* (*Drug policy in the Netherlands: continuity and change*, Ministry of Health, Welfare and Sport for the Netherlands, http:www.minvws.nl/drugnota/0/drugall.htm).

During their visit to the Netherlands, the Subcommittee visited injecting rooms in Rotterdam and Arnhem. The participation of the police in the planning and supervision of these facilities was regarded by the local authorities as fundamental to their day to day operation and their acceptance by the community. The facility in Rotterdam, the Paulus Kerk, is managed by a religious organisation and operates on church premises, while the injecting room in Arnhem, the Stichting Gelders Centrum Voor Verslavingszorg, is run by local government. The rooms have strict entry criteria: users have to be both 18 years old and have a history of injecting. Both Centres provide separate rooms for smoking drugs rather than injecting them.

3.1.1 INJECTING ROOM IN ROTTERDAM

In Rotterdam, the Subcommittee met with the Reverend Hans Visser, Co-ordinator of the Paulus Kerk Centre and staff from the Centre. The Paulus Kerk, is a church in Rotterdam which has, according to Reverend Visser, ›developed along three lines: the church as a shelter; the church as a place for mediation; and the church as a centre for action‹ (Visser, ›Regulation of the Drugs Scene in the Paulus Kerk in Rotterdam‹, September 1996). As well as undertaking the usual activities of a church, such as divine services, Bible study groups and the like, the Paulus Kerk has catered for drug users and other marginalised groups since 1982. **One member of the Subcommittee dissented from the above description of the Church's activities. See amendment at the end of the report which records the dissent.**

Reverend Visser and others had been instrumental in closing down the large open drug scene which had existed for several years at the main train station in Rotterdam (›platform zero‹), and in its place making alternative facilities such as the Paulus Kerk Centre available. The aim of the Centre is to encourage injecting drug users to inject

more safely and in private and to create an environment in which drug-related information and education could be provided. The Centre has an annual budget of 1.2 million guilders, and of all the injecting room sites visited by the Subcommittee, Paulus Kerk was the only service that had significant revenue from non-government sources. The Centre has an open sitting/recreation area with access to a cafeteria where coffee, tea, soft drinks, soup, bread and other food are available. This service is provided by volunteers. There are various rooms where people can rest, read a newspaper, play games (such as ping pong, chess or cards), and throughout the day activities and classes are offered (such as handicrafts, painting and drawing, discussion groups and Bible studies) for those who wish to participate.

There are two additional rooms (›tolerance zones=) provided in the basement for the use of drugs: one is for those who inject drugs and the other is for those who smoke drugs. Drug use is permitted within these areas at specified times: 9.30 am to 4 pm Monday to Friday; 3 pm to 4 pm Saturday and Sunday; and 7 pm to 8 pm and 11 pm to 12 midnight every night of the week. Each room is approximately 3 metres by 5 metres in size. The injecting room contains two tables that can accommodate six users at a time. Free sterile needles are provided by the Centre. The injecting room had an overall hygienic atmosphere when the Subcommittee visited.

To gain entry to these facilities at the Paulus Kerk, passes are issued after applicants have been screened by a panel which includes social workers and police. Known criminals and other trouble-makers are excluded from using the Centre. The pass system incorporates three levels of privileges: to the ›tolerance zones=; to the general facilities; or to other facilities the church offers to non-drug users. Passes have been issued to 1,000 people. Staff are able to control the flow of clients into the injecting room. On average, 100 to 200 people use the Centre each day.

Between 8 pm and 11 pm in the evenings, staff provide counselling to clients and an evening meal is prepared by volunteers. A nurse is available to provide information on safer injecting techniques to drug users who are injecting in a hazardous manner. The nursing staff also attend to other health needs of the drug users such as treating infected wounds and arranging visits to doctors where necessary.

There are 25 paid members of staff including 3 social workers who assist with applications for housing and social benefits, as well as run life skills projects at the Centre. Security personnel make up about half the staff numbers and are on the premises at all times during opening hours. Over 200 volunteers assist at the Centre and provide pastoral care to those users who seek it.

According to Reverend Visser, a recent survey of those using the Centre=s facilities found that:

- 60% of visitors to the Centre do not come only to use drugs but also to participate in the activities;
- the remaining 40% come exclusively to use the ›tolerance zones=;
- 40% of visitors are homeless and about half of them spend the night in the shelter provided by the Centre;

- 30% do not attend a methadone program;

- 76% use heroin and cocaine; 11% use heroin only; and 10% use cocaine only;
- 53% are Dutch-born; 47% originate mainly from Surinam, the Antilles, Indonesia and Morocco;

- 84% are 30 years or older; and

- 83% are male (Visser, op cit, 1996).

Some dealing is permitted at the Centre in an attempt to regulate the drug trade and protect users from exploitation. According to Reverend Visser:

> *Only three dealers, whom I have had screened by the police, are permitted to deal in the church, at certain times and on certain conditions: the quality of their drugs is tested, their prices must be reasonable; exploitation, and the use of violence is forbidden. Their customers have the opportunity to comment on the dealing in their weekly meetings* (Visser, ibid, p4).

Two of the three accredited dealers mentioned above are also users. The policy of regulation rather than prohibition of dealing was a major difference between Paulus Kerk and other injecting rooms visited by the Subcommittee.

3.1.2 INJECTING ROOM IN ARNHEM

In Arnhem, the Subcommittee met with Mr Max Daniel, Head of the Arnhem Police Department, Dr Ype Schat Head of General Health Care, and Dr Don Olthof, Director of the Stichting Gelders Centrum Voor Verslavingszorg.

The Stichting Gelders Centrum Voor Verslavingszorg in Arnhem, established as an initiative of the local government, is a Centre for drug users and has a room for injecting drug use. The project commenced as a pilot program in March 1996 and was conducted with the full participation of police and health workers. It is located next door to a methadone clinic, in a light industrial district that also contains the major prostitution area. The Centre opens from 9 am to 10 pm Monday to Friday, and from 2 pm to 10 pm on weekends. Labour costs restrict the Centre from opening longer hours on weekends.

Entry to the Centre is controlled by a worker stationed in a small office just inside the front door. Beyond this office is a large space which consists of an open sitting/recreation area with access to a cafeteria (10 metres by 8 metres) where coffee, tea, soft drinks, soup, bread and other food are available. This service is provided by staff.

There are two rooms provided for the use of drugs: one is for those who inject heroin and the other is for those who smoke crack/cocaine. The separation of those using the different substances is done because of the specific behavioural problems associated with cocaine use. Both rooms are located behind a counter where a staff member sits to regulate the flow of clients into the rooms. Both are quite spartan and small (2 metres

by 3 metres) with space for eight people at any one time in each room. In the door of each room is a 1 metre square window through which staff can observe clients.

Drug users must first apply to be approved to use these rooms. Screening for troublemakers is less formalised than in other centres, such as Rotterdam, but to prevent a ›honey pot= effect, access is limited to residents of Arnhem only. Once inside the facility, access to the injecting room is controlled by a booking system. Injecting in places other than the injecting rooms is forbidden.

The involvement of the police is crucial to the operation of the injecting room and the police use the Centre in the management of drug use in Arnhem. The facility provides the opportunity to gather information on drug use to assist the police in crime prevention. Police liaise with drug users in the Centre on a regular basis on matters relating to drug trafficking and crime. The Arnhem police have developed a different approach in the management of drug related offenders. A drug user is not charged for every offence. Instead, a point system is kept by police which accrues with each offence, eventually resulting in detention in prison or in a clinic. This initiative was approved by the Justice Department, and local police have clear instructions on the operation of the scheme.

3.1.3 THE DUTCH LEGAL POSITION

The rationale behind the drugs policy in the Netherlands is explained in a document prepared by the Dutch Ministry of Health, Welfare and Sport and provided to the Subcommittee. It states:

> *The main aim of the drugs policy in the Netherlands is to protect the health of individual users, the people around them and society as a whole. Priority is given to vulnerable groups, and to young people in particular. Policy also aims to restrict both the demand for and supply of drugs. Active policies on care and prevention are being pursued to reduce the demand for drugs, while a war is being waged on organised crime in an attempt to curb supplies. A third aim of policy is to tackle drug-related nuisance and to maintain public order. The Netherlands now has twenty years= experience of working with these policies on drugs* (*Drugs Policy in the Netherlands*, Ministry of Health, Welfare and Sport for the Netherlands, April 1997, p1).

The Dutch approach to the problems presented by illicit drugs is described in the literature as a policy of ›normalisation=. In effect this means attempting to contain and manage the consumption and abuse of illicit drugs rather than trying to eradicate them completely. In line with this ›normalisation= philosophy, although a number of drug related offences remain on the criminal statute books, the Dutch authorities refrain from arresting and prosecuting small-scale drug users, putting emphasis instead on ensuring that they maintain contact with appropriate welfare and medical facilities. Needle exchange and methadone programs are widespread and highly accessible, and information programs for young people have been prepared by government agencies.

Further detail on the legal position is provided in ›*Drugs Policy in the Netherlands*=:

> *Regulations on drugs are laid down in the Opium Act. The Act draws a distinction between hard drugs, (for example, heroin and cocaine), and soft drugs (for example, hashish and marijuana), on the ground that the former pose an unacceptable hazard to health, in comparison to the latter. The possession of drugs is an offence. However, the possession of a small quantity of soft drugs for personal use is a minor offence. Importing and exporting drugs are the most serious offences under the provisions of the Opium Act, although manufacturing, selling and attempting to import drugs are also offences. On the principle that everything should be done to stop drug users from entering the criminal underworld where they would be out of the reach of the institutions responsible for prevention and care, the use of drugs is not an offence.*
>
> *As is the case in many other countries, the expediency principle is applied in Dutch policy on investigations and prosecutions. This means that the public prosecutor may decide not to institute prosecution proceedings if it is in the public interest. The highest priority is given to the investigation and prosecution of international trafficking in drugs; the possession of small quantities of drugs for personal use is accorded a much lower priority. Anyone found in possession of less than 0.5 gms of hard drugs will generally not be prosecuted, though the police will confiscate the drugs and consult a care agency* (*Drugs Policy in the Netherlands*, ibid, p2).

3.2 SWITZERLAND

Switzerland has a population of approximately 7.5 million. The estimates of the number of regular hard drug users (that is, those who consume heroin and/or cocaine at least once a week) range from 26,000 to 36,000, depending on the method employed to calculate the figure. However, the most commonly cited figure is 30,000 addicted regular users since the beginning of the 1990s (Geense, op cit, p8).

›Low threshold‹ drug treatment programs were introduced in Switzerland in the late 1970s and injecting rooms have been available since 1986. There are now 13 legal injecting rooms in Switzerland in the three major cities of Basel, Berne and Zurich. In 1991 the federal government adopted a harm reduction approach to the illicit drug problem, which is said to have been due to four major factors:

> *Two of them concern public health issues: the AIDS epidemic (until recently Switzerland has had the highest number of AIDS cases per million population in Europe) and a growing prevalence of hepatitis, of sexually transmitted diseases and of tuberculosis among drug injectors. The two other factors concern issues of public order: highly visible open drug scenes in Swiss cities, especially Zurich and an increasing amount of drug-related delinquency* (Geense, ibid, p8).

Death related to drug use increased steadily in Switzerland between 1974 (13) and 1991 (419). Since 1993, however, this number has progressively decreased. In contrast, the number of AIDS-related deaths of injecting drug users continues to increase (5 people in 1985 to 292 in 1994). However, the incidence of HIV among

injecting drug users has started to decline. In 1990, 20% of the drug users tested were found to be HIV positive, whereas in 1994 the figure had gone down to between 10% and 15%. This decrease has been attributed to the marked decline of syringe sharing in the country. Only a minority (under 10%) still shares their syringes occasionally and mainly with their partner.

The following overall assessment has been made about the government sanctioned injecting rooms, funded either by government or non-government organisations, which have been operating in Switzerland since 1986:

- the typical injecting room is discreetly located within a larger Centre which includes a cafeteria, counselling room and clinic for primary medical care;

- the rooms where injecting occurs are small and quite sterile. They contain several tables at which clients sit to prepare and inject their drugs, and injecting paraphernalia such as needles and syringes, a candle, sterile water and spoons are placed at each position at the tables. Paper towels, cotton pads, bandaids and rubbish bins are available;

- clients generally stay in the injecting room about 15 to 20 minutes to inject with a maximum of 6 to 10 people present in the injecting room at any one time. Clients prepare their own drugs and staff are not permitted to help them inject;

- a staff member is present in the injecting room at all times, rotating hourly, as extended periods in the injecting room were considered to be too taxing. All staff are trained to resuscitate clients if they overdose with one staff member assigned prime responsibility on each shift. There are usually three or four staff on duty on each shift;

- doctors are employed on a sessional basis and visit the Centre for a few hours a week. Some centres have direct phone lines to police and ambulance services. If a client collapses, the worker in the injecting room calls another worker to assist. A small bottle of oxygen is taken to the client and administered via a face mask and simple resuscitation bag until the client regains consciousness. If the client is unable to resume normal breathing within 10 minutes, an ambulance is called. Naloxone (Narcan) is not used to revive clients in any centre in Switzerland;
- the main reasons given in 1995 by injecting drug users for attending injecting rooms were: to inject in peace (86%); and to obtain free injecting equipment (33%);

- there have been no deaths in any injecting room in Switzerland to date. Some workers believe that the number of deaths due to overdose in the community has decreased as a result of injecting rooms but it is difficult to prove this;

- some workers also believe they have made the injecting ritual less dangerous by moving clients from using 2 ml to 1 ml syringes. Injecting with smaller gauge needles causes less damage to veins and is less likely to transmit blood-borne infections);

- injecting rooms have been well tolerated in their communities with benefits

clearly outweighing costs (each centre costs about $300,000 per annum); and

- injecting rooms are now well established in Switzerland, but only seem to be needed in particular circumstances and in certain locations. There are no calls to establish more than the present number (K Dolan, ›The Swiss Experiment-, *Connexions*, December 1996/January 1997, p10).

In a further report on Swiss injecting rooms prepared for the NSW Health Department, the authors wrote that:

- all injecting rooms in Switzerland had medically trained staff; all injections on the premises were supervised by staff; all clients who have overdosed on the premises have been revived;

- staff were able to control the number of clients who entered the premises and the activities in the actual room where injecting takes place;

- all Centres were well patronised. Most Centres open for approximately seven hours a day and approximately 100 clients visit each centre every day. In some cities with a number of Centres, opening hours were staggered at the different facilities to maximise the number of hours per day that a safe injecting location would be available;

- all Centres provided free injecting equipment and advice on less hazardous methods of injecting;

- in addition to rules which are common in most drug related treatment settings such as no violence or drug dealing, there were specific rules for the injecting rooms. Clients must wash their hands on entering the injecting room and clean their own place at the table after injecting. Clients were not allowed to smoke in the injecting rooms. Breaking the rules resulted in clients being barred from the Centre for a few days or up to a few weeks depending on the nature of the infringement; and

- hundreds of thousands of injections have been supervised and thousands of abscesses treated annually (K Dolan and A Wodak, *Final Report on Injecting Rooms in Switzerland*, July 1996, unpublished report).

This report concluded that the main benefits of injecting rooms have been reduction of public nuisance and improvement of health in a very vulnerable group of injecting drug users with poor health (Dolan and Wodak, ibid, 1996).

The Subcommittee visited two injecting rooms in Switzerland, one in Basel and one in Berne.

3.2.1 INJECTING ROOM IN BASEL

In Basel, the Subcommittee met with Mr Voser, a Public Prosecutor and Mr Saaner a lawyer and Member of Parliament.

The population in Basel is approximately 171,600 and there are estimated to be 2,000 to 3,000 injecting drug users in Basel. Of these, about 700 are estimated to make use of the three injecting rooms that currently operate. These facilities are run by non-government organisations, although the Ministry of Justice pays 95% of the expenses of the three low threshold centres available. The Subcommittee visited the Spitalstrasse 36 injecting room, which was purpose built at a cost of 200,000 Swiss Francs in 1995. It has a total annual operating budget of 600,000 Swiss Francs.

The main area consists of an open sitting/recreation area which has access to a cafeteria area where coffee, tea, soft drinks, soup, bread and other food are available. This service is provided by clients and staff. There is only one room for users to inject drugs, and those who smoke drugs are no longer allowed to use the facility. Spitalstrasse 36 is open 7 days a week, with the actual injecting room open four hours a day: Sunday to Tuesday 5 pm to 9 pm; and Wednesday to Friday 11 am to 3 pm.

A queuing system is used to control entry into the actual injecting room which has 10 places for drug users. Most clients are prepared to wait, and waiting time is usually between 5 and 30 minutes to gain entry to the room. Injections are undertaken in hygienic surroundings and staff are in attendance on a rotating schedule of 15 minutes each. The majority of users complete their injection within 10 minutes but can stay longer if necessary. Staff do not assist with injections but users are permitted to help each other. There are more than 100 injections per day, and over 1,500 needles and syringes distributed each day. Since the injecting rooms have been established, workers in the injecting rooms believe fatal overdoses have decreased. In 1996 there were 142 resuscitations in the three injecting rooms.

Although the official rule is that only Swiss residents are permitted, some flexibility is permitted depending on availability and drug users do not require passes to access the facility. Staff exercise informal controls such as initial questioning of the person seeking access to the facility and using information obtained from existing clients. House rules are in place, and access can be denied for up to one week for breaches of the rules. One quarter of the clients are women and on Saturdays only women are admitted with services at this time being provided by a female lawyer, a female gynaecologist and a female priest.

The Centre also provides on site medical care to all drug users including psychiatric and STD services, with trained medical officers attending the Centre for this purpose. Information relating to safe sexual practices is made available and approximately 80 condoms a day are distributed.

Spitalstrasse 36 has a total of seven staff members, three of whom are relief staff. There is a minimum of three staff members on each shift. Staff work one hour before and after the opening times in order to discuss operational matters. All staff members do the same work and receive the same remuneration. Phone lines, staffed by former and current users, operate at the injecting room for community members to request the removal of discarded syringes found in public areas. Approximately 70 kg of needles and syringes returned to the Basel injecting room are burned each month. It is generally agreed that the public disposal of needles and syringes has decreased since injecting rooms started.

To assist in the smooth running of the facilities, the community is regularly consulted

and there are periodic open days for those in the neighbourhood to visit the Centre, to see the work undertaken and to express any concerns they may have. It would appear that as the local community becomes used to the Centre, curiosity and concern diminishes and the open days become less heavily patronised. In Basel there are two parent groups which support these injecting rooms.

Police enter the injecting room only if they believe a wanted criminal is on the premises or when called by staff. Users are banned temporarily if caught injecting just outside the Centre.

3.2.2 INJECTING ROOM IN BERNE

In Berne, the Subcommittee met with a number of people including Mr Christian Buschan, Forensic Expert from the Swiss Federal Office of Justice and Police and Dr Margaret Rihs-Middel, Head of Research in the Swiss Federal Office of Public Health.

The Centre visited in Berne is located in a basement in a street behind the main square. It has a sitting/recreation area with access to a cafeteria where coffee, tea, soft drinks, soup, bread and other food are available. This service is provided by clients and staff. Clients receive a small payment for cooking one night a week for 20 to 25 people, and the meals are provided at a minimal cost to the clients. This activity is designed to increase personal responsibility and improve self esteem. While all injecting rooms visited by the Subcommittee provide toilet facilities for clients, the Berne injecting room also has shower and laundry facilities available.

The Centre is run by a non-profit organisation and has an annual budget of 1,200,000 Swiss Francs per year. There are 9.7 full-time staff members plus an additional 1.8 staff employed specifically for the needle and syringe exchange program.

The injecting room is for the use of injecting drug users only and the smoking of drugs is not allowed. It contains three tables with a total of 12 places for drug users to sit. On the tables are needles and syringes, ascorbic acid, a cotton wool dispenser, a small sharps bins, alcohol swabs and filters. The Centre provides the first syringe free and sells additional syringes at a modest price. The Centre distributes about 15,000 needles and syringes per month. Injections are undertaken in hygienic surroundings and staff are in attendance on a rotating schedule of 15 minutes each. Staff do not assist with injections but users are permitted to help each other. Trained medical officers visit the Centre regularly to provide on-site medical care, and a room has been set aside as a ›clinic‹ to facilitate this.

As in Basel, no passes are required by those using the injecting room, but staff are aware of user behaviour and maintain strict controls. Access can be denied for up to one week for breaches of the rules. On Mondays only women are allowed in the Centre.

3.2.3 THE SWISS LEGAL POSITION

The principal Act is the 1951 Federal Law on Narcotic Drugs, as amended in 1975, which has as its main focus supply reduction. The way in which this law is applied across Switzerland differs considerably throughout the federation, as the cantons

(States) are responsible for the day to day application of the federal laws. This explains, in addition to any cultural differences between the Swiss-German speaking part of Switzerland and the French and the Italian speaking part, the widely divergent drug policies of Switzerland. As Mr Buschan pointed out to the Subcommittee in their meeting on 27 August 1997:

> *We are not a centralised community. We have 26 cantons and they are very independent. Even if the written law for everybody (sic), if you read it and travel through Switzerland, just through a few cantons, you will see extremely different kinds of dealings with and handling the law. ... We don=t have a central power, by the Federal Government to force these 26 cantons to do what we think would be the best* (Buschan, Briefing 27 August 1997).

Since 1975, any use of illicit drugs has been forbidden, although it is classified as only a minor offence. However as Swiss law works on the principle of legality and not of opportunity, this means that if the police know where illicit drugs are regularly being used they have to react and prosecute those involved. Bearing this requirement in mind, a panel of judges and prosecutors was convened to examine whether there was scope under the federal narcotics law for safe injecting rooms to be provided without the need for police to arrest and charge those using the facilities. The solution was found in Article 19a which provides:

(1) *Anyone who, illegally and intentionally, consumes narcotics or who commits a violation of section 19 in order to consume them, is liable to be arrested or fined*

(2) In less serious cases, the competent authority may suspend the sentence or decide not to impose a penalty. A reprimand may be given

(3) Criminal proceedings need not be pursued where the person who has committed the offence is already as a result of having consumed narcotics, undergoing treatment under the care of a doctor, or where he or she agrees to do so. Criminal proceedings will be commenced if he or she withdraws from treatment

(4) Where the person who has committed the offence is dependent on narcotic drugs, the judge may order him or her to be sent to a treatment centre. Section 44 of the Swiss penal code is applicable to such a case

According to the panel of judges and prosecutors if the service provided by the injecting room facility was categorised as a ›medical treatment‹, it would be possible for the police not to intervene and criminal proceedings would not need to be brought. This view has been endorsed by Dr Schultz, a Professor in Law at the University of Berne in March 1989 and consequently the provision of such services is not seen as inconsistent with the requirements of the federal narcotics law.

More detailed explanation of the Swiss legal position can be learnt from a document entitled *Swiss Drug Policy* prepared by the Swiss Federal Office of Public Health and provided to the Committee. In summary it states: the 1951 federal law on narcotics constitutes the legal basis for combatting illicit drug use in Switzerland. This law regulates medical use of narcotics and prohibits the production, trafficking, possession and consumption of drugs for non-medical

purposes. The use of opium, heroin, hallucinogens and cannabis is, in principle, prohibited. These substances may only be used for scientific research and for limited medical purposes, and even then, a special authorisation from the Swiss Federal Office of Public Health is required for all substances and for all purposes. The implementation of this law, in accordance with the Swiss constitutional principle of federalism, lies primarily with the 26 Cantons (States). The States are responsible for law enforcement (police, courts, prisons), prevention, and the care and treatment of drug addicts. It would appear that injecting rooms are seen as an appropriate measure for the ›care and treatment of drug addicts=.

Except for the control of legal narcotic use, the jurisdiction of the Federal Government is limited to support and co-ordination of activities, mainly in the areas of research, evaluation, training and continuous education of professionals. In 1991 the Federal Government decided to intensify its commitment considerably in relation to reducing drug related problems by pursuing a policy comprising four strategic elements: (i) prevention; (ii) therapy; (iii) harm reduction; and (iv) law enforcement. In relation to the harm reduction aspect the document supplied by the Federal Office of Public Health states:

> *Drug addiction represents for the majority of the people concerned a limited period of several years in their lives. Measures intended to limit harm aim at protecting the health of addicts during the addiction period as much as possible. Drug addicts are at great risk of being infected with HIV and hepatitis ... The Federal Government therefore supports a variety of measures (for example, needle exchange programmes, housing and employment programmes) to improve health and lifestyle of drug addicts and to prevent the spread of HIV and other infectious diseases. Compared with the late 1980s, HIV prevalence among drug addicts has decreased* (Swiss Federal Office of Public Health, *Swiss Drug Policy*, 1997).

3.3 GERMANY

The open drug scene in Frankfurt changed from the behaviour of the late 1960s, when small groups used to smoke cannabis in the public parks, to the public injecting of drugs in the 1980s and 1990s. The focus of the open drug scene was in a small public park located in the Frankfurt banking and business district. By 1991, it was estimated that at any time of the day up to 1,000 were consuming and dealing drugs and that 5,000 to 6,000 people (approximately 66% were non-Frankfurt residents) frequented the park daily to buy drugs. Approximately 20 ambulances were called to the park each day to deal with cases of overdose.

Concern expressed by the business and local communities led to ›a clean up= response by the local government in 1988. A drug policy co-ordination office was established and a working party, ›the Monday Group=, was founded. This working party is made up of all interest groups involved in the drug problem and includes police, politicians, state attorneys, representatives of the health department, the drug policy division, and drug workers and meets each week to discuss ways in which the drug problem can be managed. These meetings are chaired by a City Council member and are supported by all party representation. A new harm reduction approach to curtail the open drug scene and to address problems such as the rising mortality rates and the spread of HIV among injecting drug users was adopted and ›low threshold= services introduced. These services included the provision of crisis centres, day and night care, free food, medical

help, needle and syringe exchange programs, methadone and facilities for street people to bathe and wash their clothes. In 1994/95 four injecting rooms were established. Three rooms were located in the main station area, and the other in a Centre known as ›Eastside= on the city outskirts in Schielestrasse.

In 1992 German financial institutions donated over $700,000 to the city to clean up the needle park area and these financial institutions continue to provide $70,000-$140,000 per annum to support drug treatment programs.

The following results have been attributed to the implementation of the harm reduction strategy since 1988:

- illegal trafficking and smuggling of heroin decreased to less than 30% of that of the previous years;
- drug-related crime was reduced;
- the number of legal proceedings involving drug users declined. In 1996 it fell about 20% compared to the previous year;
- the low threshold services have contact with over 1,500 addicts daily;
- about 8,000 syringes are exchanged daily;
- autopsy reports describe less HIV infections among cases of drug addicts; and
- deaths by overdose fell from 147 in 1991 to 31 in 1996 (M Nickolai, ›Evolution of Frankfurt=s approach to the drug problem=, *Euro-Meth Work Newsletter*, No 12, August 1997, pp3-4).

Frankfurt has a population of approximately 650,000. There are 4,500 registered addicts in Frankfurt. The Subcommittee was told that approximately 10,000 additional drug users come to the city for their drug supply. The average age of injecting drug users in Frankfurt is 30 years. A register of drug users is kept by the police when users are arrested with details on name, age, address and drug use. While the information remains confidential to police and the public prosecutor, statistical data can be provided to research institutions and government policy agencies.

It costs approximately $1.8 million per year to run the four injecting rooms. There are also eight Contact Cafes (coffee shops where drug workers engage drug users in conversation without the users necessarily seeking help, some of which offer a medical service), nine methadone units and eight HIV prevention units in Frankfurt. In order to enter an injecting room in Frankfurt, a drug user has to be at least 18 years old. Older users who have often missed a substantial part of their schooling, are encouraged to attend special schools specifically set up for them. Methadone clients are not allowed in the injecting rooms. No deaths have been recorded in any injecting room.

An injecting room was established in Hanover in November 1997 and a number of other German cities have plans to introduce similar facilities in the near future.

3.3.1 INJECTING ROOM IN FRANKFURT

In Frankfurt, the Subcommittee met with Mr Frerichs, Vice-President of Police, Dr Körner, the Chief Public Prosecutor from the Public Prosecutor=s Office and Professor Happel, the Co-ordinator of the Schielestrasse Centre.

The ›Eastside= Centre on Schielestrasse has been converted by the local government from a factory into a multi-purpose Centre for drug users. Initially, the Centre provided only overnight accommodation for homeless drug users. However, over time the services of the Centre have become more numerous and more varied, and it comprises: a methadone clinic, accommodation for 70 people, a cafe, a workshop, a laundry, a doctor=s surgery and an injecting room, which commenced operation in December 1994. The need for a more expansive approach was commented on in the 1995 Annual Report of the organisation which runs the Eastside Centre:

> *We have attached great importance to maintaining the low threshold character of the facility. The point is to act responsibly towards homeless drug addicts while remaining, however, in a position to offer important services, particularly in the fields of job training and employment. To provide these services requires a certain degree of stability on the part of clients* (*1995 Annual Report,* integrative drogenhilfe e.V. a. d. FH FfM, p35).

The Centre is open to users for the purpose of safe injecting, daily from 2pm to 9pm. Those people wishing to use the room must be 18 years and over, and declare in writing a willingness to accept the rules and regulations of the Centre. In particular, users must not be involved with the trading and distribution of drugs.

This agreement states:

> *I hereby assure the above named premises used for IV drug use that I will follow the directions of its personnel and will obey the house rules. In particular, I confirm that I am over 18 years old, and that I am not in any substitution program at the moment. I understand that the drugs I carry with me are for my own use only, and that the buying and selling of drugs to others is not allowed. In cases of doubt, staff present are entitled to check my registration card*.

The Centre provides users with the necessary injecting paraphernalia including clean injecting equipment, water, ascorbic acid, alcohol and dry swabs, filters and ligature material. First aid is provided for emergencies as well as for other health problems. Of the 13,633 events of drug consumption registered in 1995, there were 49 emergency cases. This was 1 emergency case per 278 clients (*1995 Annual Report,* integrative drogenhilfe e.V. a. d. FH FfM, p42).

In the initial stages, use of the Centre was limited due to its location on the outskirts of the city. However, once the Centre became known, and a shuttle service commenced operation between the centre of the city and the Eastside Centre, the number of users frequenting the facility increased. Now the Centre is used approximately 650 times a day.

Since the Centre opened in 1992, Professor Happel has noted that:

- the average age of clients is 30 years;
- 80% of clients are male;
- the average period of drug use is 9 years;
- 600 users have entered methadone treatment;
- 1,200 people have stayed more than 3 days;
- 95% of residents have hepatitis C, and 25 % have HIV infection;
- 200 users have been placed in permanent housing; and
- there has been a 90% reduction in crime committed by residents.

3.3.2 THE GERMAN LEGAL POSITION

The position in Germany is similar to that which exists in Switzerland, namely although there is a federal drug law, the day to day application is left to the individual Länder (States) which explains on the one hand, seeming discrepancies between the federal and state interpretations of the law, and on the other, the divergent approach taken across the country. In the case of drug laws, the approach taken in Frankfurt is significantly different to other German cities. Dr Körner, the Chief Public Prosecutor of Frankfurt, told the Subcommittee that ›the Frankfurt policy is a two track policy based on the ›repression‹ of drug use together with a ›drug aid system‹ of low threshold services for drug users (Körner, Briefing 1 September 1997) and Mr Frerichs, the Vice-President of Police told the Subcommittee changes to drug policy to focus on both abstinence and harm reduction measures were a response to an increasingly unmanageable open drug scene (Frerichs, Briefing 1 September 1997).

The legality of injecting room facilities in Frankfurt was discussed in a legal opinion written by Dr Körner, which was provided to the Subcommittee (Report on the Admissibility of Health Care Centres for Hygienic and Stress-free Consumption by Opiate Addicts, Frankfurt, 1996). Based on this document, the position in Germany can be described as follows: Although there are provisions in the Narcotics Act which would seem to clearly prevent the running of legal injecting rooms, the sections are interpreted in such a way as to accommodate such facilities in keeping with harm reduction principles and public health measures, which are expressly recognised. Injecting rooms form part of what are referred to as ›health care centres‹.

Article 29(10) of the Federal Narcotics Act makes it an offence to:

- provide information concerning unauthorised use or acquisition of narcotic drugs;
- provide unauthorised narcotic drugs, either publicly or in self-interest; or
- provide third parties with such an opportunity or concede or incite such persons to unauthorised use of narcotic drugs. (However, the provision of sterile disposable syringes for drug addicts is not to be understood as provision of opportunity for use.)

Article 29(12) makes it an offence to

- incite others to use narcotic drugs, which have not been prescribed in the permitted manner.

The penalty for those found guilty of committing either of these offences is imprisonment of up to five years or a fine - Article 29(1).

According to Dr Körner, the section exempting the provision of syringes from the offence provision is not only a clarification of the position by the legislature, but it also emphasises the socio-political aspect rather than the criminal-political aspect and indicates the necessity of interpreting the facts of this criminal offence restrictively. When it is interpreted according to the wording as well as to the sense and purpose, the provision of **opportunity** is seen as requiring more than the provision of a **possibility**. The distinction turns on the degree of active involvement: opportunity means making

available conditions over and above what may have been possible. In other words, if a drug user has drugs and is going to use them, making available the facilities of an injecting room is not seen as providing that person with an opportunity to do something he or she otherwise wouldn=t do. By contrast, if a person was to go to an injecting room and be provided with drugs by staff or other users, this would be providing an opportunity and would clearly be a breach of the Narcotics Act. The rationale behind this interpretation is that the injecting rooms do not extend the circle of individuals participating in the consumption of drugs, they merely provide for behaviour which would occur in any event, to be conducted in a less harmful situation.

In relation to the various international treaties the following comments are made:

- The 1961 Single Convention on Narcotic Drugs: Under Article 36 1(b), the Federal Republic of Germany is not obliged to take measures to prevent the undesirable consumption of drugs. The matter is left to the contracting states to decide whether they punish or introduce therapy instead of punishment. Health care centres as welfare measures do not violate the 1961 Convention

- The 1971 Convention on Psychotropic Substances: Under Article 5 (3), a ban on any kind of possession of narcotic drug is described as desirable. Nevertheless, neither the 1971 nor the 1961 convention require that consumption or support for consumption are made criminal acts. Thus health care centres also do not violate the 1971 Convention

- The 1988 Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances: This Convention has not yet been ratified by Germany. Under Article 3(2) the contracting states now, however, accept the obligation to make the intentional, forbidden consumption of narcotic drugs liable to punishment, subject to the compliance with constitutional principles. However, according to Articles 4(c) and (d), educational and welfare measures are to have priority over punishment. Thus health care centres as welfare measures in the sense of survival aid are also not liable to prosecution according to the 1988 Convention.

The conclusion reached in Dr Körner=s legal advice is that:

> *The establishment and maintenance of health care centres do not violate: (a) the Narcotics Act; (b) the Code of Criminal Law; nor (c) the International Conventions; insofar as acquisition, dealing, and passing on within these rooms is not tolerated and effort is made to ensure care, control and supervision of hygienic, stress free and risk reduced consumption.*

3.4 Summary

This Chapter contains details of a number of overseas injecting rooms visited by the Subcommittee to gain a first hand impression of how these facilities were run. These centres were located in Rotterdam and Arnhem, the Netherlands; in Berne and in Basel, Switzerland; and in Frankfurt, Germany.

The overseas experience of injecting rooms provided the Committee with important data on the possible costs and benefits of legal injecting rooms, as well as the problems encountered in establishing and operating them. While the philosophies of the injecting rooms varied in the detail, the commonality in approaching the injecting drug problem from a harm reduction perspective was evident in all the European centres visited. The Committee is cognisant of the fact that the establishment of injecting rooms in particular cities in the Netherlands, Switzerland and Germany, needs to be viewed in terms of their specific cultural and legal context, and that this feature needs to be taken into account when considering whether such facilities would translate to an Australian setting.

Some members of the Committee hold a dissenting view which is appended to the Report.

CHAPTER FOUR

ARGUMENTS FOR AND AGAINST THE ESTABLISHMENT OR TRIAL OF INJECTING ROOMS

4.1 INTRODUCTION

In this Chapter of the Report the range of arguments for and against the establishment or trial of safe injecting rooms is presented. A useful starting point for analysing the various arguments is reflected in the following statement of principle from the 1972 Canadian Le Dain Commission which examined the non-medical use of drugs:

> *The criminal law may properly be applied, as a matter of principle, to restrict the availability of harmful substances, to prevent persons from causing harm to himself or to others by the use of such substances and to prevent the harm caused to society by such use. In every case the test must be a practical one: we must weigh the potential for harm, individual and social, of the conduct in question against the harm, individual and social, which is caused by the application of the criminal law, and ask ourselves whether, on balance, the intervention is justified. Put another way, the use of the criminal law in any particular case should be justified on an evaluation and weighing of its benefits and costs.* (Canadian Commission of Inquiry into the Non-Medical Use of Drugs, *Cannabis, A Report of the Commission of Inquiry into the Non-Medical Use of Drugs* (the Le Dain Report), Ottawa, Canada, 1972.)

In this statement the major concerns related to the problem of illicit drug use are identified, namely the concepts of self-harm, harm to others, social harm and the role of the criminal law. Many issues are raised in this Chapter, and for the purpose of analysis are dealt with under the four broad headings of health implications, social implications, economic implications and legal implications. It is recognised that a number of issues are capable of appearing under more than one heading.

From the outset it needs to be acknowledged that although there have been attempts to consolidate available information about the various harms associated with drug use, any overall assessment of whether harms are greater than benefits is constrained by the following factors:

- There is an absence of relevant empirical evidence of many of the harms that are at least quantifiable in principle;
- Many of the quantifiable harms cannot be easily translated into monetary terms;
- Many of the harms are inherently intangible and subjective; and
- It is easier to perceive the presence of harms than their absence; in other words, policy may be blamed for harms that it allows or creates, but gets no credit for harms it reduces or prevents (R MacCoun, P Reuter and T Schelling, ›Assessing Alternative Drug Control Regimes=, *Journal of Policy Analysis and Management*, Vol 15 No 3, 1996, pp330-352).

Some overall estimates of the economic and social costs of illicit drug use in Australia have, however, been made:

- In its 1989 report *Drugs, Crime and Society*, the Parliamentary Joint Committee on the National Crime Authority estimated law enforcement costs associated with illicit drug use at $123.2 million in 1987-1988. This included costs of the Australian Federal Police, the National Crime Authority, the Australian Customs Service, State police services, prisons and the courts.

- In its 1995 report, the United Nations Economic and Social Council wrote that: the costs of licit and illicit drug misuse in Australia were estimated to be equivalent to 4.6% of gross domestic product (GDP) in 1992 (approximately $17,769 million). Of this, illicit drug misuse was estimated to account for 0.5% of GDP (approximately $1,900 million). The largest part of this involved drug-related crime and law enforcement.

  It was further stated in the Report that the health costs of a drug-dependent person are estimated to be some 80% higher than those of the average citizen in the same age-group. Special concerns arise because drug use occurs most frequently in the 15-35 age group that includes young people entering or about to enter the workforce. Given current unemployment rates, entry into the workforce is a major problem. Abuse of illicit drugs reduces chances to enter or remain in the workforce, while frustration from failure to find employment favours drug consumption and creates a vicious circle.

  The social costs of drug misuse are less easily quantified, however, their impacts may be more insidious. Social integration and cohesion (at the family, community and even broader levels), are almost always compromised by an escalating drug problem. The lifestyle associated with that misuse can contribute significantly to destructive anti-social behaviour, violence and child abuse, loss of employment, financial hardship, dependency and social marginalisation (United Nations Economic and Social Council, *Economic and Social Consequences of Drug Abuse and Illicit Trafficking: An Interim Report*, March 1995 - referred to in the Penington Report at p8).

- In 1996 the National Drug Strategy published a report, *The Social Costs of Drug Abuse in Australia in 1988 and 1992*, in which the authors estimate that the tangible economic costs of illicit drug abuse (in 1988 prices) for 1988 were $908.4 million and for 1992, $1,119.7 million - an increase of 23.3%. These costs do not include ambulance services, welfare, absenteeism or crime, as the authors regard such matters as unquantifiable. About one-third of the tangible economic costs (approximately $300 million in 1988 and $370 million in 1992) were law enforcement costs. The balance of quantifiable costs were net production costs and health care costs. Production costs are the costs to production that flow from drug-related death and illness adjusted for such things as consumption resources made available to the community through premature deaths. Health care costs include the costs of medical services, hospital and nursing home beds adjusted for the savings that result from death and illness due to illicit drug use (DJ Collins and HM Lapsley, *The Social Costs of Drug Abuse in Australia in 1988 and 1992*, National Drug Strategy Monograph No 30, AGPS, Canberra, 1996).

In an earlier publication Collins and Lapsley made the following points in relation to costing in this area:

The quantification of abuse costs relies upon the prior quantification of the causal relationships between drug consumption and mortality and morbidity. If the causal relationships can be identified and quantified, the costs of drug abuse can almost always be estimated (although with varying degrees of accuracy).

The authors then provide further detail:

Major gaps still exist in relation to the causal links between drug consumption and other non-health problems. The major areas of ignorance are the relationships between:

- *all drugs and absenteeism;*
- *all drugs and on-the-job productivity;*
- *alcohol, illicit drugs and crime;*
- *all drugs and welfare expenditures; and*
- *all drugs and ambulance usage.*

Anecdotal evidence would indicate that the effects of drug consumption on absenteeism and workplace productivity are substantial but quantification of these costs does not currently appear possible. A similar conclusion must be drawn about the relationships between alcohol, illicit drugs and crime.

Certain significant government expenditures proved impossible to estimate, probably the most important being welfare expenditure ... Social welfare data in Australia are not collected in sufficient detail to indicate the proportion of payments attributable, directly or indirectly, to drug consumption ...

In the present state of information in Australia the proportion of ambulance services attributable to drug use appears impossible to estimate, let alone the types and intensity of utilisation (and so the costs).

The major categories of costs which appear to be significant, but for which comprehensive data are not available, relate to those referred to above:

- *absenteeism (all three drugs - tobacco, alcohol and illicit drugs);*
- *on-the-job productivity losses (all three drugs)*
- *welfare expenditures (all three drugs)*
- *ambulance usage (all three drugs), and*

- *crime (alcohol and illicits)* (DJ Collins and HM Lapsley, ›The Dismal Science and the National Drug Strategy: The Contribution of Economics to Drugs Policy Development‹, *The National Drug Strategy: The First 10 years and Beyond*‹, NDARC Monograph No 27, November 1995, pp34-43).

In the course of the Inquiry the Committee asked Professor Collins whether any more precise information could be provided. Professor Collins advised that given the short time frame of the Inquiry and the absence of established injecting rooms in New South Wales, it was not possible to give an assessment of the economic factors which would determine the benefits or costs of such a service.

Due to the gaps in, and limitations of, the available data, an accurate cost benefit analysis of injecting rooms cannot be provided. The tangible and intangible costs identified with the more general problem of drug abuse do, however, give some indication. Broadly speaking costs include:

(i) Health care costs, including:

- medical services: provided either as a direct result of drug abuse or for a condition other than drug abuse, but where the consultation or treatment is prolonged, more intensive or more complex because of a drug-related condition;

- prescription drugs provided: either for a condition caused by drug abuse, or for a condition other than drug abuse but where the drug abuse makes the drug less effective or necessitates a more extensive or complex drug regimen;

- hospitals: where hospital bed days are used for incidents where the specific reason for admission was due to drug abuse or where additional hospital bed days or extended length of stay are required because of the existence of drug abuse;

- other institutions such as nursing homes and hospices: where admissions are caused by drug abuse, or where drug abuse has resulted in the condition being more severe, requiring more intensive treatment, or in the case of nursing homes, causing greater dependency;

- allied health costs: the use of allied health professionals such as physiotherapists, podiatrists and dietitians for conditions which have been caused or exacerbated by drug abuse; and

- community health services: particularly but not exclusively mental health services provided to persons with a primary or secondary diagnosis of drug abuse or as the result of the drug abuse of others.

(ii) Economic costs including:

- Absenteeism and loss of productivity;

- Costs borne by the state of welfare payments such as invalid pensions; carers

pension, sickness benefits, sole parents benefits and special benefits.

(iii) Drug-related crime which has a social and economic cost, both directly through crime committed to finance a drug habit and indirectly through the police, judicial, penal, customs and immigration costs associated with law enforcement in relation to illicit drugs;

(iv) Drug-related accidents;

(v) Associated drug costs such as money spent on research and education and prevention campaigns;

(vi) Intangible costs such as the value of loss of life; consumption foregone by the deceased; pain and suffering of someone who is sick as a result of abusing illicit drugs including the reduced quality of life; and suffering imposed on others.

Benefits would be gained by avoiding some or all of the above costs.

The following information provided to the Committee by the NSW Health Department does, however, give an indication of the potential cost effectiveness of legally run injecting rooms:

> *It is envisaged that safe injecting facilities would be beneficial for a number of reasons including:*
>
> - *savings to the community through reduced and avoided HIV/AIDS treatment costs;*
> - *savings with respect to reduction in costs incurred by local councils for the management, collection and disposal of injecting paraphernalia;*
> - *savings with respect to the reduced incidence and management of overdose, both fatal and non-fatal;*
> - *the provision of such facilities in controlled clinical settings would also provide the opportunity for early interventions in the management of a range of other, sometimes costly, medical problems associated with unsafe injecting practices, such as hepatitis C, septicaemia and infective endocarditis and other medical problems such as abscessing, sexually transmitted diseases (STDs) and psychological/psychiatric disorders; and*
> - *the provision of such facilities would also enable other forms of intervention such as referral to drug and alcohol and social welfare services, thus possibly impacting on costs associated with crime associated with drug addiction.*
>
> *Any estimation of cost effectiveness associated with the operation of safe injecting facilities currently remains largely speculative, based on anecdotal information. Because no such facilities currently operate in NSW, no context is able to be provided from within which relevant data*

> *may be collected and analysed, and against which such cost effectiveness may be measured with any reasonable accuracy. Where such facilities have been in operation for some time, such as in Zurich, Basel and Berne, there is a consensus that many overdose deaths have been prevented; nuisance to local communities has reduced significantly, and low HIV transmission rates have been maintained. Given a longer time period in which to conduct a scientific trial, however, it is likely that the NSW Health Department could estimate the cost effectiveness of safe injecting rooms* (Letter from Mr O=Donoughue, Director AIDS/Infectious Diseases Unit, NSW Department of Health, 3 December 1997).

- In its October 1997 publication, *Short Term Forecasts*, the private sector analyst Access Economics, estimated that approximately $7 billion a year (or 1.4% of total Australian spending) is spent in Australia on illegal drugs. This figure is in line with international estimates of the illegal drug trade. By comparison, in 1997/97 private consumption expenditure on alcoholic drinks totalled $13.2 billion and expenditure on cigarettes and tobacco equalled $6.2 billion. Expenditure on medical drugs is estimated to have totalled $4.2 billion in 1994/95. Cannabis accounts for 70% of the spending on illicit drugs. The conclusion reached is that:

  > *The illegal drugs industry in Australia is a major industry, equivalent in size to the oil industry and larger than the tobacco industry. It generates substantial costs for society, while generating no government revenue. Prohibition appears to have failed to prevent its growth and involves substantial costs. Whether regulated use or complete legalisation of soft drugs would be more successful remains a matter of debate* (*Short Term Forecasts*, Access Economics, October 1997, pp14-18 at p18).

Safe injecting rooms may be part of the solution to the health, social and economic cost of the drug problem, and as such the implications of the establishment or trial of such a facility need to be fully examined.

HEALTH IMPLICATIONS

4.2 HEALTH IMPLICATIONS: ARGUMENTS FOR

There are a number of areas where injecting rooms may result in health benefits both to the injecting drug user and to the wider community. Possible benefits for the injecting drug user include: improvements in general health; prevention of blood-borne viral infections; facilitated entry to drug treatment programs and, if successful, the associated health benefits from reduction or cessation of injecting. A major benefit for the wider community is the reduced risk of contracting a number of transmissible diseases such as hepatitis B, hepatitis C or HIV.

There is little doubt that overdose deaths from illicit drugs are a substantial public health problem, and the figures indicate that overdose deaths are increasing. Any prevention measure which has the potential to reduce overdose deaths has to be seriously considered.

The support of health organisations for injecting rooms can be summed up in the stated position of the peak, national non-government organisation representing the interests of the Australian alcohol and other drugs field, the Alcohol and other Drugs Council of Australia (ADCA):

> *Safe injecting facilities clearly offer significant potential to reduce harm amongst injecting drug users. The improvement in the health of injecting drug users and the reduction in public nuisance through the provision of safe injecting facilities has been demonstrated by trials overseas. Australia cannot afford to disregard such evidence when lives are at stake. There is a substantial level of informed support for safe injecting facilities. ADCA supports a trial of safe injecting facilities being conducted in Australia* (ADCA, Correspondence to the Committee, November 1997).

4.2.1 INJECTING ROOMS MAY REDUCE THE NUMBER OF OVERDOSE FATALITIES

As was explained in the Penington Report, in its pure form heroin is relatively non-toxic to the body and causes little damage to body tissue and other organs. It is, however, highly addictive and depending on the dose can arrest breathing. Street heroin is usually a mixture of pure heroin and other substances known as cutting agents such as talcum powder, baking powder, starch, glucose or quinine. These additives can be highly toxic and can cause chronic health problems. Their presence also contributes to accidental overdose and death as a result of users being unaware of the level of purity of heroin they are using (the Penington Report, op cit, p6).

Dr Darke from the National Drug and Alcohol Research Centre described the fatal overdose process to the Committee:

> *The person becomes unconscious. The effect of the heroin and alcohol on the brain is to reduce breathing, which is what kills them. Gradually breathing becomes more shallow - four breaths per minute, this sort of thing - and eventually the brain forgets to tell the body to breathe. The*

> *relevant signals that there is a build up of carbon dioxide are not sent, and the person needs to breathe. The suppression of those signals is what kills people. That can take several hours* (Darke, Evidence 30 September 1997).

The Committee was presented with much evidence on fatal and non-fatal drug overdoses.

- Dr Darke gave evidence to the Committee concerning the trends in overdose deaths in Australia:

> *Unfortunately, the trend has been continuously upward. Beyond the actual increase in population, a broader perspective from 1979 through to 1995 in this country shows a seven-fold increase in the rate of heroin-related fatalities. The ages for heroin overdose have increased over the years. Basically we are talking about long-term users who are about 30 years of age, predominantly male, that is, 80% to 90% - which has continued throughout - and who are rarely in drug treatment. If I had to describe a person who is dying from heroin overdose it would be basically a 30-year-old male who is not in treatment. In fact, the majority who have overdosed on heroin have never been in any treatment, so we are talking about a group of people who have not been reached by treatment* (Darke, Evidence 30 September 1997).

- There has been a dramatic increase in heroin-related overdose deaths in New South Wales in recent years. According to the Alcohol and Other Drugs Council of Australia, the number of fatal overdoses in New South Wales has risen from 124 in 1994; to 281 in 1995 and reaching 321 in 1996 (D Crosbie, op cit, p3).
- A recent National Drug and Alcohol Research Centre study found that between 1992 and 1995, heroin-related deaths in the south-west Sydney increased from 20 to 44, an increase of 120%. In 1992, 6 deaths (30%) occurred in a public place, compared with 31 deaths (71%) which occurred in a public place in 1995. According to the authors of the study this situation represents a highly significant departure from the rest of NSW where a majority of overdose fatalities occur at home. It is clear from this study that in south-west Sydney, public injecting is strongly linked to a significant risk of fatal overdoses (W Hall and S Darke, *Trends in Opiate Overdose Deaths in Australia 1979-1995*, NDARC Technical Report No 49, 1997).

- Professor Kaldor provided the Committee with the following estimate of preventable overdose deaths in New South Wales:

> *Although there is no definitive study that would allow accurate estimation of the number of overdose deaths preventable by supervised legal injecting rooms, several sources can be used to provide approximate estimates.*
> ***(1) State overdose death rates**: There is around one death per day from overdose in New South Wales (ADCA, 1997) among an estimated 60,000 people who inject drugs (NSW Department of Health, 1996). If these people inject once per day (Loxley et al.,*

1995), the death rate is approximately 1 in every 60,000 injections. Under the assumption that these deaths all took place in situations where medical attention could not be provided promptly, one death could be prevented per 60,000 injections in a supervised injecting room. An injecting room with 600 injections per day would prevent one death every 100 days.

***(2) Kings Cross illegal injecting room report**: Information from an illegal injecting room operating in Kings Cross indicates that there are 60 injecting clients per day who inject about twice a day, and that the ambulance is called for resuscitations three times a week or about 150 times per year. On average, one death per year is reported. Based on estimates from the National Drug and Alcohol Research Centre, each fatal overdose corresponds to about 20 non-fatal overdoses, suggesting that 7/8 of the overdoses would have been fatal had they not taken place in the illegal injecting room. These data suggest that a room with 120 injections per day is preventing a death as often as once every seven weeks (49 days).*

***(3) Trends in overdose rate from overseas**: The experience of injecting rooms has perhaps been most comprehensively studied in Frankfurt. In that city, the establishment of four supervised injecting rooms in which clients administered roughly 1,200 injections per day corresponds to a reduction in the annual number of overdose deaths of around 70. Thus a death can be assumed to have been prevented every five days.*

Professor Kaldor made the following comments on the above estimates:

The results based on estimates 2 and 3 are very similar and suggests a much higher number of deaths prevented than estimate 1. This discrepancy may be due to there being a far greater risk of overdose present among injecting room clients than among the wider group of people who ever inject drugs, many of whom may be injecting less frequently and with drugs other than opiates. Based on the available information, it is plausible that the provision of access to supervised injecting rooms in which 120 injections are taking place per day among injectors at higher risk of overdose would result in the prevention of approximately 7 deaths per year. Doubling the number of injections that could be supervised would be expected to produce a doubling in the number of deaths prevented (Kaldor, Correspondence to the Committee 19 November 1997).

- Mr Porter, an ambulance officer based in the Kings Cross area, told the Committee that the Ambulance Service had administered 1,406 doses of Narcan in the Kings Cross area over the past ten months, and that this figure was probably an under-estimation of the actual number of overdoses

That figure does not include those where we turned up and the

> *person was deceased, and it also does not include those who, by the time we got there, had actually woken by some other means and had staggered off. We administer a lot of Narcan* (Porter, Evidence 30 September 1997).

- The Committee heard that paramedics were called about three times a week to respond to drug overdoses at one illegal shooting gallery and that there had been approximately ten fatal overdoses on those premises over the past nine years.

Characterising the problem on a more personal level, Dr David Helliwell a General Practitioner in Nimbin said:

> *I know that over 500 young people, many of whom are not addicted to heroin, are dying each year from overdoses. I know that 60% to 70% of injecting drug users have a positive antibody test for hepatitis C, and 10% will develop cirrhosis and 5% liver cancer. I know that most, if not all, of the heroin overdose deaths are preventable. Some would be prevented by a heroin program, some by rapid detoxification, some by counselling, some by the threat of prison, some by the methadone treatment, some by needle exchange workers, and some may even be saved by the existence of safe houses.*
>
> *What we clinicians know is that there is no right answer for heroin addiction and its attendant health risks. What is more, we do not yet have a clear idea of what is best practice in this area, although we are diligently moving and working towards this point. It would be nice to say that we could sit and wait until we know for sure what is the best approach for preventing harm from heroin addiction, but unfortunately over 500 young persons are dying under preventable circumstances. That is somebody's son, daughter, brother, sister, mother, father, uncle or aunt every 15 hours. No family is immune from this tragic situation* (Helliwell, Evidence 30 July 1997).

In submissions and evidence the Committee was told that injecting rooms may contribute to the reduction in the number of fatal and non-fatal overdoses by providing access to resuscitation and disseminating information about safer using practices.

Ms Erica Chaperlin, Co-ordinator of Youth Services for Barnardos in Penrith, informed the Committee of the dangers of overdose and of disposed syringes in the Penrith area and affirmed her support for injecting rooms:

> *The two main reasons that I support it is to reduce the incidence of fatal overdose, the medical complications that may arise when a person is drug affected. I think the evidence is clear that young people particularly find it difficult to access health services or medical attention when there is a problem, for fear, I presume, of retribution. And so people are dying, I guess, because of complications as a result of injecting. The other issue is the unsafe needle disposal which continues to be a problem on many residential estates around the Penrith area. Children are at risk and families are obviously concerned, as is the general public. The other concern is the rising incidence of transmittable diseases such as hepatitis*

> *C, HIV and AIDS. I think providing a controlled environment where we can give education and information and the necessary resources for people to inject safely will at least alter those trends* (Chaperlin, Evidence 7 October 1997).

Mr Peter Zahra, a Public Defender with the New South Wales Attorney-General=s Department with many years experience representing people on drug-related charges told the Committee:

> *Obviously the benefit of a safe injecting room is if something does happen during the injecting process that medical treatment could be given to them quickly ... I was a public solicitor for probably 12 years and I appeared for many people in the local court jurisdiction who were involved or charged with use of drugs, supplying drugs and had terrible addictions and many of them have not returned back to court, otherwise healthy young people, because of obviously the dangers involved in overdosing and injecting drugs; that is the real tragedy, seeing people who obviously have families. It is a shocking thing. We obviously need to ensure that these types of things could be minimised* (Zahra, Evidence 24 October 1997).

▸ Injecting rooms could make access to resuscitation greater

Overdose is one of the leading preventable causes of mortality associated with injecting drug use. Professor Wayne Hall from the National Drug and Alcohol Research Centre told the Committee that:

> *People revive from overdoses quite quickly. I had a personal experience four weeks ago of reviving a young man who overdosed at the end of my street. I came upon the overdose within a minute of it happening. He had stopped breathing, he was blue. It took very little to get his breathing going again and by the time the ambulance arrived 20 minutes later he was awake and wanting to leave. I suspect that is probably what happens quite frequently with non-fatal overdoses. If people do not panic, and they do assist, then there is a reasonable chance that people will revive and survive* (Hall, Evidence 24 October 1997).

If someone were to overdose in an injecting room, staff would be available to either provide immediate resuscitation or to call an ambulance. This intervention is far less likely to happen if injecting drug users inject in ›hidden= places and experience an overdose. Dr Wodak said:

> *Where there is a large drug market users are attracted and they often cannot wait to get home and inject in the comfort and safety of their own home and they inject in public places and there is a higher risk of death because there is no emergency help available. So getting those people into an injecting room ... is one of the major things we need to do to reduce drug overdose deaths* (Wodak, Evidence 9 October 1997).

In its submission to the Inquiry the AIDS Council of New South Wales wrote:

> *Safe injecting rooms have been found to have a positive impact on lowering overdose-related deaths by providing resuscitation either by staff at the site (as in Switzerland) or by notifying the ambulance who then responds* (ACON, Submission 92).

Data from a study conducted in Frankfurt where a number of injecting rooms have been in operation since the early 1990s seems to lend support for the proposition that injecting rooms may be linked to a decrease in fatal overdose deaths occurring in that city. The Table below shows the number of overdose deaths occurring across Germany and in Frankfurt over the last decade. Urban Weber, who is the Project Manager of the largest low-threshold drug treatment facility in Frankfurt, attributes the decline in the numbers of overdose deaths in Frankfurt over this period in part to the existence of injecting rooms. He writes:

> *Since the peak in lethal overdoses, which occurred in 1991 with 147 cases, the combination of all the harm-reduction efforts in Frankfurt (including methadone maintenance, low-threshold crisis intervention, cafes, housing facilities, needle exchange, injection rooms) have led to a two-thirds decline of lethal overdoses through 1995 (47 cases). A further decline to 31 cases was reached in 1996, while in Germany as a whole, lethal overdoses increased by 10% from 1995 to 1996 (after a decline by some 25% from 1991 to 1995)* (U Weber, op cit, 1996).

It is clear from this statement that while it is not possible to directly link the decline in overdose deaths to any one particular harm reduction measure, it is likely that a number of measures taken in concert explain the result (the first injecting room was established in late 1990, the Schielestrasse injecting room in 1992, and a third in 1995. Contact cafes, another low threshold service which provide an easy or facilitated access to drug treatment, also commenced in 1992.) Although Weber provides no commentary on the Germany-wide statistics, he observes in relation to the recently adopted harm-reduction approach in Frankfurt that: ›the number of drug-use associated deaths - as only one indicator - declined significantly faster in Frankfurt than in Germany as a whole‹.

Summary of the development of lethal overdoses in Germany and Frankfurt

Year	Number of lethal overdoses in Germany	Change from the previous year in %	Number of lethal overdoses in Frankfurt	Change from the previous year in %
1985	324		31	
1986	348	+7.4	45	+45.2
1987	442	+27.0	62	+37.8
1988	670	+51.6	62	0.0
1989	991	+47.9	80	+29.0
1990	1491	+50.5	108	+35.0
1991	2125	+42.5	147	+36.1
1992	2099	-1.2	127	-10.6
1993	1738	-17.2	68	-46.5
1994	1624	-6.6	61	-10.3
1995	1565	-3.6	47	-23.0
1996	1712	+9.4	31	-34.0

During the overseas study tour the Subcommittee heard evidence that as of August 1997 there had been no deaths in any injecting room in the Netherlands, Switzerland or Germany since their establishment.

In the context of New South Wales, several witnesses provided anecdotal evidence to the Committee that a number of lives have been saved when overdoses occurred in the illegal injecting rooms. According to Detective Sergeant John Maricic of Kings Cross police:

> *I would say no doubt they [injecting rooms] are saving lives to some extent. It has been evident where the ambulance officers have arrived at some of these establishments after being called by the proprietor, so yes, in a sense they are saving lives. As to how many, I simply cannot put any figure on it* (Maricic, Evidence 9 October 1997).

When Mr Porter, an ambulance officer, was asked whether the illegal injecting rooms in Kings Cross had been directly responsible for saving drug users lives, he replied:

> *The answer to that is yes, in my opinion. As to how many, I could safely say hundreds, but over many years you could say thousands ... Who would know whether that led to their death? I was working before, during and after the Police Royal Commission. I was working whilst they were closing down the shooting galleries. At one stage shortly after the Police Royal Commission closed down many of those galleries I attended eight deaths within 10 weeks in the Kings Cross area. Would those people have used the shooting galleries? I do not know, but many of them were found*

> *in back lanes and hotel rooms, which are not normally used when shooting galleries are available* (Porter, Evidence 30 September 1997).

However, other witnesses appearing before the Committee did not share the view that fatal overdoses had increased following closure of some of the more renowned shooting galleries. When asked whether there was an increase in the number of injecting drug users presenting to St Vincent=s after the closures, Dr Fulde, the Director of the Emergency Department said:

> *Having had notice of that question I did an informal discussion with my staff and the answer is no. There was not anything that we could see that there was any change* (Fulde, Evidence 7 October 1997).

- **The injecting room setting could be used to provide information to users about overdose prevention and how to minimise risk behaviour.**

According to some working in the drug and alcohol field, safe injecting rooms would be a suitable venue for providing injecting drug users with information on how to prevent an overdose and minimise risk behaviour. In its submission to the Inquiry the AIDS Council of New South Wales stated that:

> *Recent research also points to the fact that many overdoses occur due to a combination of central nervous system depressive drugs rather than opiates alone ie it is the combination of drugs such as alcohol, benzodiazepines (eg Valium) in conjunction with heroin/opiates that leads to respiratory arrest. With this understanding, programs are underway to educate drug users of the dangers of multiple drugs. Safe injecting rooms are an ideal environment in which to do overdose prevention* (ACON, Submission 92).

Mr Porter pointed to the potentially lethal outcome that combining drugs can have:

> *The average patient we see is the young male patient who has come in from the suburbs, has been drinking alcohol heavily all night, has gone to Kings Cross to pick up a sex worker for the night and has gone into one of these shooting galleries with the sex worker. It is then, while under the influence of alcohol, that quite often the scenario is that the sex worker will say to the client, >Give us an extra $100 and I=ll hit you up= with something. They do not always say heroin; sometimes they say speed or cocaine. The client says >Yep, fine. That sounds great=. Then naturally the sex worker has $80 worth and gives the client $20 worth. The client is not used to heroin and they also have another central nervous system depressant on board, that is, alcohol. They have a very small dose of heroin and they stop breathing. They are not desperate users and they are not regular users. That would represent over 70% of our clients* (Porter, Evidence 30 September 1997).

Drug users can share information with each other and injecting room staff about the dangers of drug potencies or combinations, and users educated in the injecting room may pass on information to others who do not attend, thereby generating a flow-on

effect. Mr Loveday, the Executive Officer with the Hepatitis C Council, told the Committee:

> *There is an additional peer education factor, where if we take account of the length of time that users can spend in an injecting room situation and be subject to written information, verbal information and counselling, they will in turn pass that information on to their peers outside, so there would be a knock-on effect outside of injecting rooms created as a result of the space allowed* (Loveday, Evidence 7 October 1997).

A comparative overseas study by Buerki and colleagues, which examined HIV-risk behaviour among injecting drug users attending an injecting room in Berne, Switzerland found that over time there had been a reduction in such behaviour (C Buerki, M Egger, R Haemmig, M Minder-Nejedly and R Malinverni, *HIV-Risk Behaviour Among Street IVDUs attending a shooting room in Berne, Switzerland, 1990 and 1995*, University Psychiatric Services, Department of Social and Preventive Medicine and Medical Polyclinic, University of Berne, 1996). An initial survey of injecting drug users (112 respondents) attending the injecting room was conducted in 1990 with regard to HIV-risk taking behaviours. Between that survey and the survey conducted in 1995 (155 respondents), efforts were made to educate injecting drug users as to the ways in which drug-related harm could be minimised. The aim of the 1995 study was to follow up and examine any changes in the HIV-risk taking behaviour, which may have occurred in those users attending the injecting room. According to Buerki and colleagues, a pattern of safer injection practices was noted: injecting drug users were significantly more likely to inject with sterile injecting equipment on their first injection in 1995 than in 1990; were less likely to use injecting equipment found in the street; were less likely to re-use their own injecting equipment; and less likely to accept shared injecting equipment. As regards safer sexual practices, the authors note that while the use of condoms increased, participants with steady partners and/or children were more likely to report never using condoms, which was of concern.

Mr Gration, the President of the AIDS Council of New South Wales, told the Committee:

> *... the Ronco evaluation of the Swiss safe injecting rooms found that users using those rooms experienced decreased personal risk behaviour in terms of not only infectious diseases related to injecting but also to sexual diseases because of the increased use of condoms* (Gration, Evidence 1 October 1997).

An evaluation of the three injecting rooms operating in Basel was commissioned by the Federal Department of Health and carried out by Ronco and colleagues from the Institute for Social and Preventative Medicine at the University of Basel (C Ronco, G Spuler, P Coda and R Schöpfer, *Evaluation der Gassenzimmer I, II und III in Basel*, Institut für Sozial und Präventivmedizin der Universität Basel, 1994 referred to hereafter as ›the Ronco report‹). The central concerns of the evaluation were: the effect of injecting rooms on the injecting drug users in Basel; the significance of the injecting rooms in the management of health and social drug-related harms; and the acceptance of the injecting rooms in the community. The conclusions reached in relation to the significance of the injecting rooms for the management of health and social drug-related harms are as follows:

- the three injecting rooms distributed on average 1,500 to 2,000 syringes and 3,000 to 3,500 needles daily. 80% of injecting drug users questioned (approximately 370 respondents in total) said they stocked up on sterile injecting equipment obtained primarily through the injecting rooms. These figures highlight the importance of the role played by the injecting rooms in reducing the extent to which injecting equipment is shared and thereby limiting the transmission of blood-borne viruses such as HIV, hepatitis B and hepatitis C.

- there was an increased demand for condoms, with both more condoms being distributed and a higher level of use of condoms with casual sexual partners being reported.

- there was a stabilisation or even improvement in the general state of health of injecting drug users attending the injecting rooms, including a stabilisation of HIV prevalence and a decrease in the typical illnesses associated with injecting drug use such as abscesses and hepatitis C. A further indicator of the improvement in health awareness was the active usage of doctors. The evaluation showed that injecting room facilities were seen not just as providing a safe environment for injecting purposes but also as advice and treatment centres.

- overall the evaluation concluded that the injecting rooms provided injecting drug users with hygienic and controlled conditions, prevented infections through the provision of sterile syringes and needles and condoms, and gave access to medical care and opportunities for intervention with possible emergencies such as overdoses. The evaluation team called for the continuance of the injecting room strategy so as to provide a stable environment for Basel injecting drug users.

A survey of 219 injecting drug users in Sydney in 1994 found that among the small proportion of users who were injecting in illegal injecting rooms in Kings Cross (10%), no one reported shared injecting equipment (S Rutter, K Dolan and A Wodak, ›Rooms for rent: injecting and harm reduction in Sydney‹, *Australian and New Zealand Journal of Public Health*, Vol 21 No 1, 1997, p105).

4.2.2 INJECTING ROOMS MAY REDUCE THE TRANSMISSION OF BLOOD-BORNE VIRAL INFECTIONS SUCH AS HIV, HEPATITIS B AND HEPATITIS C

Injecting rooms which provide sterile injecting equipment and a means of collecting used and possibly contaminated injecting paraphernalia, may be of further assistance in the reduction of the transmission of blood-borne viral infections, particularly in the case of cocaine injectors. Cocaine injectors tend to display more chaotic behaviour than those who inject heroin, which may lead to less care taken in the injecting process, and the likelihood of equipment being re-used. Given the short half-life of cocaine, cocaine injectors may inject as many as 10 or 15 times in one day, and increasing the number of injections, increases the possible risks associated with injecting drug use.
Although the prevalence of HIV amongst injecting drug users is now said to be relatively low, hepatitis C is endemic among the injecting drug user population with about 9,000 new infections occurring nationally per year. Approximately 65% of injecting drug users who attend needle exchanges test positive for hepatitis C infection (M MacDonald, N Crofts and JM Kaldor, ›Transmission of hepatitis C: Rates, routes and co-factors,

Epidemiology Review, Vol 18 No 2, 1996, pp137-148). Dr Fulde, the Director of the Emergency Department at St Vincent=s Hospital in Darlinghurst, told the Committee that:

> *The sero-prevalence of hepatitis C amongst intravenous drug users that we look after must be very close to 100%* (Fulde, Evidence 7 October 1997).

This suggests that in order to prevent hepatitis C among drug users, services need to target users early in their drug using career. According to the Australian National Committee on AIDS and Related Diseases (ANCARD):

> *It has been argued that Needle and Syringe Exchange Programs have been successful in reducing the spread of HIV, but that NSEPs alone are not enough to address hepatitis C due to the highly infectious nature of the disease. It should be remembered that Needle and Syringe Exchange Programs are only one component of a harm minimisation strategy, but there appears to be a continuing unacceptably high rate of transmission of hepatitis C amongst injecting drug users. It is evidence that additional and preventative measures are still required* (ANCARD, Submission 81).

One such measure would be an injecting room:

> *Results of a recent cohort study conducted by Dr Nick Crofts and colleagues into changes in risk behaviour of injecting drug users found that the incidence of hepatitis C was high (10.7 per 100 person year) while the prevalence of risk behaviour such as needle and syringe sharing decreased significantly (Medical Journal of Australia, Vol 167, 7 July 1997). This would suggest that transmission may be through environmental contamination. In a safe injecting room environment ... the environment may be controlled, together with the equipment, ensuring even greater safety for injecting drug users* (ANCARD, ibid).

Injecting rooms in Europe provide not only sterile needles and syringes but sterile spoons, swabs and water to each client. Clients were required to bring their own tourniquet and were not allowed to share them. This is an important intervention in limiting the transmission of hepatitis C which can occur through the shared use of paraphernalia other than needles and syringes. The Needle and Syringe Exchange Program currently operating in Australia does not provide all the associated paraphernalia used by injecting drug users.

4.2.3 INJECTING ROOMS MAY PROVIDE INJECTING DRUG USERS WITH BETTER ACCESS TO PRIMARY MEDICAL CARE

Some injecting drug users are in an overall poor physical and mental condition, partly as a result of long-term use of drugs. Attendance at an injecting room may provide an opportunity to improve access to primary health care. In addition it may facilitate treatment for local infections, such as abscesses, which result from the act of injecting itself. According to Dr Fulde neglect of straightforward medical problems by injecting drug users may result in the need for a far greater level of medical intervention:

> *If they are right handed they inject into their left elbow cubital fossae ... and if you get an infection in there you can quite easily have a permanent disability of your hand ... there is reluctance for people to come and see doctors, or a hospital or whatever, so by the time we get to see these people often the infection is well set in and they need to come into hospital* (Fulde, Evidence 7 October 1997).

In Buerki=s study of injecting drug users who attended an injecting room in Berne, 25% said they attended to seek medical attention, and Ronco=s evaluation of the injecting rooms in Basel also showed that those attending availed themselves of the medical services being offered. This overseas evidence suggests that injecting rooms in New South Wales could make a significant contribution to the improvement in the overall health of injecting drug users.

4.2.4 INJECTING ROOMS MAY IMPROVE ACCESS TO DRUG TREATMENT PROGRAMS

The Committee heard evidence that one of most effective ways to reduce the number of drug overdoses was to encourage more people into some form of drug treatment, such as detoxification programs, rehabilitation programs, self-help programs and substitution therapies. Injecting rooms could provide a gateway for drug workers to encourage drug users to enter treatment programs for their drug problems.

According to Dr Shane Darke, Senior Lecturer at the National Drug and Alcohol Research Centre:

> *The majority who have overdosed on heroin have never been in any treatment, so we are talking about a group of people who have not been reached by treatment ... People in treatment do not tend to die of heroin overdoses. Heroin addicts, who are not treated, die at about 13 times the rate of the population of the same age. When in treatment they die at about twice the rate* (Darke, Evidence 30 September 1997).

Commissioner Wood stated in the *Final Report of the Royal Commission into the New South Wales Police Service* that there are good reasons for the existence of approved injecting rooms in high risk locations, as *›injecting drug users, very many of whom want help, can be targeted for education and encouraged to seek treatment for their addiction and associated medical problems=* (Wood, *Vol II: Reform*, p226).

If injecting rooms can act as a gateway into drug treatment, this may assist in reducing drug use in the long term. This function was found to have been served by staff working

in the injecting rooms in Frankfurt, where a number of clients were referred to detoxification units, advice services, and methadone maintenance programs (*1995 Annual Report,* Integrative Drogenhilfe e.V. a. d. FH FfM).

4.2.5 INJECTING ROOMS MAY IMPROVE OCCUPATIONAL HEALTH AND SAFETY CONDITIONS FOR HEALTH WORKERS, POLICE OFFICERS AND AMBULANCE OFFICERS

The Committee acknowledged the less than optimum working conditions to which those attending to injecting drug users, particularly at the scene of a drug overdose, may be subjected. Ambulance officers explained the hazardous nature of attending to drug overdoses, often in isolated back lanes, surrounded by dirty injecting equipment:

> *The hazards start when we receive the call; often the person has stopped breathing so you have a limited time in which to get there. We use lights and sirens to get through the traffic which is a hazard not only for ourselves but for other people using the roadways. When we get to a scene there are hazards for ambulance officers, partners, any bystanders and the person at the scene. As you would know, about 55% of our users have hepatitis C and about 3% have HIV. The main hazard is needle stick injuries* (Porter, Evidence 30 September 1997).

From an occupational health and safety point of view, injecting rooms would ensure that in the event of an overdose, ambulance officers would be attending a location that was known, well lit and safe.

The Mayor of South Sydney Council outlined to the Committee the risks that discarded injecting equipment pose for council staff:

> *It is an enormous problem for a large number of our residents and, more importantly, it is a problem for our workers who are constantly having to avoid needle-stick injuries as they go about their work. Council is constantly receiving complaints about needles on footpaths, in parks and, most disturbingly, in playgrounds and sandpits within child-care centres. In fact, the council has been forced to close a number of public toilets in areas such as Kings Cross, not only out of public safety concerns but also because our maintenance people were constantly having to clear needles out of blocked toilets. These closures have not solved the problem. The users have moved to another location and the public has lost access to important facilities* (Smith, Evidence 1 October 1997).

The Committee also heard evidence from police in high drug-use areas such as Kings Cross and Redfern, who fear sustaining a needle-stick injury when conducting searches or being attacked with a contaminated needle and syringe:

> *As far as injecting is concerned, there are a number of problems of occupational hazards for police officers and I guess the first is the association and possible risk of contamination through associating and dealing with injecting drug users. Secondly, there is a problem of needle stick injuries, obviously accidentally through searching of prisoners, or their homes, cars, or perhaps even their baggage and also the possibility*

> *of deliberate injury through attack by an injecting drug user. Those would be the day-to-day problems that police officers face in dealing with drug injecting people* (Perin, 9 October 1997).

It would appear from the evidence presented to the Committee that the overwhelming opinion of health professionals is that injecting rooms would result not only in faster response times by ambulance officers, but also in safer working conditions for them. The improved occupational health and safety aspects were also seen as being of benefit to police officers, council workers and cleaners.

4.3 HEALTH IMPLICATIONS: ARGUMENTS AGAINST

The view has been expressed by some that injecting rooms may possibly have a detrimental impact on the health of injecting drug users. If injecting rooms give the impression that injecting drug use can be undertaken safely, more people may be encouraged to experiment with drugs, or to use more drugs than they currently do, or to put off seeking rehabilitation treatment. Another consideration is that the general health of injecting drug users may be compromised by being in constant contact with other injecting drug users whose health is poor. There is also the issue of not putting at risk the health of anyone employed in the injecting room.

4.3.1 INJECTING ROOMS MAY LEAD TO AN INCREASE IN DRUG USE AND/OR THE NUMBER OF INJECTING DRUG USERS

Another issue which requires examination is whether the establishment or trial of an injecting room could lead to an increase in drug use, either by encouraging more people to inject drugs or by encouraging current injecting drug users to use more frequently.

The Salvation Army stated in its submission to the Committee that:

> *the pragmatics are that legal shooting galleries will increase the incidence of injecting drug use* (Watters, Submission 93).

Mr Baker, a resident in Cabramatta objected to the notion of safe injecting rooms and thought:

> *the existence of these establishments would, without exception, increase the incidence of usage of illegal drugs* (Baker, Submission 38).

A similar view was expressed by Nimbin residents, Mr and Mrs Bazzana:

> *We think that making it easier for people to use drugs, such as providing drug injecting rooms, will increase drug use* (Bazzana, Submission 11).

4.3.2 THE EXISTENCE OF INJECTING ROOMS MAY DELAY INJECTING DRUG USERS FROM ENTERING REHABILITATION

Some witnesses thought that the establishment of injecting rooms may delay drug users becoming drug free as injecting rooms may act as an incentive for drug users to continue to inject rather than seek treatment.

Mrs Nugent a resident in Nimbin said:

> *An injecting room will help users to continue to destroy themselves. It will not help the user to go back to the family unit* (Nugent, Evidence 30 July 1997).

4.3.3 THERE ARE POTENTIAL HEALTH AND SAFETY IMPLICATIONS FOR THOSE WHO USE AN INJECTING ROOM

Concern was expressed for the individual drug user who may frequent an injecting room if it were to be established, given that injecting illicit drugs is an inherently dangerous practice which can never be completely risk free. The congregation of lots of drug users was also seen as posing a possible danger and one which could give rise to greater risk of infection.

According to a representative of Fairfield Council:

> *Injecting rooms can never be safe when users are injecting heroin which is an illegal and uncontrolled substance (Long, Submission 87).*

A member of the general public commented that:

> *I feel strongly about the provision of >safe injecting rooms= if injecting yourself with drugs can ever be considered safe* (Crane, Submission 10).

The question of whether or not the congregation of injecting drug users in an injecting room could lead to the spread of blood-borne viral infections can only be answered by rigorous research.

4.3.4 THERE ARE POTENTIAL HEALTH AND SAFETY IMPLICATIONS FOR THOSE WHO STAFF THE INJECTING ROOM

Another concern was that those involved in the day-to-day running of injecting rooms may be at risk. This point was made in a submission by Mr Soward:

> *What are the staff going to be able to do to maintain the rules or deal with an unruly client or someone who doesn=t want to leave?* (Soward, Submission 65).

An ambulance officer stressed that another consideration was that when people who have overdosed are administered Narcan, they can become violent towards those providing assistance when they awake, and to a certain extent ambulance officers perceive the risk of being assaulted as greater than that of receiving a needle-stick injury.

Others said that as a result of their drug use some injecting drug users, particularly those injecting amphetamines or cocaine, were likely to behave in a chaotic and irrational manner which could put those working in an injecting room at risk.

SOCIAL IMPLICATIONS

4.4 SOCIAL IMPLICATIONS: ARGUMENTS FOR

Anything which improves the harmony of society as a whole is a social benefit. Injecting rooms have the potential to benefit society in several ways. The community could benefit as injecting rooms may reduce the amount of discarded drug using paraphernalia and allow more people to go about their lives in greater safety and with less chance of affront or interference by drug-intoxicated individuals. Injecting rooms also represent an opportunity for injecting drug users to make social contacts with groups, individuals and services other than those within the drug using community. Injecting rooms thereby represent an avenue of socialisation for injecting drug users and would provide assistance towards their re-integration into society.

Concerns that injecting rooms may encourage people to start using illicit drugs can be allayed by ensuring that any such facility accept only those with a history of drug use. This approach is adopted in Switzerland where strict entry criteria are in place with the specific aim of preventing people from commencing injecting in an injecting room.

Similar apprehensions to those being raised in relation to injecting rooms were voiced when the Needle and Syringe Exchange Program commenced. The notion of making access to sterile syringes easier has historically met with considerable controversy, especially in the United States of America. According to Paone:

> *Opponents of syringe exchange have generally argued that increasing access to sterile syringes would simultaneously increase the number of injecting drug users, increase the frequency of injection for already active injecting drug users, and appear to 'condone' an illegal behaviour. To date many research studies and four major reviews of syringe exchange literature have been conducted. All studies thus far have shown no increase in illicit drug injections associated with syringe exchanges, and significant decrease in drug risk behaviour* (D Paone, D Des-Jarlais, R Gangloff, J Milliken and S Friedman, 'Syringe Exchange: HIV Prevention, Key Findings and Future Directions', *International Journal of Addiction*, Vol 30 No 12, 1995, pp1647- 83 at p1647).

The best available data in this area comes from Amsterdam, where despite a massive expansion in syringe distribution (from 100,000 needles and syringes exchanged in 1985 to over 6 million exchanged in 1995), there has been no documented increase in the number of drug injectors in the population (Paone et al, ibid). As discussed in Chapter Two, the study conducted by Wolk and colleagues appears to confirm the finding that NSEPs have not led to an increase in drug usage in New South Wales (J Wolk, A Wodak, J Guinan, P Macaskill and J Simpson, 'The effect of a needles syringe exchange on a methadone maintenance unit', *British Journal of Addiction*, Vol 85, 1990, pp1445-1450*).*

4.4.1 INJECTING ROOMS MAY LEAD TO A REDUCTION IN THE PUBLIC NUISANCE ASPECTS OF INJECTING DRUG USE

The Committee received many submissions from individuals and community organisations concerned about the level of public nuisance associated with injecting drug use. These concerns included: finding used injecting equipment discarded in public places; witnessing people injecting drugs and encountering drug-affected individuals. There was also considerable community concern about the use of public toilets and public places such as parks as de facto injecting rooms, and the link between injecting drug use and opportunistic property and street crime.

Injecting rooms may alleviate the problems of discarded injecting paraphernalia in public places and the misuse of public facilities. They may also lead to a reduction in the number of individuals under the influence of illicit drugs in public places, with the possible consequence that opportunistic property and street crime may be lessened.

Dr Weatherburn told the Committee:

> *I do not think it would have any effect on serious criminal activity such as robbery, break enter and steal, car theft, the sorts of things people do to raise money to buy heroin. It may have an effect on public disorder offences, or, if you like, the appearance of people on the street or in doorways shooting up. That is not something to be dismissed, because those sorts of quality of life issues are quite important to most people* (Weatherburn, Evidence 1 October 1997).

▸ Discarded needles and syringes

The Committee heard evidence from residents in areas of high drug use around the State, who were regularly exposed to discarded paraphernalia associated with drug use, and it was apparent that this issue was of considerable concern. In September 1997, as part of the baseline evaluation of the K2 Community Centre in Darlinghurst Road, Kings Cross, the Roy Morgan Research Group conducted a random telephone survey of 305 residents aged between 18 and 65 years with the postcode of 2011. The suburbs covered by this postcode are Kings Cross, Elizabeth Bay, Woolloomooloo, Potts Point and Rushcutters Bay. The survey covered a number of issues in relation to the opening of K2 (a branch of the Kirketon Road Centre), a syringe exchange outlet in Darlinghurst Road, Kings Cross. The survey found that most respondents (83%) had seen an inappropriately discarded syringe, and half had seen one in the last week (MacDonald, op cit, p9).

Although a recent search of scientific publications failed to identify any reported cases of blood-borne viral infection being acquired from a needle stick injury from a discarded syringe, the Committee acknowledges, nevertheless, that discarded needles and syringes are a cause of concern to the community. The public has a right not to be exposed to injecting paraphernalia. Residents of Redfern whose properties back onto Caroline Lane complained that needles and syringes were often thrown into their back yards. Some residents with children were most concerned for the safety of their family:

> *The laneway runs between Abercrombie and Eveleigh Streets and parallel to Lawson and Caroline Streets, so because of that use there is a lot of noise 24 hours a day, injecting 24 hours a day and, as we have found as well, there are also people overdosing, and I resuscitated somebody and so did Fiona, so obviously dying there as well, plus people coming over the fence as well as their needles* (Dunbar, Evidence 9 October 1997).

The Committee believes that it is reasonable to assume that inappropriate disposal of injecting equipment is indicative of public injecting and that both these problems need to be reduced. Legal injecting rooms have the capacity to remove public injecting and discarding of needles from neighbourhoods.

The Mayor of South Sydney, Mr Vic Smith informed the Committee that;

> *It is quite clear that the community is in favour of any methods that get drug use and its associated problems such as needle disposal off the streets, or moved to another area, so long as the location of the alternative is not near residential properties, local parks or playgrounds* (Smith, Evidence 1 October 1997).

▸ Public injecting

The injecting of drugs in public places not only leads to an increase in hazardous litter but can also cause affront to members of the public. Experience overseas of this problem of public injecting has led to the establishment of injecting rooms to move the injecting indoors, out of public places and away from the public. If injecting rooms were established in New South Wales then less injecting would take place in public places and the opportunities for public affront should be diminished.

During the overseas study tour, members of the Subcommittee were told of several examples of public injecting and the problems associated with an open, public drug scene:

- In Rotterdam, an open drug scene had been allowed to exist for a number of years. However, when the problem became extreme, other approaches were adopted including the provision of low-threshold services such as that made available by Reverend Visser, with the co-operation of the local police, in the Paulus Kerk. Since injecting drug users have had the choice of using this safe, clean location for injecting, the amount of public injecting has declined noticeably.

- In the Swiss city of Basel, an open drug scene was tolerated for many years in a local park known as ›Needle Park‹. The park was used by drug users from all over Europe to buy and sell drugs and was eventually closed down due to community concern about public injecting. The closure of the park resulted in the establishment of safe injecting rooms where drug use could be closely monitored by health professionals and the police. A survey in Basel found that the drug scene has moved from the street to the three injecting rooms which exist in that city and that this shift has provided relief for the general public (the Ronco report, op cit). The Spitalstrasse 36 injecting room in Basel operates a hotline

which can be contacted to arrange the removal of discarded syringes found in public places.

- In Frankfurt, the overt injecting of drugs in the central business district led to the financial sector contributing $700,000 to assist in the establishment of government approved facilities offering safe injecting rooms.

The Committee is concerned about the impact of public injecting on local communities in New South Wales. In September 1997, the Roy Morgan Research Group found that the vast majority of 305 respondents were aware of the needle exchange program (92%), could list advantages of it (83%), and thought the program should continue (82%). 40% reported having seen someone inject in a public place. In response to the question ADo you agree with making available places where drug users can inject their drugs?@, over two thirds of respondents (68%) were in favour of such a place, while approximately one quarter (24%) said they were opposed (MacDonald, op cit, 1997).

It can be confronting for people to encounter intoxicated individuals in public, whether they are affected by narcotics or by alcohol. Confrontation by drug-affected individuals and the spectacle of their condition can be alarming and distressing to members of the public. The establishment of injecting rooms may alleviate the distress felt by members of the community when faced with such situations.

The Committee heard from residents that drug-affected individuals had vomited on the footpath in front of their house and had overdosed in their presence:

> *I have found one of the increasing problems is people driving to the area to score and then injecting. We have a metre before the kerb, so cars park there, they inject and then they throw up by just winding down their windows, so sometimes when you open your door you can have this problem of vomit, and it is distressing seeing people injecting in the park with their children. I think it is trying the compassion of people who live in Caroline Street. Because we live in tiny houses we use the park, we are outside a lot, going to the shops and what-not, and I think that is trying the compassion of people. It is really upsetting seeing small children with their parents who are using. I think it is distressing for the children* (Haines, Evidence 9 October 1997).

The Committee also heard that heroin users tend to fall asleep after injecting heroin and the sight of an individual asleep in a public place can be disturbing. Residents in areas where drug use is common told the Committee that they have come across heroin users asleep on footpaths in front of their houses and were uncertain about whether they were asleep, unconscious or dead. These circumstances can lead to overdose deaths as recounted by Mr Trimingham whose son died of an overdose in 1997:

> *At 11 pm on 24 February this year my son died of a heroin overdose. A security guard heard him groaning in the stairwell of the St Margaret Hospital. Because of the protocols involved, the security guard had to call for backup assistance and it took about 10 minutes for his offsider to arrive. They then investigated my son, who was still alive at that time. An immediate call was put out to the police and for an ambulance. The ambulance responded within six minutes, at which point they put the*

> *electrical monitors on Damien and found almost no pulse. Therefore, no attempt at resuscitation was viable. We do not know how long Damien had been there. We know he left Katoomba at 7 pm and he died at 11 pm. As far as we know, he travelled straight to the city, bought needles in Bourke Street and arranged his hit from somewhere in that area. He could have been in that stairwell any time from 9 pm till 11 pm. Had there been a safe injecting room in the area, this preventable death may have been avoided* (Trimingham, Evidence 30 September 1997).

By providing an enclosed facility with qualified health staff, injecting rooms have the potential to both alleviate the distress of individual members of the community and reduce the number of overdose deaths. This view was put to the Committee by a couple who lived in close proximity to a needle exchange outlet. They said that they would prefer it if the needle exchange outlet had an injecting room so that users would not have to inject in front of their house. They made the point that *'nobody wants drugs or a needle exchange near to them, but we have got the problem and they have to be somewhere'*. They were extremely supportive of the injecting room concept.

Mr Chris Gration, President of the AIDS Council of New South Wales reminded the Committee of the community support for harm reduction in New South Wales and called for the provision of safe injecting rooms:

> *Over the last 10 years the community in New South Wales has shown a remarkably high degree of tolerance and support for harm minimisation approaches. They have supported governments on both sides of politics employing both supply reduction and demand reduction measures, including needle and syringe exchange programs and other such health measures. The community now is experiencing, particularly in areas like Cabramatta, significant and real concerns about public injecting and about disposal of syringes. In our view the provision of safe injecting rooms responds directly to those public concerns, while at the same time preserving what has been one of the fundamental planks of the national HIV-AIDS strategy* (Gration, Evidence 1 October 1997).

- **Public disturbance**

Many injecting drug users inject in public toilets. This inconveniences the public at the time and can make those facilities hazardous or unavailable. The establishment of injecting rooms may discourage the misuse of public facilities and allow for their proper public use. The Committee is aware of several reports demonstrating that public toilet facilities in high drug use areas have become de facto injecting rooms. In February 1996, Lismore Council conducted a Community Survey of 200 people on the condition of public toilets in the Central Business District. The survey found that most toilet facilities were seen by respondents as facilities used for injecting drugs. Most respondents expressed fear about incurring needle-stick injuries; and almost two thirds (62%) of female respondents felt unsafe about using these public toilets (Kohlenberg, Submission 9).

The Mayor of South Sydney informed the Committee of similar problems in his area:

> *The council has been forced to close a number of public toilets in areas such as Kings Cross, not only out of public safety concerns but also because our maintenance people were constantly having to clear needles out of blocked toilets. These closures have not solved the problem. The users have moved to another location and the public has lost access to important facilities* (Smith, Evidence 1 October 1997).

The Committee is particularly concerned about public safety issues surrounding unsafe drug injecting practices. In addition, the Committee understands that the general response to the problem has been the closure of toilet facilities and considers this to be a substantial nuisance for the public.

The need for community education if the establishment or trial of injecting rooms were to proceed was considered essential:

> *There will need to be an active educational program to educate the community about the need and benefits of safe injecting rooms* (Schutz and Stubbs, Submission 57).

The importance of involving the community from the outset in the planning and establishment of an injecting room was recognised in those European facilities visited by the Subcommittee. On-going community consultation was also evident, with the injecting room in Basel regularly seeking the views of those in the neighbourhood as to whether the hours and operating practices were satisfactory.

4.4.2 LEGALISING INJECTING ROOMS WOULD REDUCE THE OPPORTUNITIES FOR POLICE CORRUPTION

The Committee heard of concerns for the potential for police corruption with regard to drug use and illegal injecting rooms. Based on evidence given at the Wood Royal Commission into the NSW Police Service that a corrupt relationship existed between some members of the police and distributors of narcotics, and that this relationship extended to the protection of those operating illegal injecting rooms, these concerns appear well-founded. The Committee heard evidence in camera that:

> *There is also the opportunity for corruption, to use (individual X) for example, he certainly was accepting large sums of money for shooting galleries to continue on the basis that he was giving them the green light at the end of the day*.

The dilemma to be resolved for the police is the tension between their role as enforcer of the criminal law, and their community policing role in which they aim to provide a service to the public. As ›law enforcer‹ the role of the police is to close down injecting room establishments because as the law currently stands, they are illegal. From a ›community policing‹ point of view, however, there is a recognition amongst some police officers, that such facilities may be beneficial in the harm reduction approach to the problem of illicit drug use, and should be allowed to operate. Police officers who take this approach and ›turn a blind eye‹ to such establishments are placed in a difficult position. At best they are open to accusations that they are not doing their job, at worst that this situation is allowed to occur because of some corrupt relationship between them and the owners and operators of the injecting rooms.

Commissioner Wood recognised this dilemma and recommended that certain changes to the law be made to allow police to act in accordance with harm reduction measures related to the use of illicit drugs. In the *Final Report of the Royal Commission into the New South Wales Police Service*, he wrote:

> *The corrupting influence of the trade in narcotics has been emphasised at almost every stage of the Royal Commission inquiries, and although it has not been accompanied by any legislative initiative, some informal changes in policing practice have been adopted which reflect a sensible approach to minimising harm. Most of the shooting galleries identified in the evidence have been effectively closed down, either through arrest of the operators or termination of leases by building owners. Arrangements do exist for the exchange of syringes and needles, and counselling and other assistance is available for drug users through the Kirketon Road Centre in Kings Cross. Intravenous drug users are finding it increasingly difficult to find discreet and safe places to inject, but there can be no authorisation of shooting galleries without amendment to the Drug Misuse and Trafficking Act 1985.*
>
> *A co-ordinated effort by government, police and health professionals is required to properly implement the harm minimisation program that they have all espoused. A progressive but careful move towards dealing with personal use of narcotics primarily as a medical problem, would also have considerable potential to reduce the opportunities for police corruption and*

> *the conflict faced by police officers forced to deal with intravenous drug users as both law breakers and people in need of help* (Wood, *Vol I: Corruption*, 1997, pp16-17).

Dr Alex Wodak told the Committee that the police had been placed in the very difficult position of having to weigh up the possible health benefits associated with injecting rooms against their illegal status, when deciding whether to take any action to close them down. Dr Wodak shared the concern that if legal injecting rooms were not established, then the potential for corruption and for further damage to public health would continue:

> *The third type of benefit after public nuisance and public health would be reducing the opportunities for corruption in the police service. This is not an area I can claim any expertise as a medical practitioner, but I have certainly been able to observe what has been happening in Kings Cross over the last few years. I think the community put the police in a dreadful position, of being forced to choose either between acting in a way that was contrary to public health or enforcing the laws. The police, I think very bravely, chose to do the right thing by public health. They allowed a number of injecting rooms that were run by illegal operators, they allowed these to continue, and I am sure that this reduced the number of overdose deaths and reduced the number of people who got terrible infections. But by the same token the police were doing something that no-one can really feel comfortable with and where there is a great opportunity for corruption.*
> *I think the police deserve better treatment from the community than that, and I think the police deserve to be put in a position where it is very clear that they are acting both to enforce the laws and to preserve public health.*
> *I think the best way of doing this is by having the injecting rooms run by illegal operators run officially out in the open. If the community is not ready yet to have legal injecting rooms I am sure that we will continue to have illegal injecting rooms with all the problems that that ensures* (Wodak, Evidence 9 October 1997).

If a trial of injecting rooms were to be recommended, the involvement of the police service would be critical. Initially their input at the planning stage when the operational and administrative models of the injecting room facilities are being devised would be valuable, and during the conduct of any trial, police should also be called on to advise if any modifications are required. The commitment of the police service to any injecting room trial is integral to it having any success.

Professor Carney made this point to the Committee:

> *Whether the law achieves its purpose at all - and many of them do not - depends on whether the police, or whoever else is responsible for administering around the edges of those laws, feel that they have a sense of confident ownership in the operation of those laws. If they do not, they will find ways of bringing the most carefully written laws undone ... the police will only have that sense of ownership if they believe that they can fine-tune whatever policy the Parliament sets* (Carney, Evidence 24 October 1997).

4.4.3 ALLOWING INJECTING DRUG USERS TO AVAIL THEMSELVES OF AN INJECTING ROOM MAY LEAD TO A REDUCTION IN CERTAIN CRIMINAL ACTIVITIES

While none of those supporting the establishment or trial of injecting rooms believe that the link between crime and drug use will totally disappear if injecting rooms become available, the reasoning behind this statement is that when an injecting drug user gains more control over his or her life, it is more likely that will cease or reduce their involvement in opportunistic or petty crime. As long as drugs remain available only on the black market, resort to more serious criminal activity will continue.

Overseas evidence from a study done of the injecting room in Berne suggests injecting rooms can reduce drug dealing activities. The study provided comparative data on injecting drug users= behaviour in 1990 (112 users) and again in 1995 (155 users). Drug dealing as a source of income was mentioned significantly less in 1995 (28%) than in 1990 (65%) (Buerki, op cit, 1996). Clear staff policies and procedures with regard to drug dealing would be required for injecting rooms if they were to proceed. Any drug dealing inside the European injecting rooms leads to expulsion of the client and the police are called. The Buerki study also showed that the number of clients in receipt of social benefits increased significantly from 12% in 1990 to 49% in 1995, which may indicate that injecting drug users had turned away from criminal activity and were relying instead on the welfare system. If those using an injecting room can be encouraged into drug treatment programs as happens in Switzerland and Germany, this may also lead to a reduction in crime.

Having a number of injecting drug users in one known place may also make it easier for police to keep a watchful eye on them, which in turn may lead to less opportunity for injecting drug users to commit opportunistic crime.

Injecting rooms may also be of assistance in reducing the numbers of injecting drug users who obtain their drugs, use them in their cars and then drive away while obviously drug affected. Evidence of this occurring in areas such as Redfern and Kings Cross was presented to the Committee.

Mr Kemp, a Kings Cross resident, told the Committee:

> *I live on the first floor of my building and I have witnessed many times people injecting in their cars, who then drive off. You notice when you look down, a car with a cigarette lighter lit in the car. It is perfectly obvious what they are doing. It is lit for quite some time while they are heating the heroin in the spoon ready to inject. We see this happen day in and day out* (Kemp, Evidence 8 October 1997).

Ms Haines, a resident in Redfern said:

> *I have found one of the increasing problems is people driving to the area to score and then injecting. We have a metre before the kerb, so cars park there and they inject* (Haines, Evidence 9 October 1997).

Ms West, a North Coast resident also saw injecting rooms as presenting an opportunity to decrease the incidence of those driving under the influence of drugs:

> *People travelling from Lismore and near-by areas who now stop by the road and have their hits on the way out of town and rejoin the road could safely consume their drug and level out before driving* (West, Evidence 30 July 1997).

This Committee condemns driving while intoxicated with any substance. Injecting rooms may alleviate the problem in that they would provide an area where the drugs could be used and injecting drug users would be able to remain on the premises until they were no longer drug affected. A witness told the Committee that in one illegal injecting room in Sydney, people who are intoxicated are encouraged to stay on the premises after injecting drugs.

Another aspect in relation to the reduction of criminal activity relates to that perpetrated on the injecting drug user him or herself. This was alluded to by Commissioner Wood when he said in the Final Report that an injecting room environment would ›reduce violence and theft perpetrated against injecting drug users= (Wood, *Final Report Vol II: Reform*, p226).

Dr Mitchell, Secretary of the Nimbin Older Women=s Forum referred to occurrences of this in her evidence to the Committee:

> *In the last month I have observed something which I find quite worrying and most unfortunate and that is some violence among young people, non-drug users against drug users* (Mitchell, Evidence 30 July 1997).

Ms Henry, a needle and syringe exchange worker told the Committee that in a focus group she had held with 15 injecting drug users to canvas their views on an approved injecting room:

> *All of those people, by the way, had been treated differently because they were injectors. All of them had been verbally abused and most of them had been physically attacked* (Henry, Evidence 30 July 1997).

4.4.4 INJECTING ROOMS MAY PROVIDE A VENUE TO IMPROVE THE LIKELIHOOD OF RE-INTEGRATION OF INJECTING DRUG USERS INTO MAINSTREAM SOCIETY

In addition to providing a safer place to inject drugs, injecting rooms may assist drug users to re-integrate into society. International experience appears to suggest that injecting rooms which provide activities and job schemes, as is the case in Rotterdam and Frankfurt, allow some clients to control, and therefore reduce, their drug use. Dr Rihs-Middel, from the Swiss Federal Office of Public Health, explained to the

Subcommittee that the Health Department had no difficulty expressing disapproval of drug injecting on the one hand, but making provision for those who still chose to inject, on the other (Rihs-Middel, Briefing 27 August 1997).

Many injecting rooms in European cities provide opportunities for drug users to develop vocational and life skills, for example, drug users are employed in the cafe in the injecting room in Basel. People who attend the Schielestrasse, in Frankfurt can join a job scheme as well as participate in photography, metal work and gardening courses. In addition, the injecting room provides especially designed education programs for injecting drug users who have missed schooling due to their drug use. In Rotterdam, drug users are encouraged to join in group meals. Accommodation was provided by two other injecting rooms in Europe. For many drug users, injecting rooms provide their only source of social interaction and support.

Evidence gathered on the Subcommittee=s study tour was that drug users actually decreased their use of drugs when provided with the opportunity to engage in skills programs in Frankfurt and in community activities in Rotterdam.

The evaluation of the three injecting rooms in Basel concluded:

> *A very important function of the injecting rooms is in the improvement of social integration of drug addicts. Of those surveyed 20% did not nominate any support person or professional carer as a significant support - for these individuals the injecting room was an important social network ... of central significance for the social integration of drug addicts is their relationship to the teams at the injecting rooms ... the users are not pushed to do anything, but the team members try and help them with their current problems, to build an important relationship of trust between the user and the team member* (the Ronco Report, op cit, 1994).

This finding suggests that injecting rooms could contribute to the social re-adjustment and re-integration of injecting drug users into society. Dr Manderson told the Committee that if we want drug users to rejoin our society, we have to help them every step along the way:

> *The fact is about drug users, almost without exception ... they do change their behaviour over time, if they do not die first. Injecting rooms not only are a way of saving people=s lives while they have time to think, but show something very important to these people; it shows a community that wants to help, a community that respects and a community that has an amount of patience to enable them to change their lives in their own time. I would suggest that is the kind of community that you would want to come back to and you would want to be a part of* (Manderson, Evidence 24 October 1997).

It is generally accepted that most young people who experiment with illicit drugs eventually grow out of it. This was described in the Penington Report as follows:

> *Preventing young people commencing use or reducing the levels of misuse is one of the potentially most significant initiatives that could emerge from this investigation. The vast majority of young people who try illicit drugs are simply experimenting, primarily with cannabis, and will*

> *not develop a dependency on this or other illicit substances* (the Penington Report, op cit, p94).

Mr Trimingham told the Committee:

> *There is a huge gap, particularly for young people, in the right sort of rehabilitation and the motivation for rehabilitation. I believe that for a lot of users it is possibly 10 years of staying alive, supporting their habit almost, until they get to the point of deciding to move into recovery. If we can save their lives for that period - and if you are looking at the economics - it is better and probably cheaper to do it as a health procedure than as a criminal procedure in terms of the cost of keeping them incarcerated, et cetera* (Trimingham, Evidence 30 September 1997).

Mr Donald Griffin, a Health Education Officer who works at St George and Canterbury Hospitals re-iterated Mr Trimingham=s call when he said to the Committee:

> *Harm reduction for me means keeping people alive until they can get enough information to modify their behaviours. I have seen that as people get older they get more willing to modify their behaviours* (Griffin, Evidence 7 October 1997).

4.4.5 INJECTING ROOMS WOULD PROVIDE A VALUABLE POINT OF CONTACT

A number of witnesses appearing before the Committee stressed that injecting rooms would provide a valuable point of contact not currently available with the most marginal injecting drug users, the group most likely to use such a facility. Even in the case of those who attend a needle syringe exchange outlet, there is rarely the time available to establish a rapport and build a relationship of trust which may then give health workers the opportunity to provide information on other drug treatment services and programs.

Mr Griffin told the Committee:

> *In dealing with injecting drug users you get certain intervention points and since we started the first needle exchanges here, we have had an intervention point where we can expose them to education, relate to them and talk to them about behaviour changes and so forth. With a safe injecting room, you suddenly do get a much longer period of time in which to interact with these people. I have seen this work at the injecting rooms in the Cross, whereby there is no hurry to get out of the place. In fact, they are feeling quite often relatively mellow, having used the facilities and are accessible and open to information being given to them* (Griffin, Evidence 7 October 1997).

Ms Karen Henry, a former injecting drug user said:

> *I, as a drug user, made an isolated choice. I was alone when I decided to use heroin. The only people I had access to were other heroin users, my friends. I did not have access to information, the awareness of health, my own individual health that I do today ... The difference between what is*

> *happening now and what would happen if there were an approved injecting room is that the treatment gateway would move from 3 or 4 years down the track to a lot closer to the initial decision to reject the drug* (Henry, Evidence 30 July 1997).

Injecting rooms would be of benefit not only to the wider community but to individual drug users themselves, by providing a means by which they could re-integrate into mainstream society.

4.5 SOCIAL IMPLICATIONS: ARGUMENTS AGAINST

From the submissions put to the Committee the following areas of general concern surrounding the establishment or trial of injecting rooms emerged: it was claimed that it would send the ›wrong message= to the community, especially young people, about the acceptability of using illicit drugs; the fact that there would be a congregation of drug users in areas where injecting rooms were located would lead to stigmatisation of those areas as drug centres; injecting rooms would lead to an increase in crime; and the quality of life in some regions would be diminished.

4.5.1 THE ESTABLISHMENT OF INJECTING ROOMS COULD LEAD TO THE ASSUMPTION THAT INJECTING DRUG USE IS CONDONED

Witnesses said that the establishment or trial of injecting rooms could be interpreted as condoning illicit drug use, especially in areas where high use is already apparent. Councillor Ngo from Fairfield City Council told the Committee:

> *The community has been tainted over the years of living in criminality and may I say that, by proposing introducing some safe injecting rooms, I would have thought that we are sending very wrong signals, the wrong message, to the drug addicts and the drug dealers in that particular region in Sydney* (Ngo, Evidence 9 October 1997).

Sending the wrong message to young people was of particular concern:

> *The provision of formal support for illegal activity and hard drug addiction sends the message to our youth that hard drug use is condoned by our community leaders* (Ubrihien, Submission 50).

Others like Mr George, whose son was a former injecting drug user, felt that injecting rooms were not the answer as:

> *the provision of ›illegal drug= injecting rooms will not solve the drug problem. It could, however, maintain drug addicts in a permanent state of mental oblivion to which they may as well be dead* (George, Submission 5).

Other comments were of a more general nature such as ›prohibition works= and ›harm reduction has failed=. It was suggested that a trial of an injecting room would be a

flawed approach to the question of drug addiction and would signal that ›the war on drugs= has been lost.

4.5.2 INJECTING ROOMS MAY LEAD TO THE CONGREGATION OF DRUG USERS

It was put to the Committee that injecting drug users would be attracted to those areas where an injecting room was located - ›the honey-pot effect=. Further, if injecting rooms were established or trialled in areas where illicit drug use is already a problem, it would result in only more problems being created:

Councillor Ngo from Fairfield City Council felt:

> *It would make Cabramatta a place where people can think they can just jump on the train or jump in a cab and go to ... to have access to drugs easily and then even use the facility to use the drugs there* (Ngo, Evidence 9 October 1997).

One suggestion to overcome the ›honey-pot effect= was that more than one injecting room should be established or trialled:

> *Providing a ›safe house= will only make this scene worse. If it is proposed that Nimbin be set up as the only ›approved injecting room=, the ›honey-pot effect= will be horrendous ... we certainly do not agree to Nimbin being in isolation, which I have already pointed out is not in isolation anyhow. If we had only one it would only create a honey pot effect. If it is going to happen let us have lots of them* (Soward, Evidence 30 July 1997).

There was concern that not only would injecting rooms attract more drug users to specific areas, but that they would lead to a reduction in the quality of life for local residents.

> *Establishing ›safe injecting rooms= in Nimbin, however, would maintain and is likely to add to, the disproportionate number of users in this area to the further detriment of other residents* (Lang, Submission 23).

> *... my vehement objection to the establishment of the proposed injecting rooms anywhere in Australia and particularly in my home town of Cabramatta ... the existence of these establishments would, without exception, increase the incidence of usage of illegal drugs* (Baker, Submission 38).

Negative experience with other drug services, such as needle and syringe exchange programs and methadone maintenance treatment programs, had led some witnesses to believe that the establishment of injecting rooms would have a similar effect.

> *The honey pot effect will occur, this has been proved in Nimbin, with the establishment of the methadone programme. Heroin addicts are travelling to Nimbin from far afield, because it is known that it is easy to get access to the program at Nimbin* (Johnston, Submission 25).

Dr Maher told the Committee:

> *My personal opinion is that Cabramatta is perhaps not the best place to trial the safe injecting facility, given that there are very complex issues to do with the ethnic communities there. There is already, I think, a high degree of perhaps hostility and opposition that we have seen in relation to the needle and syringe issues in that community. What young people are attracted to is not, I think, the idea of needle exchanges and safe injecting rooms, it is this incredibly vibrant street scene. It is a convergence of people from the local area. It is out there, it is happening and it is on the edge and a really cool place to be.*
>
> *You need to be very careful in terms of the fact that there is a large population of young people who are at risk in that community means that the kind of services that you put in there should perhaps more be aimed at prevention and education as well as taking care of the health needs of those people who are using drugs in the area* (Maher, Evidence 8 October 1997).

Dr Garsia, Chair of the Ministerial Advisory Committee on AIDS Strategy drew the Committee=s attention to the following point:

> *There is one other issue and if I could finish with potential cost, and one thing which we have not explored and one reason why a trial is so important, that is, there is a potential risk one would encourage networks and that there will be interaction between geographical users who have not previously had that interaction. That is one area which has to be explored. One has to do the sociological and ethnographic research with these sorts of proposals if one is to go beyond that sort of facility in the future to something which might be more effective as well. The committee [Ministerial Advisory Committee on AIDS Strategy] does view this very much as a pilot, a trial, something to be learnt from. It may be that it has a short life and that something better emerges from it in the future* (Garsia, Evidence 8 October 1997).

4.5.3 AREAS WHERE INJECTING ROOMS ARE LOCATED MAY BECOME LABELLED AS DRUG CENTRES

Councillor Ngo of Fairfield strongly objected, even on a trial basis, to the introduction of injecting rooms within the Fairfield local government area boundaries. He was particularly concerned about the public image of Cabramatta and the City of Fairfield as a drug centre, and felt that an injecting room would only exacerbate this problem:

> *The public image of Cabramatta or the City of Fairfield has been somewhat that is far less than desirable and the public perception of the place, I must say, has been very, very damaging to the local community who live there ... no doubt we would send a very wrong signal to the community that: 'Oh, well, because that particular region of Sydney has such a large concentration of Indo-Chinese or Asian communities, if we cannot have it elsewhere in Sydney we will just dump it in that area of Cabramatta because those Indo-Chinese would not know how to react, would not know how to object; let them have it if nobody else wants it'* (Ngo, Evidence 9 October 1997).

In a submission to the Committee, Ms Harrington wrote:

> *This move will surely attract drug addicts to Cabramatta and its areas, and this will definitely make Cabramatta 'the drug capital of Australia'. To think it will not is a very naive outlook* (Harrington, Submission 2).

Similar apprehensions were expressed by residents in Nimbin:

> *We believe that the provision of a 'safe house' in Nimbin will serve to further identify our town as 'the drug capital of Australia', and as such, will attract more itinerant, untidy, unlawful, indolent and unemployed youth of the type we already have an excess of* (Ubrihien, Submission 50).

4.5.4 INJECTING ROOMS MAY LEAD TO AN INCREASE IN DRUG DEALING IN THE NEARBY VICINITY

Another concern expressed to the Committee by local government representatives, residents and drug and alcohol workers, was that injecting rooms could lead to an increase in drug dealing in the nearby vicinity.

Several local residents voiced the opinion that:

> *We can only see these rooms as being 'honey pots' for drug takers as well as 'Meccas' for drug dealers who would no doubt take advantage of extra customers. Of course all of this also goes hand in hand with crime to feed the habit* (Ellen, Submission 15).

The following remark by Major Brian Watters, a Salvation Army drug and alcohol worker evidences similar concern:

> *Can it seriously be denied that the provision of legal facilities for the use of drugs and safe from police interference will not generate a supply to*

> *meet the demands for the substances ? These places will become a 'Mecca' for dealers and pushers. They will not only be supplying the existing demands, they will be stimulating and expanding their markets* (Watters, Submission 93).

4.5.5 THE CONGREGATION OF INJECTING DRUG USERS WHERE INJECTING ROOMS ARE LOCATED MAY LEAD TO AN INCREASE IN OPPORTUNISTIC STREET AND PROPERTY CRIME

It was thought by some witnesses that as a consequence of increased numbers of injecting drug users in any one place, there would be an increase in unruly behaviour, intimidation, vandalism, opportunistic crime, and street crime.

When asked whether injecting drug users travelling to a particular location where an injecting room was situated were likely to perpetrate property crime in that community, Dr Weatherburn replied:

> *I think the answer is yes. If more heroin users are drawn to Cabramatta, there will be more crime in Cabramatta, simply because people tend to commit crime when they need a fix. They are not going to say 'I need a fix, I think I had better travel back to Double Bay' unless there are limited opportunities for committing crime in Cabramatta* (Weatherburn, Evidence 1 October 1997).

Mr Ubrihien, a resident in Nimbin wrote:

> *We believe that the provision of a 'safe house' will only serve to increase the degree of drug-related crime in our local area* (Ubrihien, Submission 50).

4.5.6 THERE ARE MORAL GROUNDS FOR OBJECTING TO THE ESTABLISHMENT OF INJECTING ROOMS

Many people in the community regard illicit drug use as morally wrong and therefore oppose on principle any proposals which seem to sanction the practice even if these are being suggested as part of a harm reduction approach. Professor Penington, who was Chair of the Premier's Drug Advisory Council in Victoria, made this point in a presentation he gave at the New South Wales Parliament House in July 1996, when he described his involvement in the Council:

> *I went into it knowing that it would be controversial, I went into it knowing that we would be dealing with a situation where a number of people in the community have very strongly held views, that use of illicit drugs is to them an immoral act, open and shut, that anything to do with illicit drugs is something wicked, something that is very closely aligned to peoples' religious views or peoples' set of moral values. That is one problem and many of those people are not willing even to have questions raised to analyse the situation to see whether or not arrangements, as they now stand, are working, whether they are productive or counter-productive.*

Mrs McKay, whose son died of an overdose, believed that an injecting room would encourage drug use:

> *No Government should encourage addiction - that is what this is doing. It is morally wrong to encourage people to inject heroin and other illegal substances* (McKay, Submission 30).

Mr Smith a resident of Lismore wrote:

> *The use of addictive drugs is a voluntary action and if the person becomes an addict to heroin, morphine etc it is for the want of a better word 'a self inflicted wound' and the law abiding citizens and society owes the addict nothing. The suggestion of safe injecting rooms for drug addicts is revolting, vulgar and an insult to all law abiding citizens who face every day problems without turning to drugs. Safe injecting rooms would be a reward for illegal actions and would encourage weak willed persons to follow the same road* (Smith, Submission 6).

In correspondence to the Committee, Dr Bernadette Tobin, Director of the Plunkett Centre for Ethics in Health Care canvassed a number of issues surrounding the question of whether there is an ethical obligation on the state to provide a service such as an injecting room, which appears to reduce mortality and morbidity amongst a particular group in the community. Dr Tobin concluded that while it could be argued that the state might have a responsibility not only to protect the society from the harms inflicted upon it by drug users, but also to protect drug users from the harms they inflict on themselves:

> *Further questions need to be answered in order to see what would fulfil that responsibility, and in particular to see whether the state is (morally) obliged to set up 'safe injecting rooms'. Specifically:*
>
> *1 Is the establishment of 'safe injecting rooms' likely to reduce the harmful effects of injecting drug use on (a) drug users themselves and (b) the rest of society ?*
>
> *2 Would the putative benefits of the establishment of these rooms be outweighed by their likely disvalue (or 'social cost') ?*
>
> *3 Given limited resources, are there more pressing social needs than those to which this form of harm minimisation is addressed ?* (Tobin, Correspondence 16 October 1997).

4.5.7 AREAS CHOSEN AS SITES FOR INJECTING ROOMS MAY FEEL THAT THEY ARE BEING TREATED AS SOCIAL EXPERIMENTS

Some witnesses appearing before the Committee expressed the view that locating an injecting room in their town or suburb, whether it was as a trial or on a more permanent basis, would be making them the 'guinea pigs' for the rest of the State:

Mr Douglas Whitlen, the Treasurer of the Nimbin Chamber of Commerce told the Committee:

> *Further, to develop the methodology to compare the Nimbin trial with other potential approved injecting rooms in Australia the Chamber does not feel that Nimbin is an appropriate venue for such a trial. It has been the brunt of socialist experimentation for the past 25 years. Some of these experiences have been very exciting and educational and some, to say the least, have created very heavy and uninvited burdens for a small community and have created deep division within the community* (Whitlen, Evidence 30 July 1997).

ECONOMIC IMPLICATIONS

4.6 ECONOMIC IMPLICATIONS: ARGUMENTS FOR

There is evidence to suggest that economic benefits from establishing injecting rooms would be likely and that the expenditure on their establishment and maintenance would ultimately reduce the financial burden on the government and the community. Savings would be made from reducing the costs associated with treating overdoses and blood-borne infections, and by re-integrating people into society.

4.6.1 INJECTING ROOMS MAY REDUCE THE COSTS TO THE COMMUNITY ASSOCIATED WITH THE TREATMENT OF OVERDOSES AND THE TREATMENT OF PEOPLE WHO CONTRACT BLOOD-BORNE VIRAL INFECTIONS

In addition to the tragic loss of life, there are significant financial costs involved in the treatment of drug overdoses. This includes the cost of ambulance response, admission and treatments in hospital emergency departments, intensive care units, general hospital wards and the cost of rehabilitation if the user does not die but is seriously disabled. Brain damage (of varying severity) may also be an injury sustained in some non-fatal overdose cases.

The costs to an individual of contracting HIV, hepatitis B or hepatitis C infection are very large as is the cost to the community. The medical cost of treating infections such as HIV and hepatitis C are significant. With regard to HIV infection, Professor Kaldor made the following comment to the Committee:

> *One HIV infection in terms of medical and health care costs represents about $100,000 to the Australian health budget* (Kaldor, Evidence 7 October 1997).

The lifetime cost of treating a person with hepatitis C has yet to be calculated, but is also likely to be significant as many sufferers develop liver cancer or cirrhosis and require expensive drug treatment and/or liver transplants. The Committee heard evidence from the Hepatitis C Council on the extent of hepatitis C infection and the associated costs:

> *We assume that there are around about 88,000 or 90,000 people in New South Wales with hepatitis C and it is going to cost the health system $1.258 billion for the current pool. For the new infections which are taking place, it is adding $71 million per year to the already high number* (Loveday, Evidence 7 October 1997).

Mr Tim Sladden, an epidemiologist with the Northern Rivers Area Health Service wrote in his submission to the Committee:

> *A North Coast study that we conducted showed 85% of local hepatitis C transmission was via injecting drug use. With interferon treatment and long term liver transplant as the only two major treatments currently available, the costs of treatment for this disease will continue to be substantial in the years to come* (Sladden, Submission 12).

If injecting rooms contribute to a reduction in the transmission of these blood-borne viral illnesses, the financial burden on the community of supporting individuals with HIV, hepatitis C or hepatitis B would be lessened. In Dr Wodak=s assessment:

> *I do not think we are going to get the enormous benefits that we get from needle exchange and methadone programs, for example, but I think the benefits are going to far outweigh the costs. I do not think there is going to be any difficulty there. You do not really have to prevent many overdose deaths or HIV infections to have institutions like injecting rooms pay for themselves several times over* (Wodak, Evidence 9 October 1997).

Evidence from Europe seems to indicate that injecting rooms can make a contribution to the prevention of HIV and hepatitis C, which results ultimately in savings to the health budget. In Frankfurt, for example, the ratio of HIV positive tested victims of lethal overdoses steadily declined from 21% in 1986 to 8% in 1995, and has been attributed in part to the establishment of safe injecting rooms and the increased opportunity for injecting drug users to obtain sterile injecting equipment (Weber, op cit, 1996).

4.6.2 INJECTING ROOMS MODELLED ALONG THE LINES OF A MORE GENERAL HEALTH FACILITY MAY REDUCE THE SOCIAL AND ECONOMIC COSTS TO THE COMMUNITY OF INJECTING DRUG USE

Health costs of a drug dependent person are estimated to be some 80% higher than those of the average citizen in the same age group. If injecting rooms provided information to injecting drug users on issues such as primary health care, how to avoid needle-site infections and overdoses, and how to access drug treatment and rehabilitation programs, economic and social costs to the community related to injecting drug use may be reduced.

The Committee heard evidence on the overall cost to the health budget related to the treatment and care of injecting drug users. Treatment ranges from localised infections of injecting sites to illnesses such as pelvic inflammatory disease, damaged heart valves and lung and brain abscesses.

Dr Andrew Penman, Director of the Centre for Disease Prevention and Health, NSW Health Department, informed the Committee that:

> *Reducing diseases such as injecting site infections is... a very likely outcome and an important issue in the chronic user. The severity and expense of treating these conditions should not be under-estimated* (Dr Penman, Evidence 24 October 1997).

If these problems could be avoided there would be an immediate saving of money. Moreover, if information and education provided at an injecting room led to an injecting drug user seeking earlier entry into drug treatment and rehabilitation, the costs associated with illicit drug use would be lessened. Professor Hall referred to the long term cost-effectiveness of drug treatment programs:

> *The American research - and there has been a substantial amount - indicates that all the major forms of treatment for injecting drug use are of economic benefit, that is, they return much more to the tax payer than the cost to provide them, and that includes methadone maintenance treatment, drug free treatment such as therapeutic communities and drug free outpatient counselling. In terms of value for money, methadone comes out in front largely because more people are attracted into and are retained in it as a form of treatment* (Hall, Evidence 24 October 1997).

4.6.3 INJECTING ROOMS MAY MEAN LESS TIME, AND CONSEQUENTLY LESS MONEY, WILL NEED TO BE SPENT BY COUNCILS ON REMOVING DISCARDED SYRINGES FROM PUBLIC AREAS

Local government representatives told the Committee that removing used injecting paraphernalia from public places represented an additional cost to councils. While the activity was necessary in the interest of community protection, it meant funds used in this manner were unavailable for other more useful activities. Details on the ever present fear of needle-stick injuries amongst council workers and the potential risk that such injuries posed for the community at large were presented. Injecting rooms may assist in removing this concern, and on a practical level, they may lead to a possible reduction in costs associated with workers compensation claims for injuries sustained

removing the used injecting drug paraphernalia, or civil damages brought by members of the public who receive needle-stick injuries in public places.

In addition, facilities such as public toilets are sometimes closed as a means of dealing with the problem of discarded injecting equipment. This results in a loss of amenities to the general public. If the problem can be alleviated by injecting drug users attending an injecting room, general public access to the otherwise closed facilities will be restored.

The Mayor of South Sydney Council outlined the situation in his local government area to the Committee:

> *It is an enormous problem for a large number of our residents and, more importantly, it is a problem for our workers who are constantly having to avoid needle-stick injuries as they go about their work. Council is constantly receiving complaints about needles on footpaths, in parks and, most disturbingly, in playgrounds and sandpits within child-care centres. In fact, the council has been forced to close a number of public toilets in areas such as Kings Cross, not only out of public safety concerns but also because our maintenance people were constantly having to clear needles out of blocked toilets. These closures have not solved the problem. The users have moved to another location and the public has lost access to important facilities* (Smith, Evidence 1 October 1997).

4.6.4 THE RETURN FOR MONEY SPENT ON INCREASED LAW ENFORCEMENT DOES NOT APPEAR TO DATE TO HAVE BEEN COST EFFECTIVE

It seems generally accepted that prohibition laws and tough enforcement measures have not been able to stem the use of illegal drugs. The view that a drug free New South Wales is possible conflicts with a large body of evidence presented to the Royal Commission into the New South Wales Police Service. In the Final Report on the New South Wales Police Service, Commissioner Wood said that: ›it is fanciful to think that drug addicts can be prevented from obtaining and using prohibited drugs= (Wood, *Vol II: Reform*, op cit, p226).

When Dr Don Weatherburn, Director of the NSW Bureau of Crime Statistics and Research, was asked whether the balance between law enforcement and drug treatment was right he gave the following answer:

> *Not if you believe the most recent analysis of this same problem by the Rand corporation in the United States. We have not done this work but that corporation did an elaborate simulation analysis of the balance between law enforcement and treatment in the United States, basically comparing what might crudely be called the ›bang for the buck=. In other words, trying to work out where to invest resources to get the biggest reduction in social costs. The corporation argued that the United States would get a bigger reduction in social costs if it shifted more emphasis towards treatment and less emphasis on law enforcement. The only caveat or reservation I would have about the applicability of its conclusions here is that Australia already invests a lot more in treatment than the United States does ... I think the thing we are missing here is a*

> *real determination to try to integrate treatment and law enforcement* (Weatherburn, Evidence 1 October 1997).

Dr Weatherburn also commented as to what effect, if any, drug seizures had on drug markets:

> *Nil. We spent two years investigating the seizures of heroin around Australia in excess of one kilo while, at the same time, monitoring the price, purity and availability of heroin in Cabramatta, which is generally considered to be the largest street market for heroin. We could find no effect whatsoever of seizures. It did not matter how large the seizure, it had no effect at all on price, purity and availability* (Weatherburn, Evidence 1 October 1997).

Responding to illicit drug issues is more than just a question of ›sending messages=. It is also a matter of using the available resources to achieve the best health, social and economic outcomes for the entire community.

4.7 ECONOMIC IMPLICATIONS: ARGUMENTS AGAINST

A number of witnesses questioned the appropriateness of spending finite resources on establishing or trialing injecting rooms, given that there was no guarantee that they would prove to be beneficial or cost effective. Others thought that funding should be directed to other drug treatment and rehabilitation services and on increasing law enforcement efforts. The view that injecting rooms would have a negative impact on businesses and property values in the nearby vicinity was also put to the Committee.

4.7.1 CONCERN THAT SPENDING MONEY ON INJECTING DRUG USERS IS A WASTE OF RESOURCES

The reaction of the general community to injecting drug users is varied. Some feel sympathy and concern, others are apprehensive and fearful, and some feel injecting drug users only have themselves to blame. In his evidence to the Committee, Professor Webster, Professor of Public Health at the University of New South Wales, said:

> *I think there is a general attitude in the community which despises drug using people. That was evident recently in a Morgan poll reported by the Bulletin magazine, where about 65% of the population said that they would not be prepared to live next door to a drug using person. Those sorts of attitudes permeate many of our systems* (Webster, Evidence 8 October 1997).

It was claimed by some that injecting rooms would be expensive to run, and a degree of resentment that funds were being expended on illicit drug users was apparent.

The views expressed below are illustrative of this sentiment:

> *While smokers have been savagely attacked and campaigned against from every corner, drug addicts have been given more than a fair go. A lot*

> *of hard earned cash has been spent for these addicts, places like methadone clinics etc. These addicts have brought their misery on themselves ... I very strongly object to having my hard earned money used to open shooting galleries* (Deguara, Submission 1).
>
> *If you have $175,000 to 'waste' on setting up some comfy place for addicts, it would be better used to give us some law and order in this community to help rid us of these 'non-local' individuals* (Wilde, Submission 16).
>
> *It would be too costly to the public to establish these premises. To open them in one or two areas around the state would be paying lip service to the problem* (Bingham, Submission 3); and
>
> *As a member of the general public, I object to our taxes being wasted in this way* (Crane, Submission 10).

Mr Gregory Soward, the President of the Nimbin Agricultural Industrial Society said:

> *Why should we make their lives comfortable ? Why should we pay for their habit ? Why should we feel uncomfortable walking down the main street of our own town ? Why are their problems in life any worse than ours ? ... We have all suffered grief and despair but we know if you hang in there and plug on you can get on top of it. Letting yourself slide down and hide behind a veil of unreality is not the answer, and expecting to be picked up at society's expense is unrealistic and grossly unfair on those who do play on and climb out. Society is already feeding them, housing them, clothing them ... How much further do we have to go ? Ask them what they give back to society ?* (Soward, Evidence 30 July 1997).

One person believed that blood-borne viral infections are diseases which affect only a small minority, and therefore do not warrant money being spent on facilities such as injecting rooms to prevent their transmission. Mr MacNeill wrote in his submission:

> *I now come to the most insidious aspects of the problems in Nimbin. I have dealt with the external government/health department interference (on the pretext of 'stopping disease' spreading) or the AIDS scam, as it really is a scam as AIDS, hepatitis C etc are such minor diseases in such a small minority of the population that their 'prevention' in no way can justify the spreading of the far more serious 'disease' of Opiate Addiction. In fact, it is ridiculous worrying about addicts having diseases or overdosing as it is a self inflicted problem* (MacNeill, Submission 46).

4.7.2 INJECTING ROOMS WOULD HAVE A NEGATIVE IMPACT ON BUSINESSES AND ON PROPERTY VALUES IN THE NEARBY VICINITY

A number of residents were worried that the introduction of an injecting room would have an adverse impact on businesses and properties in the nearby area:

> *If the establishment or trial of safe, sanitary injecting rooms were to be conducted in only one selected location this potentially could attract significant numbers of drug users to the one location. Possible*

> *depreciation of property values of houses and businesses in the selected area as a result of being in a location where safe, sanitary injecting rooms are being conducted. Insurance premiums could also potentially rise* (Ettinger House, Submission 56).

A number of other examples were given to the Committee of potential costs which may be incurred if injecting rooms were established. These included:

- the need to upgrade security to prevent injecting drug users from using their premises, particularly toilet facilities provided for staff and customers;

- the congregation of injecting drug users may lead to the possible increase in shoplifting;

- the presence of injecting rooms may affect the level of custom in the businesses nearby. The Committee was told that the close proximity of the public toilet facilities in Nimbin, which are extensively used by injecting drug users, to the Nimbin School of Arts, led to the cancellation of TAFE programmes being conducted on its premises, resulting in a significant loss of revenue to that organisation.

- the existence of an injecting room in a regional centre may affect tourism. Mr MacNeill wrote: *Nimbin, which used to be a tourist mecca, is now experiencing negative tourism growth, as there is now nothing to see that is any different from Kings Cross or Cabramatta* (MacNeill, Submission 46)

- insurance premiums on premises located near an injecting room may rise. Mr Malouf, the President of the Australian Pharmacists Against Drug Abuse, wrote: *Heavy insurance and legal liability of official workers at the clinic would be another significant cost consideration* (Malouf, Submission 55); and

- workers compensation premiums for those working in the injecting room precinct such as council workers, emergency service personnel may also increase.

4.7.3 MONEY SPENT ON INJECTING ROOMS WOULD BE BETTER SPENT ON ALTERNATIVE DRUG TREATMENT AND REHABILITATION PROGRAMS

Another concern was that drug services, especially those promoting abstinence, should be funded before injecting rooms, especially given the fact that funding to drug and alcohol programs is finite. It was put to the Committee that scarce resources used to establish or trial injecting rooms would be better spent on expanding the range and capacity of drug treatment programs. The kinds of services mentioned were: rehabilitation; methadone detoxification, and ultra rapid opiate detoxification.

According to Mr Brad Soward:

> *If this program is implemented on a wide scale, it is going to cost the taxpayers of this State millions, money which could be more efficiently and more productively utilized by providing detox and mental health programs to actually address the reasons why people use in the first place*

*and helping them to stop (*Soward, Submission 65).

Mrs Quinton whose son has a drug and alcohol problem wrote:

> *We should be spending that money on rehabilitation programmes of which there are far too few and don't have enough beds ... we should be investigating detoxification programmes such as the one being run by the Israeli doctor recently reported on the 60 Minutes programme* (Quinton, Submission 7).

The various alternative treatments brought to the attention of the Committee were not examined in any great detail as the Terms of Reference were limited to the consideration of safe, sanitary injecting rooms only. However, the Committee recognises they form part of the panoply of possible treatment options.

The view of the Fairfield City Council was that:

> *The current initiatives by the Council, State Government and non-government agencies are targeting the drug problems by positive measures based upon education, detoxification, rehabilitation and control. Notwithstanding these current proposals regarding detoxification Council notes that while a facility is proposed for the future, no facility currently exists in Fairfield or within the South Western Area Health Service. Drug dependent persons urgently need access to these facilities and it is imperative that other issues do not result in funds or the priority of providing rehabilitation and detoxification facilities be reduced or delayed. The debate about the establishment of injecting rooms has this potential* (Long, Submission 87).

Mr O'Halloran, Chairperson of the Byron Bay Community Safety Committee told the Committee:

> *Funding of the trial safe injecting house program should it eventuate in Nimbin or anywhere else in this region should not jeopardise or in any way subvert funding away from much needed detoxification options and programs* (O'Halloran, Evidence 30 July 1997).

The need to increase education about the harms of drug use and about the safe disposal of injecting equipment was also called for. Allocating funds to the Needle and Syringe Exchange Program, and to prevention and counselling programs was preferred to using funds for the establishment or trial of an injecting room. A need for a variety of strategies and programs to combat the problems associated with drug use was, however, acknowledged by many witnesses.

Some held the view that compulsory treatment of drug users should be introduced. Mr O'Grady, the President of the Fairfield City Chamber of Commerce suggested:

> *My vision for reducing the drug problem, would be a system of compulsory or voluntary care in a 'drug asylum' ... these centres should operate as centres of excellence devoted to the care of the addict* (O'Grady, Submission 24).

4.7.4 MONEY SPENT ON INJECTING ROOMS WOULD BE BETTER SPENT ON INCREASED LAW ENFORCEMENT

A number of submissions dealt with responses to the drug problem other than those involving harm reduction strategies which involved increased law enforcement measures such as harsher penalties for drug dealers. Some of the views illustrative of this position are:

> *I point the finger at our government officials who spent millions of dollars (again our community money) investigating drug pushers and when these offenders are caught, they just give them a slap on the wrist and fine them a few dollars. How stupid, and what a waste of time and money* (Deguara, Submission 1).

> *We also need much tougher penalties for pushers. Automatic life sentences for the big guys, 3 years jail for a Ist offence on a minor level, 5 years for a 2nd. And deportation if they are not an Australian citizen* (Quinton, Submission 7).

> *Another way the dealers could be punished, is by publishing their names in the local papers accompanied by their photos* (Brecse, Submission 71).

Mr Gregory Soward told the Committee,:

> *We would like to see more money spent on controlling, arresting, fining and imprisoning all those caught dealing in the first place. What use is it now with our weak laws that sees them back on the streets the same day?* (Soward, Evidence 30 July 1997).

It would appear from the allocation of additional funding announced recently by the Federal Government in an attempt to address Australia=s illicit drug problem that the bulk of the money is to be used pursuing law enforcement strategies.

LEGAL IMPLICATIONS

4.8 LEGAL IMPLICATIONS: ARGUMENTS FOR

The introduction of approved injecting rooms is seen by many as presenting an opportunity to reconcile the tension between the need to uphold the law while at the same time permitting harm reduction measures to take place. Police are often placed in the unenviable position of having to decide which of these functions takes precedence. Arguments have also been put for the repeal of the self-administration offence in the context of an approved injecting room as a means by which safer injection practices could be encouraged.

4.8.1 LEGALISING INJECTING ROOMS WOULD CLARIFY THE ROLE TO BE ADOPTED BY THE

POLICE IN RELATION TO BOTH THOSE USING AND THOSE RUNNING SUCH ESTABLISHMENTS

Police have the discretion not to arrest or lay a charge in a wide range of circumstances, subject to their duty to protect the peace and to uphold the law. It is this latter aspect which causes many officers a degree of difficulty. On the one hand, they are expected to uphold the law by arresting those suspected of committing drug related offences such as self-administration; possession; possession of drug paraphernalia (other than needles and syringes); aiding and abetting; or involving another person in the administration of drugs. On the other hand, they are encouraged to tolerate practices which are seen as necessary from a harm reduction perspective. Reconciling these conflicting demands creates a dilemma for the police, particularly those at an operational level. This was recognised by Commissioner Wood:

> *Tension exists between law enforcement and the recognition that addiction to prohibited drugs is also a medical and social problem. Criminal sanctions do not and cannot address the latter. The National Drugs Strategy objective is harm minimisation ... there remains a substantial area of potential conflict between traditional law enforcement methods and the harm minimisation mode* (Wood, *Vol II: Reform*, 1997, p225).

Legalising injecting rooms and exempting certain activities which would occur at such places from the appropriate offence provisions in the *Drug Misuse and Trafficking Act 1985* would resolve this problem for the police. It would also reassure the community that the police were doing their job and not ›turning a blind eye‹ to illegal activities.

As one police officer told the Committee:

> *It has to be clear cut. You cannot say let us turn a blind eye ... you cannot ask someone not to do their job ... we have to gauge by the expectations of the community and for the benefit of the community as a whole and the police service we provide*

The operation of the law as it applies to injecting drug users would continue to be the basis of policing beyond the injecting room. The community and the police would be clear about their expectations and their roles.

4.8.2 ELIMINATING THE NEED TO PURSUE SELF-ADMINISTRATION OFFENCES IN THE COURTS WOULD SAVE POLICE AND COURT TIME

It would appear that in practice the offence of self-administration is pursued less often than the offence of possession in New South Wales. Figures from the New South Wales Judicial Commission would support this claim (between August 1992 and July 1997 there were 2,380 charges for possession of heroin or cocaine, but only 568 matters of self-administration brought before the local courts). If the law were amended to provide for self-administration of illicit drugs in an approved injecting room, police and court resources would be made available to deal with more serious matters including those in the drugs area such as supply, manufacture and trafficking. Not all Australian jurisdictions have a self-administration offence on their statute books, and despite

repealing the offence of self-administer from the *Drugs Misuse Act 1986,* the Queensland government has not sought to repeal offences relating to the possession of illicit drugs.

The authors of *Beyond Prohibition* list the following as other positive aspects of repealing the self-administration offence:

> *Removing the criminality of the act of using a drug would improve the capacity of educators and researchers to communicate in direct and plain terms with people about their past and present levels of drug use, and use behaviours. It may also increase the likelihood of an injecting drug user discussing frankly any drug-related health problems with a doctor or other health professional ... In practical terms, it would mean that a person who had recently consumed a drug but had no other drugs in their possession, would not be subject to arrest or criminal charges. This would encourage larger numbers of injecting drug users to responsibly dispose of used needles and syringes, positively contributing to reduction in new HIV and hepatitis infections, and to community perceptions of public safety* (*Beyond Prohibition*, Report of the Redfern Legal Centre Drug Law Reform Project, September 1996, p12).

Although the comments made in *Beyond Prohibition* were directed at the offence of self-administration at large, they would apply equally if the offence were repealed only in the context of an approved injecting room.

Commissioner Wood called for solutions other than mere enforcement of the current drug laws:

> *Rhetoric based upon a 'war against drugs' or similar notions, is empty, and incapable of fulfilment. The problems associated with 'drug use' require a different approach to the issues related to the 'drug trade'. Law enforcement should continue to aggressively target the drug trade and heavy criminal sanctions should be applied to those who supply narcotics. Alternate solutions however need to be found in order to address drug use - the criminal process does little to reduce the availability of drugs or to discourage their use. It continues to provide opportunities for corrupt police* (Wood, *Vol II: Reform*, 1997, p224).

Both the Bar Association and the Law Society of New South Wales indicated their support for approaches to the drug problem that was consistent with harm reduction measures.

When asked if the Bar Council supported the establishment and trial of injecting rooms Mr Toner, the Secretary of the Bar Council replied: '*Yes, we are strong supporters of the Wood recommendation*' (Toner, Evidence 24 October 1997). He amplified his answer telling the Committee:

> *We have formally adopted policies that narcotic abuse ought to be treated as a medical problem rather than a legal problem ... I can assert with some confidence that the Bar supports the trial of injecting rooms, at least, and the philosophical underpinning of the idea* (Toner, Evidence 24

October 1997).

The Bar Council's support for injecting rooms was shared by the Law Society of New South Wales. Mr Roger Prowse, Chair of Law Society Criminal Law Committee said:

> *I must say the proposal is something that I personally support. I would be confident though, not only because I am the Chair, I would be confident that the views that I have expressed would find support amongst the majority if not all of the [Criminal Law] Committee* (Prowse, Evidence 24 October 1997).

According to Mr Prowse drug use must be treated as a 'medical problem' because the 'heavy hand of the law rarely brings about a beneficial outcome.' When asked if he could see any disadvantages in the establishment of injecting rooms, Mr Prowse replied to the Committee: '*No. I cannot see any disadvantages at all, in fact I can only see benefits*' (Prowse, Evidence 24 October 1997).

The Law Society supports harm reduction principles and believes that drug dependence should be viewed as a medical problem. It has resolved that:

> *Drug laws should be reformed so as to make central to policy the minimisation of the harm drug use can cause to individual users and to the general community; such a policy should incorporate containment of drug usage alongside a recognition that those dependent on drugs have a medical problem* (Copy of Resolution 2 passed at the meeting held on 2 November 1995 provided to the Committee).

It was apparent from submissions and evidence before the Committee that for some people it is important to distinguish between those who use illicit drugs and those who supply them:

> *Firstly we believe a distinction needs to be made between the heroin addict and the heroin pusher and they must be treated accordingly. The real problem is the drug pushers. These people must be dealt with harshly and made accountable for the problems they are causing. It is fair to say that the crime which accompanies drug addiction is largely the responsibility of those who have made the drugs available in the first place and who continue to supply users' habits. The government should be looking to increase the penalties for such offences and give police greater ability to find and deal with these people* (Nash, Submission 28).

Mr O'Halloran said:

> *I favour harsher penalties for those involved in the importation of heroin. Their actions constitute a crime against humanity. Those caught up in the misery they peddle must be treated for the illness of addiction and not prosecuted as criminals* (O'Halloran, Evidence 30 July 1997).

This distinction was also made by police officers appearing before the Committee. Detective Sergeant Maricic from the Kings Cross Police said:

> *Particularly at Kings Cross at this present time the situation is that we have not really been targeting the actual user. We have been trying to focus our attention on the suppliers* (Maricic, Evidence 9 October 1997).

4.9 LEGAL IMPLICATIONS: ARGUMENTS AGAINST

There is an essential conflict between some drug-related activities being legally sanctioned, while the substance being used remains illegal. This issue was identified in a number of submissions: *›How can you possibly have legal shooting galleries to shoot up an illegal drug?‹* (McKay, Submission 30) and *›The proposal is fundamentally wrong because it offers formal support to the illegal use of illicit drugs‹* (Ubrihien, Submission 50).

4.9.1 MAKING A DISTINCTION BETWEEN BEHAVIOUR WHICH IS LEGAL IN AN APPROVED INJECTING ROOM BUT ILLEGAL ELSEWHERE WILL LEAD TO THE CREATION OF ›FUZZY‹ LAW

The point was made to the Committee that there is a degree of artificiality in saying that activities undertaken within the confines of an approved injecting room were legally sanctioned, while the same activities occurring anywhere else in the State would be illegal. This would result in a distinction as to criminality being drawn with the result that two categories of injecting drug user would be created for the purposes of the criminal law. This creation of ›fuzzy law‹ could lead to disparate and artificial enforcement practices.

Mr Button, the Director of the Criminal Law Review Division commented that:

> *... one cannot get away from the fact that there are going to be arbitrary cut off points and there are going to be undoubted anomalies, and all of those things simply arise from ... seeking to say that something is legal in one part of New South Wales and illegal in another part* (Button, Evidence 24 October 1997).

4.9.2 POTENTIAL ISSUES OF LEGAL LIABILITY SURROUNDING INCIDENTS OCCURRING IN AN INJECTING ROOM

On the one hand, there are possible civil liability issues for the injecting room operators if a user dies in an injecting room, and on the other, there are possible actions for civil damages if a person employed in an injecting room is injured.

These liability aspects were referred to by representatives of the NSW Department of Health:

> *... given the potential for deaths, and serious injuries occurring on premises operated by/through NSW Health, a subsequent potential for substantial personal injury claims and court actions was also identified.* (Reid, Submission 101); and

> *... you have a situation where you will have people on premises who are involved in activities which could cause them harm, they could overdose, they could die, they could be seriously injured, there could be a risk of cross-infection of some sort ... By the very fact that it is done on premises that perhaps are public sector premises would raise the question of liability if someone, a relative or that person themselves when they were seriously injured, chose to sue for negligence for some reason* (O=Shannessy, Evidence 24 October, 1997).

4.10 SUMMARY

This Chapter examines the question of costs and benefits associated with the establishment or trial of injecting rooms. It should be stated at the outset that while the general costs and benefits of establishing or trialing injecting rooms can be identified, a mathematically precise cost-benefit analysis cannot be provided. Those accustomed to working in the area of costing aspects of the illicit drug problem list a number of reasons, most of which are linked to limitations of, and gaps in, data collection for why this is the case. With this in mind, the Committee has looked at the arguments for and against the establishment or trial under the broad headings of health implications; social implications; economic implications and legal implications. At the end of the day which arguments are seen as compelling, are to a certain extent, a matter of individual value judgement. As was articulated in one submission to the Committee:

> *There is no simple or objective basis on which to decide whether legal injecting rooms should be established. Considerable uncertainty exists in*

predicting what their effects would ultimately be, and there is significant concern about potential and perceived problems; while at the same time a decision not to establish or allow them would be equally difficult because it would leave unaddressed the serious problems associated with public injecting (Reid, Submission 101).

CHAPTER FIVE

LEGAL CONSIDERATIONS

This Chapter of the Report examines the current legal position in New South Wales in relation to injecting rooms, and presents a number of options, both legislative and non-legislative, for reform if the establishment or trial of injecting rooms were to be recommended.

5.1 THE CURRENT LEGISLATIVE POSITION IN NEW SOUTH WALES

The starting point for this discussion necessarily has to be whether the activities of those using a safe injecting room, or the activities of those operating or staffing such a place, are going to be in breach of the law. An examination of the current *Drug Misuse and Trafficking Act 1985* (the Act) and the Drug Misuse and Trafficking Regulation 1994 (the Regulation) indicates that this is likely. For example, the current Act makes it an offence for a person to possess a prohibited drug (Section 10) and to self-administer it (Section 12). As for those who may be involved in the running of a safe injecting room, it is an offence to aid and abet the commission of an offence (Section 19 covers summary offences and Section 27 indictable offences. The amount of drug involved will essentially determine whether a matter is dealt with summarily or on indictment.) However, before proposing any legislative amendments the scope of the current legislation needs to be more closely examined.

5.1.1 AN ADMINISTRATIVE OPTION

The first option to consider is whether injecting rooms could be set up administratively as the legislation currently stands. The obvious benefit of such an approach is that it can be achieved relatively quickly and simply. The problem would be reconciling actions taken as a public health measure, which are nonetheless in conflict with provisions of the criminal law. Commissioner Wood acknowledged the potential conflict between traditional law enforcement methods and the harm reduction model, but referred to the approach currently taken by the police in relation to needle and syringe exchange programs (NSEP) and methadone maintenance treatment (MMT) as an illustration of how this potential conflict is avoided:

> *To this end police have been directed to maintain informal communication with premises where such services are offered and not to make unnecessary visits. These guidelines do not deter police from attending such premises in the event of a threat to the safety of staff or others, but they should not be seen as a magnet for drug users who might be harassed or made the subject of easy arrest. Otherwise their utility will cease ... These initiatives, and the exercise of discretion in targeting injecting drug users are both sensible and appropriate. However, the basis on which the discretion is exercised needs to be found in a clear statement of policy. It is appropriate that the Police Service in conjunction with the Department of Health, publish guidelines setting out the agreed*

> *basis on which the policing of NSEP and MMP programs and similar public health initiatives takes place. These guidelines need to be widely publicised within the Service and the community so that both the police and citizens know where they stand in relation to enforcement of this aspect of the law* (Wood, *Final Report, Volume II: Reform*, May 1997, p227).

It should be kept in mind, however, that these guidelines have been issued in a context where legislative amendments to the Act have made possession of needles and syringes no longer an offence.

It would be possible for this sort of approach to be adopted in relation to injecting rooms. The decision as to which areas of criminal behaviour are pursued by the police and/or prosecuted by the Director of Public Prosecutions is a matter for those agencies, and to a certain extent the government of the day. This approach has been used in certain parts of Britain, where the police in agreement with local health authorities do not operate near needle exchange outlets. Similarly, in the Netherlands, in regards to a number of criminal offences including certain drug offences, the police, the prosecution agency and the Ministry of Justice have an agreement that no action is to be taken, although the activities remain crimes on the statute book.

The difficulty with such an approach is that it gives rise to a number of criticisms. These include the view that ›turning a blind eye‹ to the actual legal position makes a mockery of the law; that it can cause disquiet amongst those whose duty it is to enforce and uphold the law; that it can give rise to a lack of confidence in the community which expects the law to be enforced and upheld; and that it creates an opportunity for individual law enforcement officials to abuse their discretion. Some of these concerns were put in submissions to the Committee.

Mr Craig Thompson, the Magistrate at Bankstown Local Court, was of the opinion that:

> *... to direct police to turn a blind eye in respect of areas where the law is being broken, and clearly in circumstances where they know that to be so, must create public concern. Indeed it is usurping the role of Parliament and could be seen by the public as police aiding and abetting the commission of a crime (drug use). Police officers take an oath of office to uphold the law, just as do members of the judiciary. Would it be right for judges and magistrates to ignore their sworn duty in favour of some policy established by a health department in the absence of legislative approval ? It would attract, I would think, much criticism if indeed not contempt* (Thompson, Submission 69).

Mr John Malouf, President of the Australian Pharmacists Against Drug Abuse wrote:

> *... one argument was put that police could show discretion with their policing activities towards injecting drug places. It would appear that an unnecessary dilemma would be imposed on the police and even with the best of intentions, the potential for corruption or what might be construed as corruption would follow. The unanswerable question of the degree of discretion would vary from individual to individual and would not only cause a problem for the police in the field but also for their superior*

officers (Malouf, Submission 55).

Others drew the Committee=s attention to the uncertainty of relying on the exercise of police discretion. Mr Steve Bolt and Ms Karen Henry stated that:

> *... the alternative to legislation is for the police as a matter of discretion to decide not to police these offences in the approved injecting room. However, this provides an uncertain situation where police co-operation could be withdrawn at any time. This would limit use of the centre by injectors, unless some guarantee can be given that they can inject there without hindrance* (Bolt and Henry, Submission 83)

Furthermore, it has been clearly established by case law that the discretion of an individual police officer to prosecute or not prosecute a particular offence, cannot be fettered by the Chief Commander or the Chief Commander=s instructions. In *R v Commissioner of Police of the Metropolis; Ex parte Blackburn* [1968] 2 QB 118, the English Court of Appeal held (as per Lord Salmon at 138-139):

> *The chief function of the police is to enforce the law ... they owe the public a clear legal duty to enforce the law, a duty which I have no doubt they recognise and which generally they perform most conscientiously and efficiently. In the extremely unlikely event, however, of the police failing or refusing to carry out their duty, the court would not be powerless to intervene ... For example, if ... the chief police officer in any district were to issue an instruction that as a matter of policy the police would take no steps to prosecute any housebreaker, I have little doubt but that any householder in the district would be able to obtain an order of mandamus for the instruction to be withdrawn. Of course, the police have a wide discretion as to whether or not they will prosecute in any particular case. In my judgement, however, the action I have postulated would be a clear breach of duty. It would be so improper that it could not amount to an exercise of discretion.*

In examining whether the approach adopted in the Netherlands would be feasible in Australia, the former Attorney General and Minister for Crime Prevention for South Australia, the Hon C Sumner, said in a paper, A*Drug use and crime: the need for intersectoral co-operation in crime prevention*=, presented at a conference AThe Window of Opportunity: An intersectoral approach to drug related problems in our society= in Adelaide in December 1991:

> *The Dutch system is not feasible for a number of reasons, one of which would be the Australian justice system=s ability to tolerate the systematic ambiguity between law and criminal justice practice which is inherent in the Dutch system. Under Dutch law, use of cannabis and Ahard= drugs have remained criminal offences but, as a matter of policy, are never prosecuted. This outcome is achieved through close co-operation between police, prosecutors and the Ministry of Justice, and through clear guidelines laid down by the Ministry of Justice. In Australia, where there is far greater emphasis on the formal independence of law enforcement and prosecution bodies from the government of the day, I doubt whether such close co-operation between police, prosecution and government*

> *could be achieved.*
>
> *I would suggest that we Australians probably need to look further for examples of enlightened approaches which could be implemented locally. In this context, recent initiatives in the United Kingdom seem particularly relevant. In several parts of Britain, law enforcement bodies seem to be coming to terms with the inevitability of some level of hard drug use, and achieving co-operative arrangements with health and welfare authorities to ensure harm minimisation. In Merseyside, for example, police have developed a strategy which they term 'responsible demand enforcement'. This involves vigorous enforcement of the law at the supplier level, but a different strategy towards users. By agreement with local health authorities, police do not operate near needle-exchange outlets, and do not prosecute for possession of syringes and similar equipment. First time drug offenders possessing quantities consistent with personal use are eligible for a caution, and are directed to clinics and advice centres. Merseyside police claim that, as a result of these policies, their area has one of the highest rates in Great Britain of addicts seeking treatment. It will be interesting to see whether, over time, Merseyside also sees some reduction in HIV infection and other problems. Whatever the outcome, it seems to me that this sort of low-key approach toward managing hard drugs has much to offer* (Drug and Alcohol Services Council, South Australia, *Drug Problems in our Society: Dimensions and Perspectives*, 1992, pp85-90 at p88).

(To clarify the comment in relation to prosecution for possession of syringes and similar equipment, in 1986 the *Misuse of Drugs Act 1971* (UK) was amended and a new section, section 9A, introduced. The offence created under section 9A(1) was intended to cover the supply of ready made kits for snorting cocaine or heroin which had appeared on the market. Section 9A(2), however, exempted the supply of syringes from the section 9A(1) offence. The exemption was designed to protect needle exchange schemes. There is no specific provision in the UK legislation relating to possession of syringes.)

The following views are illustrative of the evidence taken by the Committee, as to the suitability of relying on police instructions or guidelines, to permit the establishment and operation of injecting rooms.

Mr Robert Toner, Secretary of the NSW Bar Council said:

> *If you do it ... by a suggestion to the Police Commissioner who might issue a directive, it just strikes me as being a very dangerous way of doing things without having something within a proper legislative framework and creates a very fertile area for corruption* (Toner, Evidence 24 October 1997).

Mr Roger Prowse, Chair of the New South Wales Law Society's Criminal Law Committee said:

> *... the Commissioner's Instructions by and large are not worth the paper they are written on. They are routinely ignored by police. They do not have the force of any authority ... How can you have a document that has*

> *no force of law rendering things lawful which are otherwise unlawful ? ...Therefore as an administrative scheme I think would be replete with contradictions and replete with difficulties ... I really do not think, unless they are given some force of law, that they are a very good vehicle for this proposal* (Prowse, Evidence 24 October 1997).

Professor Carney from the University of Sydney Law School, however, emphasised the importance of guidelines in the overall context of legislative reform, as a necessary means of achieving a satisfactory outcome:

> *I am not saying that there is not a case for making some legislative amendment to reduce or eliminate some of the criminal sanctions that are liable to attach to people who use any injecting rooms that are established, but rather that the most critical component of policy is flexibility and ownership by the people who will be responsible for establishing where the boundaries are to be drawn. Laws written by Parliament rarely do set the boundary in practice at the correct point* (Carney, Evidence 24 October 1997).

5.1.2 A REGULATORY OPTION

There are several reasons for framing rules as regulations. Some of the most apparent are:

- matters of administration are best left for the executive arm of government to reduce the pressure on parliamentary time;
- regulations are more appropriate where technical matters or matters of detail are involved; and
- when facts which are the subject of the legislation are likely to change rapidly, it is more sensible to deal with them in a form of legislation which can be changed with relative ease. (G Morris, C Cook, R Creyke, R Geddes, and J Seymour, *Laying Down the Law: The Foundations of Legal Reasoning, Research and Writing in Australia*, 4th Edition, Butterworths, 1996, p152).

The first step in the regulation making process is to determine whether the enabling Act permits the making of a particular regulation. If it does, consideration then needs to be given to a number of more practical matters as laid down in the Guidelines in Schedule 1 to the *Subordinate Legislation Act 1989* to decide whether proceeding by way of regulation is appropriate. Some of the more pertinent considerations are:

- whether the objectives sought to be achieved by the regulation accord with the objectives, principles, spirit and intent of the enabling Act; and are not inconsistent with the objectives of other Acts, statutory rules and stated government policies; and
- if the regulation would impinge on, or may affect, the area of responsibility of another authority, consultation must take place with a view to ensuring in advance that (as far as is reasonably practicable in the circumstances): any

differences are reconciled; and that there will be no overlapping of or duplication of or conflict with Acts, statutory rules or stated government policies administered by the other authority.

(Statutory rules are regulations, by-laws, rules or ordinances made or approved by the Governor on the advice of the Executive Council. In this Chapter, reference is made only to ›regulations=).

Having considered all of the above, if it is still thought appropriate to proceed by way of regulation, Ministerial approval will be sought, the regulation will be drafted by the Parliamentary Counsel=s Office and an opinion as to legality provided as per section 7 of the *Subordinate Legislation Act 1989*. Regulations may, however, be disallowed. This can occur if: they do not comply with the requirements of the *Subordinate Legislation Act 1989*; they unduly trespass on individual rights, deal with matter more suitable for inclusion in an Act, or impinge in a major way on the community.

The regulation making power of the *Drug Misuse and Trafficking Act 1985* is contained in section 45, which states:

Section 45 - Regulations

(1) The Governor may make regulations, not inconsistent with this Act, for or with respect to any matter that by this Act is required or permitted to be prescribed or that is necessary or convenient to be prescribed for carrying out or giving effect to this Act.

(2) The regulations may, in relation to such prohibited plants or prohibited drugs as may be specified in the regulations, exempt any person or any class or description of persons from such of the provisions of this Act or the regulations as may be so specified in such circumstances, if any, as may be so specified.

(3) A regulation may impose a penalty not exceeding 10 penalty units for any contravention of the regulation.

(4) An offence under the regulations may be prosecuted summarily before a Local Court constituted by a Magistrate sitting alone.

(5) A provision of a regulation may:

(1) apply generally or be limited in its application by reference to specified exceptions or factors,

(2) apply differently according to different factors of a specified kind, or

(3) authorise any matter or thing to be from time to time determined, applied or regulated by any specified person or body, or may do any combination of those things.

The following points can be made in relation to section 45:

Section 45(2) of the Act states:

> *The regulations may, in relation to such prohibited plants or prohibited drugs as may be specified in the regulations, exempt **any person or any class or description of persons** [emphasis added] from such of the provisions of this Act or the regulations as may be so specified in such circumstances, if any, as may be so specified.*

It may be that the words ›any person or any class or description of persons= in section 45(2) are wide enough to permit the creation of a specific class of persons, namely ›those attending an approved injecting room= set up as part of a clinical trial. If this were possible, provision might then be made in the regulation itself for activities such as self-administration, which are otherwise criminal, to not be so categorised if occurring in an approved injecting room. However, given the fact that specific amendments have been made in the past to both the Act and the Regulation to accommodate public health initiatives, it would be unlikely that such a major initiative as establishing an injecting room, even if only on a trial basis, would be considered as appropriate to be dealt with in this way. The validity of such a regulation could be open to challenge in the courts.

From evidence given to the Committee, it would appear that differing views are held as to the current usefulness and scope of the regulations to permit the establishment of injecting rooms. Professor Carney was of the opinion that:

> *... given the strictures of the public law principles which confine the operation of regulation-making power even when expressed in very ambulatory and generous language, as is the case here, I believe it is almost certainly legally correct that the amplitude of that language, that regulation-making power, must be read down to the extent that it conflicts with substantive provisions of the Act ... that conclusion is reinforced by ... the recent amendments providing for the destruction of plants, there is a separate regulation making power ... Unlike section 45, it does locate itself in the preceding substantive provisions which quite expressly foreshadow and authorise the making of regulations as exceptions to, or to facilitate the workings of, the plant destruction provision* (Carney, Evidence 24 October 1997).

(The point being made by Professor Carney is that section 39S of the Act specifically provides for regulations to be made relating to the destruction of plants. This means reliance on the more general regulation making powers provided for in section 45 is unnecessary.)

Mr Toner said:

> *I would have thought that by doing it by regulation you run into real problems about the regulation being inconsistent with the Act itself and, as you know, the Interpretation Act essentially says that the regulation cannot rise higher than its statutory source or, alternatively, cannot be inconsistent with the statute from which the regulation springs* (Toner, Evidence 24 October 1997).

Dr Manderson, Senior Lecturer in Law at Macquarie University, however, felt that there

may be scope to use the existing regulations (see **Appendix 7**) at least in relation to an injecting room trial:

> *... it seems to me that it would still be possible to use section 10(2) for the trial and perhaps to modify regulations 4 to 6 of the 1994 regulations which currently apply only to needle exchange programs, but could, with very little difficulty, be expanded to protect persons involved in the supply of needles or in the management of premises in relation to injecting rooms: for example, by getting rid of the words 'needle exchange' and replacing them with 'harm reduction'* (Manderson, Evidence 24 October 1997).

If Dr Manderson's suggestion were followed an example of how the regulation would read would be: *the exemption applies only for the purpose of enabling the pharmacist to participate in an approved harm reduction program*. Clause 5(2) currently reads: *the exemption applies only for the purpose of enabling the pharmacist to participate in an approved needle exchange program*.

5.1.3 A LEGISLATIVE OPTION

As stated at the beginning of this Chapter, a close examination of the Act seems to suggest that amendments are needed to ensure the legality of establishing safe injecting rooms. This point was made by many legally qualified witnesses who appeared before the Committee:

Mr Toner said:

> *I think that given the structure of the Act as it presently is there will need to be amendment to legislation to permit the establishment of injecting rooms. I do not think it is an overly difficult task* (Toner, Evidence 24 October 1997).

Mr Prowse said:

> *I think there is a fundamental tension between the Drug Misuse and Trafficking Act 1985 saying things are illegal and then a regulation or some other form of power, without the Act being amended, saying that some things which are otherwise illegal, are legal* (Prowse, Evidence 24 October 1997).

Mr Richard Button, Director of the Criminal Law Review Division of the New South Wales Attorney-General=s Department said:

> *My opinion would be that it [establishing an injecting room under the current Act] would be very difficult to do so and if one proposed to do so one should take great care about doing it* (Button, Evidence 24 October 1997).

The issues which need to be considered range from the most obvious such as self-administration and possession and aiding and abetting to more subtle offences such as that set down in section 6 of the Act, which could, in certain circumstances, lead to those running the injecting room facing a charge of supply. These individual offences are considered in detail below.

The Terms of Reference require the Committee to make recommendations specifically in relation to safe injecting rooms. It is not the role of the Committee to enquire more widely into other potential areas of law reform. Having identified the activities and behaviours to be carried out in an injecting room, the Committee is faced with the task of identifying possible means by which these can be given effect to.

Activities and behaviours at some remove will be dealt with as they are now, namely at the discretion of police. For example, a person apprehended on a train, who has in his or her possession an amount of drugs over what could be considered a single dose, may say that he or she is on route to a particular safe, injecting room. Whether this is accepted by the police is a matter for them. This is no different to the current practice. The police arrest and charge where they reasonably suspect an offence has been committed. If the matter is proceeded with, it is ultimately a matter for the Court to decide whether an offence has been proved.

Any legislative changes suggested by the Committee would be limited to changes to protect those operating, as well as those using, any prescribed injecting room which may be established, if this course of action is recommended. Such changes do not amount to decriminalisation. A certain degree of confusion exists over what is meant by this term, and it is common to observe it being used inaccurately in every day speech. Decriminalisation does not make an offence, a non-offence. It retains the offence, but imposes a penalty other than a criminal sanction.

This point was well illustrated by Mr Prowse:

> *A parking ticket is a parking ticket; a speeding ticket is a speeding ticket. That is not decriminalised in the technical terms of the word. I suppose, it is reducing the penalty so that, whilst it is still illegal, it is not visited at first instance by arrest and charging in court* (Prowse, Evidence 24 October 1997).

If it were proposed to issue people using an injecting room with an infringement notice or a fine, then the term ›decriminalisation= could be said to apply. This is not being suggested. Moreover, as the very motivation underlying the establishment of an approved injecting room trial is to encourage people to use the facilities in an attempt to reduce harms which may otherwise occur, punishment of any kind is not contemplated. Any legislative change in relation to the establishment of an injecting room trial would be

legalising specific actions and behaviour which occur in this narrowly prescribed situation. It would not be making the wholesale use and possession of drugs by anyone, anywhere, at any time, legal.

Perhaps a ›discrete dosage unit‹, which is the language used in section 3 of the Act to describe a single dose, could be specified in relation to those using injecting rooms to help define the category to be exempted. It would also send a clear message that offences where larger quantities of drugs are involved may still be pursued. It should be pointed out that the Act already provides for a person in possession of an amount of a prohibited drug, not less than the traffickable quantity, to be deemed as having that drug for the purposes of supply - section 29. The amounts set down in section 3 in relation to heroin, cocaine and amphetamines are: small quantity - 1gm; indictable quantity - 5 gms; traffickable quantity - 3 gms. There is no amount currently stipulated in relation to a discrete dosage unit for these particular drugs.

5.2 INDIVIDUAL OFFENCES UNDER THE *DRUG MISUSE AND TRAFFICKING ACT 1985*

In this section an analysis of the scope of the existing legislation is presented, indicating the degree to which protection may already be available.

5.2.1 SECTION 10 - POSSESSION OF A PROHIBITED DRUG

(1) A person who has a prohibited drug in his or her possession is guilty of an offence

(2) Nothing in this section renders unlawful the possession of a prohibited drug by:

(1) a person licensed or authorised to have possession of the prohibited drug under the Poisons Act 1966,

(2) a person acting in accordance with an authority granted by the Secretary of the Department of Health, where the Secretary is satisfied that the possession of the prohibited drug is for the purpose of scientific research, instruction, analysis or study,

or

(3) a person for or to whom the prohibited drug has been lawfully prescribed or supplied

Currently, section 10 makes it an offence to have drugs in your possession unless one of the exceptions in 10(2) applies. Section 10 (2)(b) makes it an exception if you are authorised by the Secretary of the Department of Health (this probably should now read ›Director-General‹.) Any authorisation granted by the Secretary is to be in writing; is granted **subject to such conditions** [emphasis added] as the Secretary thinks fit; and may be revoked at any time - section 41. Such authorisation is given, on an individual basis, if the Secretary is ›satisfied that the possession ... is for the purpose of scientific research, instruction, analysis or study‹. If the Secretary of the Department of Health

was of the view that the injecting room trial came within this ambit, and an authorisation given, possession may not be illegal. However, it would not extend to a casual user, a person simply coming in off the street. The section does not permit a blanket authorisation to be given, but is granted on a case by case basis. This was expressed by Professor Carney in the following terms:

> *Section 10, it seems to me, requires ... that your authority be personalised and be owned and possessed by the person to be exempted from the operation of the other criminal provision* (Carney, Evidence 24 October 1997).

The question of individual authorisations aside, if the Secretary is not persuaded as to the scientific research etc purpose, the section would need amending. No amendment was needed to section 10 when section 11 (possession of equipment for the administration of prohibited drugs) was amended in 1987, as the offences in section 10 and section 11 are discrete offences. Although a person cannot now be charged for possession of a needle and syringe, he or she can still be charged for possession of drugs. In the context of an injecting room, while section 11 would provide protection against a charge for the needle and syringe, it would appear that possession of the drug and self-administering it are still going to be offences. This gives rise to the obvious contradiction that people using the injecting rooms would be committing crimes and those running them would be assisting. As discussed above, a decision could always be taken simply not to enforce the law in this area.

To remove any doubt, amendments to section 10 need to be made to legally exempt those using the injecting room, and those involved in its running, from criminal prosecution. Such exemptions could be done along the lines of the amendments to section 11, specifying in this instance that the offence did not apply to those using an approved injecting room. This could be done for all relevant sections such as section 10 - possession; section 11 - equipment; section 12 - self administration; and sections 19 and 27 - aiding and abetting. Amendments could be made in relation to authorisation given by the Secretary of the Department of Health to exempt those using an approved injecting room. It may even be possible to broaden the regulation making powers to provide for developments related to public health initiatives. Clearly all the other offences in the Act would remain. An approved injecting room would not be some sort of sanctuary where illegal activities would be tolerated.

However, it is correct to say that if amendments were made to legally permit certain activities, such as the possession and use of an illegal substance to take place in an approved injecting room, a distinction as to criminality will be drawn between those using the injecting room facility and those who are not. This would result in two categories of injecting drug user being created for the purposes of the criminal law, and would lead to disparate enforcement practices. Those undertaking the same activity outside an approved injecting room would be committing an offence and liable to prosecution and possible conviction. This consequence was identified by various witnesses.

Mr Toner said:

> *In other words, if you step across this magic line you are committing a crime, but inside the magic line what you are doing is lawful because of*

> *the way the legislation is drawn ... how you then deal with it on a practical policing basis is a difficulty because clearly somebody on one side of the line is committing a crime and on the other side of the line is not* (Toner, Evidence 24 October 1997).

Mr Button commented that:

> *... one cannot get away from the fact that there are going to be arbitrary cut off points and there are going to be undoubted anomalies, and all of those things simply arise from ... seeking to say that something is legal in one part of New South Wales and illegal in another part* (Button, Evidence 24 October 1997).

Others expressed the view that while such a distinction may be somewhat artificial, artificial distinctions are often made under the law. One pertinent example is section 11(1A) in the *Drug Misuse and Trafficking Act 1985* itself, which exempts the possession of needles and syringes from the possession of drug paraphernalia offence provided for in section 11(1). Mr Steve Bolt, a solicitor with the Northern Rivers Community Legal Centre wrote:

> *We acknowledge that this package of legislative reforms and police guidelines would create a somewhat artificial distinction between what is legal inside an approved injecting room and what remains illegal outside its front door. However, there is a similar artificiality now with the police being instructed to not stop and search clients approaching needle exchange outlets, although obviously many of these clients would be in possession of prohibited drugs at that time. Being artificial is not to say it is not workable. The workability and practicality of these arrangements is clearly one aspect of injecting rooms which would need to be evaluated in any trial* (Bolt, Submission 64).

Commenting on the artificiality aspect, Mr Toner said:

> *... There is inevitably artificiality about doing this ... but the way ... you could do it is by prescribed premises and by having activities done on those prescribed premises, which elsewhere would be illegal, legal ... the analogy is the licensing laws everywhere really. That is all you are really doing: you are effectively licensing premises to allow conduct, which would elsewhere be illegal, as legal* (Toner, Evidence 24 October 1997).

Another point made was that if the aim of an injecting room was to encourage injecting drug users to inject in more appropriate conditions and not to inject in the street or other public places, then the fact that it would be legal in an injecting room but remain illegal elsewhere, may act as an incentive and assist in achieving the stipulated objective.

If official sanction were given to the establishment of approved injecting rooms, then it would be possible to issue formal directions or guidelines similar to those issued in relation to needle and syringe exchanges and methadone maintenance programs that people attending such places are not to be harassed and so on.

5.2.2 SECTION 11 - POSSESSION OF EQUIPMENT FOR ADMINISTRATION OF PROHIBITED DRUGS

(1) A person who has in his or her possession any item of equipment for use in the administration of a prohibited drug is guilty of an offence.

(1A) Subsection (1) does not apply to or in respect of a hypodermic syringe or a hypodermic needle.

(1B) Subsection (1) does not apply to or in respect of a person prescribed by the regulations, or a person who is of a class of persons prescribed by the regulations, who has in his or her possession any item of equipment that is required to minimise health risks associated with the intravenous administration of a prohibited drug.

(2) Nothing in this section renders unlawful the possession of an item of equipment by:

(a) a medical practitioner, dentist, veterinary surgeon, pharmacist or nurse acting in the ordinary course of his or her profession,

(b) a member of any other prescribed profession acting in the ordinary course of that profession,

(c) a person licensed or authorised to have possession of the item of equipment under the Poisons Act 1966,

(d) a person authorised to have possession of the item of equipment by the Secretary of the Department of Health, or

(e) a person for use in the administration of a prohibited drug lawfully prescribed or supplied.

Under section 11(2)(d), it is not unlawful to have ›an item of equipment for use in the administration of a prohibited drug‹, if authorisation has been given by the Secretary of the Department of Health. It could be argued that as it stands, this section is wide enough to offer protection to anyone involved in the running of an approved injecting room. On the other hand, the protection offered by this section and clauses 3, 4 and 6 of the Regulation, may apply only if the level of involvement currently permitted is not exceeded. (See the discussion of this issue referred to above.) A specific amendment would clarify the position.

Another aspect in relation to section 11 is that while there are currently exemptions for a person to have possession of needles and syringes, there is no exemption for possession of paraphernalia such as spoons and tourniquets, which are likely to be found in an injecting room setting. Possession of this equipment would, without amendment, constitute an offence.

Data from the New South Wales Judicial Commission reveals that in the period between July 1992 and August 1997 there were 775 matters finalised before the local courts for incidents relating to possession of equipment.

5.2.3 SECTION 12 - SELF-ADMINISTRATION OF PROHIBITED DRUGS

(1) A person who administers or attempts to administer a prohibited drug to himself or herself is guilty of an offence.

(2) Nothing in this section renders unlawful the administration or attempted administration by a person to himself or herself of a prohibited drug which has been lawfully prescribed for or supplied to the person.

Anecdotal evidence seems to suggest that police attending an overdose generally exercise their discretion not to lay charges in this instance. This approach seems to have the support of the Self-administration Working Group, which reported at the 31 July 1997 Ministerial Council on Drug Strategy meeting that:

> *the preparation of guidelines on the use of discretion by the police, and the management of offences when attending an overdose or self administer incident such as those in South Australia and New South Wales should be considered by all States and Territories* (Minutes of the Ministerial Council on Drug Strategy meeting held on 31 July 1997).

Information provided to the Committee by the NSW Police Commissioner=s Office indicates that the issue of repealing the self-administration offence in those jurisdictions where it remains an offence was also discussed by the Ministerial Council on Drug Strategy.

> *As not all jurisdictions have a law on self-administration, it was not made a formal resolution to delete the laws but it was recommended that those jurisdictions eg NSW, where such a law did still exist should approach their Attorney-General with a view to having those laws deleted from the statute books* (Assistant Commissioner B Lawson, letter dated 11 November 1997).

An examination of the figures provided by the New South Wales Judicial Commission for matters brought and determined before the local courts between August 1992 and July 1997 indicate that while there were 2,380 charges for possession of heroin or cocaine (section 10) processed in this period, there were only 568 matters of self-administration (section 12) brought before the courts.

5.2.4 SECTION 13 - ADMINISTRATION OF PROHIBITED DRUGS TO OTHERS

(1) A person who administers or attempts to administer a prohibited drug to another person is guilty of an offence.

(2) Nothing in this section renders unlawful the administration or attempted administration of a prohibited drug to another person by:

(1) a person licensed or authorised to do so under the Poisons Act 1966, or

(2) a person authorised to do so by the Secretary of the Department of Health.

(3) Nothing in this section renders unlawful the administration or attempted administration of a prohibited drug to a person for or to whom the prohibited drug has been lawfully prescribed or supplied.

and

SECTION 14 - PERMITTING ANOTHER TO ADMINISTER PROHIBITED DRUGS

(1) A person who permits another person to administer or attempt to administer to him or her a prohibited drug is guilty of an offence.

(2) Nothing in this section renders unlawful the giving of permission for the administration or attempted administration of a prohibited drug by a person for whom or to whom the prohibited drug has been lawfully prescribed or supplied.

These two sections are considered together as they are essentially the same act, namely the administration of drugs by another person (section 13 is from the perspective of the person administering, whereas section 14 is of the person being administered to). Some users are incapable of self-injecting and seek the assistance of others to administer the drug. This activity constitutes a breach of the criminal law by both the person administering the drug (section 13) and the person receiving it (section 14). The New South Wales Judicial Commission figures indicate that in the period from August 1992 to July 1997, there were eight cases of administering heroin to another; and 12 cases of permitting another to administer heroin, making 20 cases in total for these offences.

5.2.5 SECTIONS 19 AND 27 - AIDING AND ABETTING THE COMMISSION OF AN OFFENCE

A person who aids, abets, counsels, procures, solicits or incites the commission of an offence under this Division is guilty of an offence and liable to the same punishment, pecuniary penalties and forfeiture as the person would be if the person had committed the first mentioned offence.

Section 19 covers summary offences and section 27 indictable offences. The amount of drug involved will essentially determine whether a matter is dealt with summarily or on indictment. It would appear from the submissions and evidence given to the Committee that these sections would need amending to ensure those involved in the day to day

running of an injecting room were not guilty of an offence. The following statement is illustrative of this view:

> *I think that the provisions of the legislation in relation to ... the aiding and abetting or accessories before and after the fact, would seem to suggest that to establish injecting rooms in those circumstances would be to have people who were monitoring and controlling those injecting rooms at least be seen to be aiding and abetting the commission of a criminal offence* (Toner, Evidence 24 October 1997).

5.2.6 SECTION 6 - MEANING OF 'TAKE PART IN'

For the purposes of the Act and the regulations, a person takes part in the cultivation or supply of a prohibited plant or the manufacture, production or supply of a prohibited drug if:

(a) *the person takes, or participates in, any step, or causes any step to be taken, in the process of that cultivation, manufacture, production or supply,*

(b) *the person provides or arranges finance for any such step in that process; or*

(c) *the person provides the premises in which any such step in that process is taken, or suffers or permits any such step in that process to be taken in premises of which the person is the owner, lessee or occupier or in the management of which the person participates.*

In evidence to the Committee, Mr Peter Zahra, a Public Defender with the New South Wales Attorney-General's Department, gave a number of examples of behaviour and activities which commonly occur in the injecting drug community to illustrate the point that simply amending sections related to possession, use and aiding and abetting may not be sufficient to ensure protection of those operating or using in a safe injecting room.

One example was in relation to the deemed supply aspect contained in section 6.

> *Section 6 of the Drug Misuse and Trafficking Act extends the definition of various acts which could amount to various offences. For example, knowingly take part in ... includes a number of different other acts which could amount to supply, for example providing the premises where the supply was to take place could amount to an offence ... in practice you have a whole range of other activities such as group purchasing and sharing of drugs, and injecting into others. Some of that activity can in fact amount to a supply ... Obviously if that were known to the person who was carrying out an injecting room, then they would be technically providing the premises for the supply of drugs* (Zahra, Evidence, 24 October 1997).

5.3 LEGAL ISSUES OF A GENERAL NATURE

Consideration needs to be given to any consequential amendments to other legislation which may be required to ensure, if change occurs to permit the trial or establishment of safe injecting rooms, that breaches of other laws do not occur. A fundamental issue which needs to be addressed is that of liability. Amendments to the *Drug Misuse and*

Trafficking Act 1985 would primarily address the question of criminal liability. It should be kept in mind, however, that although the matter may not be pursued by the State through its law enforcement officials, an individual citizen may still bring a private prosecution. How far through the court system such an action would progress, would remain to be seen.

The civil liability implications, for staff running the injecting room, and possibly for any government department associated with the scheme, need to be examined. This was raised as a significant concern by representatives of the Department of Health. In its written submission, the following points were made:

> *... given the potential for deaths, and serious injuries occurring on premises operated by/through NSW Health, a subsequent potential for substantial personal injury claims and court actions was also identified. One option to address this would be to provide Health with some form of statutory indemnity in respect of the operation of injecting rooms* (Reid, Submission 101).

The civil liability aspect was again referred to in evidence given by Leanne O=Shannessy, Deputy Director Legal Branch NSW Department of Health, to the Committee:

> *... you have a situation where you will have people on premises who are involved in activities which could cause them harm, they could overdose, they could die, they could be seriously injured, there could be a risk of cross-infection of some sort ... By the very fact that it is done on premises that perhaps are public sector premises would raise the question of liability if someone, a relative or that person themselves when they were seriously injured, chose to sue for negligence for some reason* (O=Shannessy, Evidence 24 October, 1997).

The need to address the question of liability was also raised in the Debate on the Motion to establish the Joint Select Committee on Safe Injecting Rooms. Mr J Brogden MP said:

> *I am sure that if this motion is passed and a Committee established, the Committee will examine closely the question of what would happen if a drug user injecting in a shooting gallery were to overdose or come to harm in any way for whatever reason, perhaps because of the quality of the drugs used. Who would be legally liable ? Would the Government be liable because it had passed legislation for the galleries ? Would owners and operators of the shooting gallery be liable ?* (Mr J Brogden MP, *NSWPD*, LA, 19 June 1997, p10789).

It would be possible to insert a provision into the Act to exempt in specified circumstances, those involved in the running of the injecting room (and other users) from civil and criminal liability. It would, however, be a matter for the Court as to the degree to which any such provision may be read down. It could be modelled, for example, on section 21DA of the *Human Tissue Act 1983*, which places restrictions on legal proceedings which can be brought in relation to infection by a prescribed contaminant. Section 21DA provides that in certain circumstances proceedings for an

offence or in tort or for a breach of contract cannot be brought against donors or suppliers of substances, such as blood, for infections which may later occur providing specified requirements have been met. If the infection was attributable to negligence on the part of a donor or supplier, or if procedural requirements were breached, these defences would not be available.

Thought would also have to be given to any particular liability issues which may arise in relation to participants of an injecting room trial. There are a number of ethical and legal issues involved in experimentation on human beings. These were examined in some detail in relation to the proposed ACT controlled availability of heroin trial (N Cica, 'Civil liability issues associated with a heroin trial', Working Paper Number 11, *Feasibility Research into the Controlled Availability of Opioids, Stage 2*, National Centre for Epidemiology and Population Health and the Australian Institute of Criminology, June 1994) and would need to be considered. Similarly, the question of criminal liability issues associated with such trials would also need to be addressed. This facet was examined in relation to the proposed ACT controlled availability of heroin trial (S Bronitt, 'Criminal Liability Issues Associated with a Heroin Trial', Working Paper Number 13, *Feasibility Research into the Controlled Availability of Opioids, Stage 2*, National Centre for Epidemiology and Population Health and the Australian Institute of Criminology, May 1995) and would need to be taken into account.

Another question raised in relation to liability was the possibility that users may be required to remain at the injecting room for a certain period of time after injecting as a means of reducing the risk of harm which may befall them. It would appear that such a suggestion has been made in an attempt to limit potential liability. Mr Nicholas Cowdrey QC, the Director of Public Prosecutions, stated in correspondence to the Committee that such action may constitute unlawful detention in some circumstances. It should be pointed out, however, that if a condition of entry to an injecting room was that the user remain on the premises for a specified period of time after injecting, such detention would not be unlawful. This principle was referred to by O'Connor J in *The Balmain New Ferry Co Ltd v Robertson* case - (1906) 4 CLR 379:

> *... The abridgement of a man's liberty is not under all circumstances actionable. He may enter into a contract which necessarily involves the surrender of a portion of his liberty for a certain period, and if the act complained of is nothing more than a restraint in accordance with that surrender he cannot complain ... Prima facie, no doubt, any restraint of a person's liberty without his consent is actionable. But, when the restraint is referable to the terms on which the person entered the premises in which he complains he was imprisoned, we must examine those terms before we can determine whether there has been an imprisonment which is actionable ...*

In much the same way as a shopper entering a supermarket is informed by a well-placed notice that management reserves the right to search bags on exit as a condition of entry, a similar notice could be displayed in an injecting room. Moreover, it would be possible to have a form stipulating a number of conditions to be signed by users prior to entry to an injecting room. Such forms are in use in some of the European injecting rooms. In this way a person could be required to agree to any rules and conditions which may apply to a particular injecting room. This could include matters such as: they are over the age of 18 (if this were deemed appropriate); they are local residents (if this

were deemed appropriate); they will not take part in any illegal activities on the premises, such as dealing etc, and they agree to remain on the premises for a specified time after injecting. A waiver of liability in specified circumstances could be printed on such a form, however, as stated above, this may still be read down by a Court.

In correspondence to the Committee dated 21 October 1997, the Director of Public Prosecutions, Nicholas Cowdrey QC, also referred to the common law offence of incitement. It is a common law misdemeanour for one person to incite or solicit another to commit or attempt to commit a crime, although such crime is not actually committed or attempted. It is also a common law misdemeanour to attempt to incite or solicit the commission or the attempted commission of such a crime. Without specific statutory clarification, this offence may apply to those running an injecting room.

5.4 INTERNATIONAL TREATIES

Australia-s international obligations in relation to illicit drugs were raised in the debate regarding the proposed ACT controlled availability of heroin trial, and must be considered in any discussion surrounding the trial and/or establishment of safe injecting rooms in New South Wales.

The Australian government is signatory to a number of international treaties which relate to illicit drugs. A list of these is attached at **Appendix 8**. The most significant are:

- the 1961 Single Convention on Narcotic Drugs (which defines the drugs covered and details the agreement that the trade and use of these drugs should remain illegal), and

- the 1988 Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (which enhanced the provisions relating to inter-jurisdictional co-operation in the detection and prosecution of drug trafficking. It sets standards for signatories in such matters as dealing with possession and purchase of illicit drugs.)

Mention should also be made of:

- the 1972 Protocol which attaches to the 1961 Convention. It places greater emphasis on treatment, education and rehabilitation for abusers who commit minor offences as an alternative or adjunct to imprisonment, and

- the 1971 Convention on Psychotropic Substances, which added synthetic hallucinogens, stimulants and sedatives to the list of banned drugs, and provided improved structures to distinguish medical use of drugs from other purposes.

5.4.1 THE 1961 SINGLE CONVENTION ON NARCOTIC DRUGS

Article 4 of the Single Convention on Narcotic Drugs sets out the general obligations of the Parties to the Convention:

> The Parties shall take such legislative and administrative measures as may be necessary: (a) to give effect to and carry out the provisions of this Convention within their own territories; (b) to co-operate

with other States in the execution of the provisions of this Convention; and (c) subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.

Article 36(1) sets out what constitutes an offence:

(1) Subject to its constitutional limitations, each Party shall adopt such measures as will ensure that cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention, and any other action which in the opinion of such Party may be contrary to the provisions of this Convention, shall be punishable offences when committed intentionally, and that serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.

Reading Articles 4 and 36(1) together, the activities outlined in 36(1) are offences, however, an exemption has been provided in Article 4, for ›production, manufacture, export, import, distribution of, trade in, use and possession of drugs‹ if these activities occur in the context of ›medical and scientific purposes‹. Further, **Article 2(5)(b)** provides:

A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.

On face value, this Article appears to allow two possible interpretations. (To illustrate the difference, emphasis has been added). The first interpretation is:

> *A Party shall, **if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare,** prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.*

Read this way, the Article could be interpreted such that ›use and possession of a drug‹ in ›an approved injecting room‹ should not be an offence because making such behaviour an offence is ›not the most appropriate means of protecting the public health and welfare‹. (Presumably this argument would be relied upon to justify the amendments already made to the *Drug Misuse and Trafficking Act 1985* which make possession of equipment to administer drugs not an offence.)
On the other hand, if the emphasis is changed as follows:

> ***A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import***

> ***of, trade in, possession or use of any such drug*** *except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.*

Read this way, the Article seems to permit certain activities, which would otherwise be offences, where these activities are necessary for medical and scientific research including clinical trials. If this interpretation is correct, use and possession of a drug in the context of injecting rooms set up as part of a clinical trial pursuant to the recommendation made by the Royal Commissioner and any recommendation of the Parliamentary Joint Select Committee, would not constitute an offence.

Taken as a whole, the 1961 Convention appears to be aimed primarily at the larger scale activities such as manufacture, distribution and supply of illicit drugs. It is perhaps noteworthy that ›use‹ or ›self-administration‹ does not apply in Article 36(1) which sets out what constitutes an offence. Moreover, specific provision is made in Articles 4 and 2(5)(b) for exceptions to be made in relation to activities related to ›scientific or medical purposes‹.

5.4.2 THE 1988 CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES

The question which then needs to be answered is, whether ratification of the 1988 Convention has altered what appeared to be permissible under the 1961 Convention? On the one hand, the 1988 Convention amplifies and strengthens the stance taken against illicit drugs, making it virtually mandatory to criminalize any and all aspects of the drug trade (Article 3). Having ratified the Convention, the discretion as to whether certain activities should be made criminal offences is no longer available. On the other hand, Article 3(1)(a)(i) makes ›production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation of any narcotic drug or any psychotropic substance‹ an offence, if it is ›**contrary to** the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention‹ [emphasis added]. Similarly, Article 3(2) makes ›possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the 1961 Convention, the 1961 Convention as amended or the 1971 Convention, an offence‹. These provisions would seem to suggest that as long as an activity is taking place for medical and/or scientific purposes, it is not contravening the 1961 Convention, therefore it is not an offence. If this reasoning is correct, the 1988 Convention does nothing to affect the status quo.

In relation to the actual establishment of injecting rooms, it could be argued that **Article 3(4)(d)** of the 1988 Convention is wide enough to permit such a course of action. It states:

> *The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social re-integration of the offender.*

Whether there is sufficient scope under the international treaties to proceed with the establishment or trial of injecting rooms is a matter of interpretation. Evidence given to the Committee by those familiar with international law were of the opinion that the arguments advanced above could be supported. When asked whether Australia=s international obligations in regard to illicit drugs would impinge on any recommendations which either the Committee or the New South Wales government may make in regards to injecting rooms, Dr Manderson replied:

> *I do not think so ... there are a number of conventions to which Australia is a signatory. They lay down general principles and there is certainly pressure from some sources, particularly the United States, for them to be interpreted in a certain way, but interpretation is a question of State parties and the practices of State parties. It seems to me pretty clear within the practice of State parties that the kind of limited harm reduction measures that we have been talking about today fall within the acceptable boundaries of State discretion within the terms of those conventions. I think that has been even more the case over the last ten years, where the movement towards some of these harm reduction principles has been taking place in a number of countries ... including Australia. I think there is a pretty good State practice as to a broad interpretation of what those requirements are, although there may be some countries in the world that think they have ownership of the meaning of those conventions, they do not* (Manderson, Evidence 24 October 1997).

Professor Carney agreed that an injecting room trial would not be inconsistent with the provisions of the 1961 Single Convention on Narcotic Drugs, but stressed that for it not to be inconsistent with the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, it would need to come within Article 3(4)(d). He told the Committee:

> *It is lawful for there to be an injecting room experiment if it is legislated as such, for that legislation not to be in contravention of that treaty [the 1988 Convention], only if it falls within the Article 3(4)(d) that it can be characterised as a measure (as I believe it can) for treatment, education, after care, rehabilitation or social re-integration ... the kind of model that was being outlined ... it being a controlled and evaluated trial, would in my view unquestionably be consistent with the international treaties ... Professor Penington in his report to the Victorian Parliament ... like me, is saying that there is sufficient fuzziness even on the jaundiced view to say that what you are proposing here today is consistent with international law* (Carney, Evidence 24 October 1997).

In its *1996 Annual Report*, the International Narcotics Control Board (INCB) which is a drug control body drawing its powers from a number of treaties including those referred to above, acknowledged that:

> *The Board is aware of the difficulties that many Governments face in making their criminal justice systems more effective. It therefore notes with interest that some have begun to rationalize their criminal justice systems by prioritizing cases deemed to be of greater importance. Some countries are targeting a greater proportion of their resources where the*

impact of law enforcement efforts upon the flow of the illicit traffic is greatest, namely drug kingpins and key drug traffickers. In other countries, however, high-drug related crime rates have forced law enforcement resources to be used on a more ad hoc basis. More rational use of those resources would reduce the pressure exerted on law enforcement authorities to deal with drug-related arrests and on criminal justice systems to process those arrests.

It is recommended that States should consider targeting, as a matter of priority, large-scale drug traffickers and the organizers of drug trafficking operations. Arresting one large scale drug trafficker has a greater impact than arresting minor offenders; it also frees resources so that the criminal justice system can concentrate more on such higher priority cases ...

The Board considers it vital that the penalties imposed by criminal justice systems be commensurate with the seriousness of the offences ... only when the threat of lengthy prison sentences and the loss of all financial gain are perceived to be real will persons seeking to make a fast fortune be deterred from drug trafficking. Making greater use of treatment and alternative penalties, as well as imposing shorter prison sentences on minor offenders, in accordance with the provisions of the 1988 Convention would result in more effective administration of justice and would free resources to deal more effectively with major instigators of drug-related crime.

The Board reiterates that the problem of drug abuse must be dealt with simultaneously from the different perspectives of law enforcement, prevention, treatment and rehabilitation. The alternatives to imprisonment that have been developed in different parts of the world should be examined more closely, bearing in mind the differing legal philosophies and systems.

In their Articles on penal provisions, three of the international drug control treaties refer to measures for the treatment, education, after-care, rehabilitation or social re-integration of the offender as alternatives to conviction or punishment or in addition to conviction or punishment: the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol - Article 36; the Convention on Psychotropic Substances of 1971 - Article 22; and the 1988 Convention, Article 3 ... It should, however, be clearly understood that the Board, in supporting appropriate recourse to treatment and non-custodial measures for minor offences, is in no way suggesting that drug-related offences should be decriminalised or that the implementation of the international drug control treaties should at all be weakened.

There are different ways in which a criminal justice system may make better use of available resources: for example, by management of the flow of arrested persons into the criminal justice system by prioritizing the offences to be targetted; and also by management of the arrested persons within the various stages of the criminal justice system and by making appropriate use of various sentencing modalities.

> *Many countries are exploring alternative ways of dealing with drug offenders. Minor drug offenders may be diverted from the criminal justice system because of a desire to avoid the imprisonment of first-time offenders or juveniles, the need to provide for treatment and rehabilitation or the need to relieve courts and correctional systems overburdened by large numbers of people charged with minor offences. Drug treatment can be a cost effective alternative to imprisonment, reducing related health-care costs as well as costs associated with criminal proceedings and imprisonment* (*Report of the International Narcotics Control Board For 1996*, United Nations publication, on the Internet at: http://undcp.orat/reports/incb96/e/index.html)

It is also worth noting that ratification of a treaty, is not necessarily the end of the matter. Two other important considerations are: the question of enforcement and the option of withdrawal.

Enforcement: Although there is a fundamental principle of the law of treaties which is that treaties are binding on parties and must be performed in good faith, (this rule of ›pacta sunt servanda‹ is reflected in Article 26 of the Vienna Convention on the Law of Treaties, 1969), actual enforcement of treaty obligations is, however, another issue as no one country can be made to comply by another country or a supranational body such as the International Narcotics Control Board, and no international police force exists. Even the International Court of Justice is limited in its enforcement powers. First, because individual countries have the option of recognising the Court's jurisdiction, which means that the Court has no powers over those countries which do not recognise its jurisdiction. Secondly, even though the UN Security Council can be asked to enforce decisions of the International Court of Justice which are binding in the case of those countries which do recognise the Court's jurisdiction, such action has never taken place. The explanation for this is that all countries are seen as sovereign nations which do not have to do another's bidding. So while signing to a treaty is a legally binding act, remedies for breach are limited. If enforcement is necessary this usually comes about through political pressure and international embarrassment.

Withdrawal from a treaty: The option of withdrawal, termination or denunciation are usually provided for in the terms of the treaty. A typical provision in a multi-lateral treaty is that the parties may withdraw on twelve months' notice. Withdrawal can, however, occur at any time by consent of all parties after consultation (Article 54 of the Vienna Convention). Where a treaty does not contain a provision regarding its termination and it does not provide for denunciation or withdrawal, then denunciation and withdrawal can only occur if either it can be shown that the parties intended that denunciation or withdrawal were possible, or if this option can be implied (Article 54 of the Vienna Convention). In all cases Federal Executive Council approval needs to be given prior to Australia's withdrawal from a treaty. It is also possible for the Federal Parliament to repeal domestic legislation binding Australia to the terms of a particular treaty any time this action is considered appropriate, without withdrawing from the treaty itself.

5.5 OPTIONS FOR REFORM

If it were decided that amendment to the provisions of the Act should be made, this could be achieved in a variety of ways.

The first option is to amend on a section by section basis all those sections identified as being inconsistent with the establishment, use and day to day operation of a safe injecting room. This model would follow that used in 1987 when the amendments to repeal the offence of possession of needles and syringes were inserted.

The second option is to create a new Part to the Act. This may be of more use given the number of sections which would possibly need to be amended. There is in fact precedent for such an approach, as Part 3A, which deals with the destruction of exhibits and comprises some twenty odd sections, was inserted into the *Drug Misuse and Trafficking Act* in 1986. Having a new Part inserted would allow a number of miscellaneous issues to be addressed including:

- what are the parameters of the trial.

- what is an approved injecting room for the purposes of the Act. There are a number of possible options for describing the premises to be used. These include: ›approved‹, ›prescribed‹, ›proclaimed‹, ›declared operational area‹ and ›licensed‹ to name but a few. Which form is ultimately chosen would be a technical decision for the Parliamentary Counsel‹s Office. Models along these lines can be found in the *Children (Protection and Parental) Act 1997* - section 14; and the *Intoxicated Persons Act 1979* - section 3 (see **Appendix 9**).

- how activities which would otherwise be unlawful would be exempted.

Witnesses appearing before the Committee suggested the *Casino Control Act 1992* and the *Gaming and Betting Act 1912* contained possible models (see **Appendix 10**).

Mr Toner said:

> *The way it can be done is to establish a cordon sanitaire or prescribed premises, like the casino for instance where certain games of chance are lawful within the casino but played outside, except perhaps for Anzac Day, are unlawful. Two-up for instance is ... illegal in the whole of the community for the whole of the year except at the Casino and on Anzac Day* (Toner, Evidence 24 October 1997).

- a sunset clause indicating the cessation of the Part at some specified time in the future. Models for sunset clauses can be found in the following Acts: *the Special Commissions of Inquiry Amendment Act 1997*- Section 33H and Section 10(1) of the *Subordinate Legislation Act 1989* (see **Appendix 11**).

Inserting a new Part into the Act would make it possible to clarify that the general offence provisions in the Act stand, and that those identified as needing amendment for the purposes of the trial, have not been repealed, but in fact, suspended. At the conclusion of the trial or whatever time frame is determined as appropriate for the sunset clause, those exemptions will no longer apply.

The third option would be to have a separate Act dealing specifically with injecting

rooms. Witnesses before the Committee indicated that amendments could be made in any of the three ways described and that it would ultimately be a matter for the drafting experts, the Parliamentary Counsel=s Office, to advise on the merits technically for favouring one option over another. This point was made by Mr Button:

> *I guess it is a technical or almost mechanistic question whether or not one would create a new Part which expressly disavowed for certain purposes the rest of the Act, or rather whether one would attach to each section a sub-section saying notwithstanding the above provisions of this section for certain purposes and so on and so forth. I guess that is the kind of question that I in practice would leave to Parliamentary Counsel and they would say which way they felt more comfortable with and which was more convenient. From a technical point of view, we are always keen to make criminal laws as clear and accessible as possible and perhaps creating a separate part where it was all in one spot would be a neater and more accessible way to do it* (Button, Evidence 24 October 1997).

It can be seen from the discussion above that a mix of legislative and non-legislative options exist along a continuum. These are:

- do nothing

This option maintains the status quo, that is, there would be no legislative instruments permitting the establishment of injecting rooms. However, a purely administrative decision could be taken to establish and/or trial a safe and sanitary injecting room, with non-enforcement of applicable sections of the Act agreed to by police and the Director of Public Prosecutions.

- amend the regulation under the current legislation

If there is authority under the Act, it may be possible to amend the Drug Misuse and Trafficking Regulation 1994, (or to create a new Regulation) to exempt as a class those using an approved injecting room from applicable sections of the Act;

- amend the Act

Make legislative amendments to the Act to provide specifically for exemption for those using an approved injecting room from applicable sections of the Act. This could be done: section by section; by inserting a new Part; or by creating a new Act dealing specifically with injecting rooms.

- amend the Act and the Regulation and issue specific guidelines

This approach would provide the most certainty and arguably the most flexibility. Substantive amendments would be made to the Act, with provision for day to day details to be made by way of regulation. Once these legislative changes had been made, guidelines from the Commissioner of Police, developed in consultation with officers from the Director of Public Prosecutions and the Department of Health, could be issued. These would be similar to those currently existing in relation to needle and syringe exchange programs and methadone maintenance programs. It would allow the discretion available to police to be used in a positive way, yet remove any concerns

about potential illegality.

5.6 SUMMARY

This Chapter examines the current legal position in New South Wales in relation to injecting rooms, and presents a number of options, both legislative and non-legislative, for reform if the establishment or trial of injecting rooms is recommended. While it would appear technically feasible to achieve the establishment and/or trial of injecting rooms through administrative means such as the amendment of the Police Commissioner=s Instructions, or possibly through amendment to the Drug Misuse and Trafficking Regulation 1994, the Committee is of the view if this were to go ahead legislative amendment to the *Drug Misuse and Trafficking Act 1985* would be more appropriate. While the form of amendment would be ultimately a question for the Parliamentary Counsel=s Office, the insertion of a new Part into the *Drug Misuse and Trafficking Act 1985*, exempting those activities taking place in an injecting room which would otherwise be an offence, would be a useful way to proceed. If a trial, as opposed to establishment of injecting rooms were recommended, these exemptions would only apply for the time specified for the trial. It would remain the case that all other drug-related activities occurring in a non-injecting room context would remain offences, and would be rigorously pursued by law enforcement officials. Legal issues of a general nature, particularly those related to liability, will also need to addressed. It would appear that while Australia=s international treaty obligations do not prevent the trial of injecting rooms, the position as regards their actual establishment is less clear, with expert opinion divided as to the possibility.

CHAPTER SIX

MODELS FOR INJECTING ROOMS

6.1 INTRODUCTION

Under the Terms of Reference for this Inquiry, the Committee is required to make recommendations to Parliament as to whether or not there should be establishment or trial of safe injecting rooms under the licence or supervision of the Department of Health. In the words of Commissioner Wood:

> *The model which the Commission invites for consideration is one that would permit such facilities to operate in conjunction with needle exchange services, under licence and with the supervision of the Department of Health. It would be important that any such premises operate under strict guidelines. They must not become associated with the supply of prohibited drugs and they should be a resource for immediate assistance for those injecting drug users who seek help with their addiction or health problems* (Wood, *Final Report Vol II: Reform*, p226).

A number of injecting room models have been suggested to the Committee and these are presented in this Chapter along with indicative costings as estimated by those putting forward the proposal. The Committee is not in a position to verify the accuracy of these costings.

Three main models have been proposed: the creation of a new facility designed specifically to address the needs of injecting drug users; the incorporation of an injecting room into a pre-existing health or drug treatment service; and the licensing and regulation of those commercial services already in operation. The advantages and disadvantages of each of these models are examined in this Chapter.

Decisions would also need to be made in relation to the management and funding of an injecting room facility. The service could be both government funded and government run by an appropriate agency such as the NSW Health Department, or it could be government funded but run by an appropriate non-government organisation under the licence or supervision of the NSW Health Department, or it could receive no government funding but operate as a commercial concern, licensed and supervised by the NSW Health Department. In any case, a Code of Practice would need to be developed and compliance mechanisms put in place. This Code would stipulate the minimum standards which any legally sanctioned injecting room should meet, and operational details such as how an injecting room would be monitored and evaluated would need to be addressed.

As outlined earlier in this Report, the broad aims of an injecting room would be:

- to reduce deaths from drug overdose;
- to reduce the spread of blood-borne viral infections from the shared use of injecting equipment;

- to reduce the public nuisance associated with drug injecting in streets and parks, and the subsequent inappropriate disposal of used injecting equipment; and

- to provide opportunities for referral of drug users to appropriate treatment.

In keeping with these aims, an injecting room should not simply be a place to inject drugs, but should be part of a broader multi-purpose facility which would act as a ›gateway= to further treatment, primary health care, counselling and referral to other relevant services. This view was held by a number of witnesses appearing before the Committee. According to Dr Andrew Penman, the Director of the Centre for Disease Prevention and Health Promotion, NSW Health Department:

> *In my view the facilities should involve more than just access to safe injection facilities. I believe they should involve places where people can have a degree of socialisation; be secure from the rigours of the street when they are in crisis; where they can be brought into contact with people who can help them with personal, social and rehabilitation issues. There should be access to medical care. There should be the availability of drug counselling and referral for more formal treatment. In my view they should be operated within a broader health framework within a broader health setting* (Penman, Evidence 24 October 1997).

Mrs Owen, whose daughter died from a heroin overdose told the Committee:

> *They (injecting rooms) would allow the community to have a direct intervention into this so-called subculture or area that has become marginalised and isolated and of which we have no knowledge. We have two cultures: the people like us who do not take drugs and the people who are dying from heroin overdose. Safe injecting rooms, properly administered, maybe within a clinical setting with a medical-type emphasis, would allow us to oversee, supervise and intervene. Flowing from that would be a general picture going out to drug users of a medical-type intervention which would hopefully take the glamour away - a dubious glamour - from using heroin - at the moment a seedy back street, a bar or something seems to have appeal to some people. They would see the community views drug users as a medical problem, and that it is prepared to put time and effort into doing something about it. Safe injecting rooms would also provide an access to educate people about the dangers of drug taking* (Owen, Evidence 30 September 1997).

Many of those hesitant about the general concept of injecting rooms acknowledged that their utility would be enhanced if part of a broader multi-purpose facility.

Councillor Phuong Ngo from Fairfield City Council said:

> *The fact is that the council would not mind to consider the establishment of a facility properly supervised by health professionals that provides the services within that harm minimisation program, including a clinical area where the drug injecting will be properly supervised by health professionals - no doubt the council would be very hard to support such a facility in Cabramatta itself. That is what I said, you know, with the lack of*

> *a comprehensive drug reform package I cannot see that alone the safe injecting room would work ... We cannot see injecting rooms themselves would help to address the problem facing our community, our society, on this issue of drugs. I also mentioned ... the possibility of the council looking to or considering a facility, as such, being part of the harm minimisation program and it is not just an injecting room but a clinical type of facility ... What I am saying is that the council would not mind considering a facility where detoxification and also harm minimisation and the injecting room is a package.*
>
> *There are two different issues here and I cannot see that my expressing of opinions has been conflicting at all because, on one hand, you just say, all right, you take your own drugs, you go there and have a free shot. On the other hand, what I am saying is properly administered and supervised with the intention at the end of the day that those addicts, those users, will be helped to quit those bad habits. It is completely different. On one hand the proposed injecting room is just to give you a facility to please yourself, please your bad habits. On the other hand, what I am saying is I am prepared to look at a facility where, in the long run, you can see at the end of the tunnel some light, some future* (Ngo, Evidence 9 October 1997).

All of the injecting rooms observed by the Subcommittee on the overseas study tour provided health and support services in addition to space for safe injecting. For example, the Schielestrasse in Frankfurt has a methadone clinic, a cafe, a workshop, a laundry, a doctor=s surgery and accommodation for homeless drug users. Female clients who attend the injecting room in Basel have access to a female lawyer, a female gynaecologist and a female priest.

Injecting rooms may not be used by the majority of injecting drug users, but by those belonging to the most marginal group, who do not have homes or safe places where they can go to inject drugs. Given that this group may indeed be the hardest to reach, encouraging them to attend a safe injecting room is considered a worthwhile objective.

Dr Garsia told the Committee:

> *My perception, and I think the Committee [Ministerial Advisory Committee on AIDS Strategy] is of the view, that safe injecting rooms will primarily cater for a marginalised group of injecting drug users, some of whom have no accommodation, some of whom in fact live in refuges and live wherever they can get a roof that night and, therefore, have no place in to which they can take their drugs and paraphernalia and inject in privacy. It is that group particularly who are more prone because of their chaotic lifestyle and many of them are compulsive intravenous drug users and because more, we think, inject cocaine as well* (Garsia, Evidence 7 October 1997).

A similar point was made to the Committee at a meeting with injecting drug users, where it was said that: ›the people who I see using the rooms would be those who do not have a safe place of their own or do not have a friend=s place to go to= and ›the people who will benefit most will be the on-the-street users, whether they are homeless

or they cannot inject at home because they live with a family, or a partner who is not aware of it. These people are at the highest risk ... these are the most marginalised of injectors anyway and are in the highest risk category; there are overdoses and communicable diseases=.

Some witnesses were of the opinion that although there have been some studies which claim that the majority of people who purchase drugs inject them within about 15 minutes of purchase, nonetheless they felt that if given a choice, an injecting drug user would make an effort to get to an injecting room because it was safe. When asked whether it was realistic to expect a person whose behaviour may be classified as >out of control= and chaotic to use a safe injecting room, Dr van Beek told the Committee:

> *I still think that that sort of person would prefer to use indoors in a well-lit area where there is going to be staff who are supportive, compared to in a back lane which is poorly lit where they run the risk of the police or an angry local resident coming across them and being busted up and in the meantime possibly losing their drugs and so on, but I do think that is where the policies and procedures that are put in place will have to be very carefully thought through so that they are not that restrictive that they will end up excluding such people* (van Beek, Evidence 7 October 1997).

Ms Madden said the fact that most injecting drug users use their drugs at home illustrates that many can and do seek out safe places to use their drugs. Moreover the trade experienced by the illegal shooting galleries shows that there is a market for such establishments.

> *There is ample evidence that people are willing to travel quite some distance after scoring to go to Porky's because, as I said, there is plenty of evidence of people who have gone on the public record for this inquiry who are willing to travel to use the shooting room at Porky's. That was an option that gave more safety; they did not have to shoot up in a public place. I think this is about opportunities for people and whether people have opportunities to use a venue that is safe. People will not choose to inject in the street if they have the option of injecting somewhere safe. The reason that people inject in public places is that those people, for whatever reason, do not have the option of injecting somewhere safe. If we are providing them with that, I am absolutely certain that the majority of those people will choose to use the safe option over the public option* (Madden, Evidence 30 September 1997).

Others expressed the view that this chaotic behaviour may in fact prevent injecting drug users from utilising an injecting room facility. Dr Maher commented:

> *It is like any kind of health service that you establish, there are always difficulties attracting those most in need of the service. It may be that safe injecting rooms would attract the people who engage in the least risky behaviours because they are the people most concerned to inject in a clean, sanitary environment and the ones doing the type of >off the wall= stuff cannot get their act together enough to go to a facility like that* (Maher, 8 October 1997).

6.2 MINIMUM MANDATORY REQUIREMENTS THAT AN INJECTING ROOM MUST MEET

Taking into consideration advice received from health professionals, experts in the drug and alcohol field, concerned members of the community and the overseas experience, it is clear that if a trial or establishment of injecting rooms were to proceed, a number of minimum mandatory requirements have to be met.

6.2.1 INJECTING ROOMS WOULD ONLY BE AVAILABLE TO THOSE OVER THE AGE OF 18, WHO HAVE A HISTORY OF INJECTING DRUG USE

A number of submissions to the Committee pointed out that as injecting drug use occurs across a range of age groups including those under the age of 18, the reasons for supporting the trial or establishment of injecting rooms would apply equally to young people, and therefore they should be able to access an injecting room.

This issue was referred to by two police officers, one from Kings Cross, the other from Redfern:

> *We do have young people who use drugs, as you are probably aware. My view, and this would be my personal view, is that if a person is using, then the program should apply to one and all. I cannot see how we can distinguish between one drug user and another. If we are going to be serious about it, the program should be available for everyone as an injecting drug user* (Perrin, Evidence 9 October 1997).

> *It is unfortunate that it might be a 13 year old, but I think facing reality, rather than discriminate, that all and one are included* (Maricic, Evidence 9 October 1997).

While the Committee acknowledges that some people under the age of 18 do use injecting drugs and that there is a need to ensure the health and safety of these young people are protected, young people at risk are the responsibility of the Department of Community Services. This Committee believes that adequate resources should be directed to the Department to assist it in dealing with people under 18 who are injecting drugs in New South Wales. The Committee does not consider it appropriate that entry to an injecting room be permitted to those under 18. This view was held by others making submissions to, or appearing before the Committee. Mr Bill Hoyles, the Director of Youth Services and After Care, Barnardos Australia, sees an injecting room as a service for adults:

> *We would not be prepared to operate a safe injecting room. The reason for that is that Barnardos has always been a child focused organisation and the purpose of a safe injecting room would be, as I see it, to target adults - younger adults, older adults, but adults generally. We do not see ourselves as a health facility. We see ourselves as an organisation working with young people, with children and their families. So, it is not an area where we are particularly keen to move into. However, we would*

> *wish to provide ancillary services in support of such an injecting room and I make mention in our submission to the need for outreach services and follow up services and the provision of services to support families in their problem, in their addiction* (Hoyles, Evidence 7 October 1997).

The Committee notes that all injecting rooms visited in Europe had an age restriction of 18 years.

6.2.2 INJECTING ROOMS SHOULD PROVIDE ACCESS TO STERILE INJECTING EQUIPMENT AND APPROPRIATE MEANS FOR DISPOSAL OF USED EQUIPMENT

The Committee heard evidence about the importance of providing access to free sterile injecting equipment and means for its disposal to reduce the spread of blood-borne infections such as HIV, hepatitis B and hepatitis C. Experts in the area of epidemiology told the Committee that there is considerable evidence to say that the relatively low prevalence of HIV infection among injecting drug users in Australia can be attributed to the introduction of needle and syringe exchange early in the epidemic. Given that the other viruses are transmitted not just through contaminated needles but injecting drug paraphernalia such as swabs and tourniquets, it is important to ensure all the sterile equipment necessary is available.

In a meeting with injecting drug users the Committee heard that if sterile equipment is not available, people will use whatever is at hand including ›the tops of bottles, cans and shoelaces and things instead of tourniquets and spoons.‹

Mr Porter, an ambulance officer based in the Kings Cross area told the Committee:

> *People would be using the same needle over and over again and sharing needles even to the point that when they went into a public toilet and closed the door behind them, if they needed some water to dissolve the drugs they had they would take water out of toilet bowls. You can imagine the bugs that they were injecting into themselves. we are getting a lot of people with septicaemia, septic shock and problems like that* (Porter, Evidence 30 September 1997).

6.2.3 INJECTING ROOM STAFF SHOULD INCLUDE APPROPRIATE NUMBER OF TRAINED WORKERS

Trained workers should be available to provide emergency assistance in the event of a drug overdose occurring in an injecting room. They should also be able to offer basic health care and provide advice and assistance to clients. To ensure staff are able to fulfill these requirements, they will require training in resuscitation techniques, first aid, safer injecting techniques, and drug and alcohol counselling. The Committee notes that in the overseas injecting rooms workers came from a variety of backgrounds.

> *There was another thing I think that is important and that is that the staffing of the facilities was a combination of people with health backgrounds and people with social work backgrounds and I thought it was a model of industrial co-operation actually because you really had a*

> *very small degree of demarcation between the health people, on the one hand, and the social work/street work people on the other hand. They basically were able to cover each other, respond to medical emergencies, as well as provide the services that would be custom in a social work environment. I thought the flexibility of approach there was quite outstanding* (Penman, Evidence 24 October 1997).

The level of staffing would largely depend on whether the facility was a new service or part of an existing service. However, there should always be a minimum of two staff on duty at any time and four would be preferable. The facility and staffing levels will determine the number of clients that can be accommodated by the service. For safety reasons, it is essential that injecting room staff are able to control the flow of clients into an injecting room. If a trial were to go ahead, the Committee believes that it is in the interests of both staff and the injecting drug users themselves that the number of clients using the facility is restricted.

Dr van Beek made this point to the Committee:

> *It would be necessary from a safety point of view to put in place some sort of limits and certainly where these rooms operate in Europe there is a maximum number of people who can access the rooms at any one time and also they would have a certain amount of time that they can spend in the room before they have to move out into the general area* (van Beek, Evidence 7 October 1997).

The needs of staff employed in an injecting room was one of the arguments presented to the Committee for incorporating an injecting room into an existing facility. Mr Gration said:

> *From the point of view of administering a safe injecting room, it is pretty important that the workers who are running the safe injecting room operate in a professional context of support with other workers and can be rotated. In terms of support for the workers and providing an appropriate professional context for their work, there may be value in associating the safe injecting facility with other related facilities* (Gration, Evidence 1 October 1997).

6.2.4 INJECTING ROOMS SHOULD HAVE A REGISTRATION SYSTEM AND STRICT ENTRY CRITERIA

The purpose of registration in European injecting rooms is to restrict entry to people on a regional or geographical basis. However, it will also be necessary to limit the number of clients registered at an injecting room in New South Wales to facilitate the success of the service. The registration system would need to be adapted to reflect the injecting drug population in the vicinity. It is evident that injecting drug users in some parts of New South Wales are local residents, while in other parts they are much more transient in nature.

Dr Penman told the Committee:

> *A key element of the program in Holland and Switzerland appears to be the restriction of entry into injecting rooms to registrants or local residents with the police actively sweeping the streets of drug users, either repatriating non-residents to home counties or directing resident users to the facilities. In a sense the injecting rooms therefore make the job of the police easier and the support of the police for them is strengthened ... This approach may not work or be appropriate in high impact areas like Cabramatta where a greater proportion of public drug use involves non-residents and where county and national borders and jurisdictions are less meaningful. It may also run counter to some of the other objectives for establishing safe injection rooms which may be adopted* (Penman, Evidence 24 October 1997).

There are advantages and disadvantages associated with a registration system. On the one hand, a registration system would undoubtedly assist research as individual clients could be tracked over time and their progress monitored. It could be used to prevent first time users from trying to gain access to the premises and thereby preventing injecting rooms from being seen as instrumental in encouraging young people into injecting drug use. On the other hand, a registration system may deter those injecting drug users who are in most need of a safe, sanitary place to inject drugs, who are concerned at a potential loss of privacy and anonymity. However, for the purposes of operating an injecting room which can be evaluated effectively for future policy determination, the Committee regards a system of registration as being an essential requirement. The registration system could be modified to suit locations of distinct client groups.

The Kirketon Road Centre, a primary health care centre with two fixed and one mobile needle exchange outlets in Kings Cross, operates a client registration system. It has registered 25,000 clients over a ten year period, more than half of whom are injecting drug users. The registration system is designed in such a way as to protect the confidentiality of their clients. Clients provide a first name, first three letters of surname, date of birth, sex and postcode and are then issued with a numbered card which they present when attending one of the Kirketon Road facilities. Having a registration system in place has allowed the Centre to collect general purpose data, enabling the Centre to calculate the number of different clients attending, how many syringes they distribute and collect and to periodically conduct surveys of its clients to gain an insight on various health issues affecting their injecting drug user population.
A similar system of registration would be of use in an injecting room context not only as a means by which the client load could be monitored and adjustments to staffing levels

made as required, but also as a tool in evaluating the facility.

Dr van Beek made the following suggestion to the Committee:

> *There would be other ways, I think, to filter people through, such as requiring, for example, registration at Kirketon Road Centre as a client. That might be one way of ascertaining that that person is from the local area and has not just sort of come in for the night, but then, of course, you need to look at what are you going to provide for the person who wants to come in just for the night, which is not an infrequent event, particularly on weekends where people come in from all over the place often to drink and have a party and then, later on in the evening, that also includes injecting drugs. If you exclude that group of people, that is a significant population when you are looking at drug overdose. They are perhaps most at risk of drug overdose because they are not habitual drug users, so that issue would need to be managed* (van Beek, Evidence 7 October 1997).

Entry criteria for an injecting room should be clearly stated and rigorously enforced.

Access should be denied to:

- people who are unregistered with the injecting room;
- people under the age of 18;
- people involved in selling drugs in the vicinity of the injecting room; and
- people who create a public nuisance in or near the injecting room.

Dr Penman described the situation in the overseas injecting rooms:

> *Well, it was quite clear when talking to the workers in injection rooms that a lot of detailed thought had gone into the rules and the procedures governing the injecting rooms, particularly with cocaine users but also with chaotic drug users generally. You are clearly creating a situation which has the potential for disorder. It was quite stunning in fact how little disorder was actually reported by the operators of the rooms and I think the key to that was that the operators of the room had a very low threshold, trigger point, for intervening early on in the appearance of any disharmony. They also had a very highly detailed and prescribed set of expectations and rules for people in the injection room. Now again these are rooms which are dealing with a known clientele rather than a casual clientele. There was known clientele with detailed rules of the house, so to speak, and ability to change those rules and modify those rules as the situation demanded, so the sensitivity to evolving disorder and preparedness to intervene, the rules that govern the operation of the facility and, of course, the general security provision relating to access and controls on-site* (Penman, Evidence 24 October 1997).

In Frankfurt, the Schielestrasse injecting room requires its clients to sign a declaration, acknowledging and accepting the ›house rules‹, in particular: that they are over 18 years

of age; that they are not currently in any drug-substitution program; that any drugs they have in their possession are for their use only; that the giving and trafficking of drugs to others is not allowed; and that injecting room staff are entitled to check users= registration cards to ensure entitlement to enter.

Final determination of the entry criteria should be a matter for the management committee of an injecting room in relation to particularities of drug use in the area. Other issues which may need to be examined include: prohibiting those on the premises from using drugs communally; not admitting those already under the influence of drugs or those undertaking a drug substitution program.

Although the Committee has heard that injecting drug users sometimes do pool resources to purchase drugs which are then shared, the view was expressed that permitting such a practice in an injecting room may not be appropriate.

Dr Maher said:

> *The other issue is that if you are providing a clinical setting, a lot of people have problems in raising or in financing their drug use on their own. Obviously you could not allow people to share drugs in a clinical setting. You could not allow them to inject in the same conditions that they commonly inject in now, which is making a communal solution and drawing up lines of heroin from a solution. You would not be able to do that in a facility run by the health department and/or a non-government agency* (Maher, 8 October 1997).

6.2.5 DETERMINING THE LOCATION FOR AN INJECTING ROOM

While it is not within the Committee=s Terms of Reference to recommend a specific location for an injecting room, it is appropriate to provide some guidelines on what issues should be considered in determining the location of such a facility. The most fundamental is that it should be located in an area where there is already evidence of a public drug injecting problem. Essentially, the process of deciding where to place an injecting room should be determined by the NSW Health Department in consultation with the local community, local police and health workers, but it is important that it is situated in an accessible, non-residential area and is on a public transport route.

Mr Bill Hoyles told the Committee:

> *The drug dealers know where to go. They know where their customers are. The customer will follow the drug dealers wherever they go ... I do not think that drug users or drug dealers congregate in an area for any other reason than commercial profit. If it is commercially profitable to be in the Marrickville area, that is where the drug dealers will be. If it is commercially profitable to be in Cabramatta, then that is where the drug dealers will be. I do not think the presence of a safe injecting room will attract dealers. I think it is the other way around. The dealers are already there. You put the safe injecting room where the dealers are or close by*
>
> *...*

> *The siting of the injecting room is a difficult question because you have two issues. Do you site the injecting room close to where the current supply is ? or do you site it close to an area where people are likely to go to shoot up ? The reason I make that distinction is if you site one in Cabramatta and the police do one of their big operations and clear the place out, everybody knows that the next place will be Fairfield or Bankstown, so all the dealers will move to Fairfield or Bankstown until the police operation moves to Bankstown and then they will move back to Fairfield or Cabramatta until the police presence there quietens down or the media attention quietens down ... We need to have a range of safe injecting rooms in different localities which are known to have a history of drug sales and drug use. That would be Fairfield, Cabramatta, Bankstown, Marrickville and you are talking basically about the train line. That is the line that most people follow. Not everybody is wealthy enough to tear around in their BMWs* (Hoyles, Evidence 7 October 1997).

Mr Steve Bolt said:

> *I think there is a genuine concern about whether injecting rooms would attract users from other places. My view is that heroin users in particular are attracted to a particular location to buy heroin. Heroin use is widespread throughout New South Wales, Australia and probably throughout the western world. There are injecting drug users in every town and suburb, but there are some congregations of injecting drug users where the heroin market happens to be at any particular time. That is subject to a whole lot of forces that injecting rooms do not necessarily address, but users will travel a distance to make a drug purchase, but I do not believe that users, and having spoken to a number of them this is what they tell me, would move their address simply to access an injecting room if there was one some distance away. Users say they would use it if it was there, but they would not move their residence or travel any particular distance to access an injecting room* (Bolt, Evidence 30 July 1997).

Dr Wodak was of the opinion that:

> *Among the other major things we should be doing I think is having injecting rooms in key areas and the key areas are where we have major drug markets. We probably only have four or five major drug markets in the whole of New South Wales. Where there is a large drug market drug users are attracted and they often cannot wait to get home and inject in the comfort and safety of their home and they inject in public places and there is a higher risk of death because there is no emergency help available* (Wodak, Evidence 30 September 1997).

In its submission to the Committee the New South Wales Users and AIDS Association (NUAA) suggested that:

> *injecting rooms should be established in a number of hot spots across New South Wales including Kings Cross, Nimbin, Cabramatta and a Koori*

specific centre at Redfern (Madden, Submission 27).

Ms Madden, the Co-ordinator at NUAA, stressed that while there may be a number of requirements which would be appropriate for any injecting room, it was important to recognise local differences:

> *There is value in siting safe injecting rooms close to public transport. If they are able to purchase drugs in the vicinity of the public transport and there is a safe injecting room close by they are more likely to use it. If, however, they can not purchase the drugs close to the public transport, it hardly matters. You want to site the injecting room close to where they purchase the drugs, rather than the public transport. Once again, it is a local issue. It depends on the scene in the centre that you are talking about, how drugs are purchased, how they are used, people's movements before and after they purchase drugs, whether they are likely to come off the public transport, purchase the drugs, go to the needle exchange and then go to a safe injecting room, in which case you would want the safe injecting room located close to the needle exchange, rather than where they get off the transport or purchase their drugs.*
>
> *Local scenes differ greatly, as I am sure you have seen in your travels. Nimbin is a different place to Cabramatta, which is different again from Penrith, et cetera. Different things go on in different places. We need to base the injecting rooms on what is going on locally. They need to be flexible enough to respond as things change* (Madden, Evidence 30 September).

It was evident from submissions and testimony to the Committee that while the possibility of only one location being chosen in which to trial or establish an injecting room gave rise to a high degree of concern, the idea of several locations lessened this concern.

Councillor Vic Smith from South Sydney Council said:

> *The second point that I would like to make relates to other councils but affects your considerations. If South Sydney chose, after extensive consultation, to approve a trial of safe injecting rooms, it would have to be part of an overall trial across Sydney and possibly the State. The fact is that heroin use is a problem that stretches across Sydney, and this must be acknowledged. It is untenable to have safe injecting rooms in South Sydney and not in Cabramatta or other parts of Sydney where heroin use is high, or vice versa. Confining safe injecting rooms to one area would attract dealers and users to that area and create a bottleneck of drug use in Sydney. I am sure that Fairfield council would feel the same way if we proposed injecting rooms for that area and not ours* (Smith, Evidence 1 October 1997).

Mr Kemp a member of the Kings Cross Residents Group told the Committee:

> *Last night at a meeting of Kings Cross Chamber of Commerce I mentioned that I was coming today to this Committee. We took a vote on*

> *the members present. Now I point out that this was not a previously ordained vote. Nobody was aware that it was going to be taken, so we have limited coverage of the membership in that respect. But those present voted, I think, unanimously or one abstained. They voted in support of safe injecting rooms, provided that that not be limited solely to our area. I know that you are looking across the board, but we wanted that proviso* (Kemp, Evidence 8 October 1997).

At a meeting in Wollongong in September 1997 the Committee was told that:

> *If X was made an experimental trial area perhaps we might induce a lot of people and then we would really be in trouble with the residents. If the Committee is to recommend a trial on safe injecting rooms that has to be statewide, everywhere, not just a trial area here and there.*

The Committee acknowledges that there is an apprehension by some that the establishment of an injecting room in a particular locality may have a ›honey-pot effect‹, and attract an increasing amount of users and dealers. Without conducting a trial of injecting rooms it is not possible to verify this claim. However, in evidence to the Committee, Dr Maher, Research Fellow in the Department of Community Medicine at the University of New South Wales said in relation to this possibility:

> *I think it is very similar to the needle and syringe exchange issue. People go to Cabramatta to buy drugs, not to avail themselves of the needle and syringe exchange or any other kind of health service in the area ... they are going there to buy the drugs. It is the drugs that draws people to Cabramatta, not free availability of needles and syringes or other harm minimisation strategies such as safe injecting rooms* (Maher, Evidence 8 October 1997).

Similarly Dr Darke from the National Drug and Alcohol Research Centre told the Committee:

> *People tend to go where the drugs are. I doubt that they would go where the injecting rooms are. It is the same sort of argument as with needle exchange. They would not go to where the needles are; they go where the drugs are, so you place the needles near the drugs. You have asked me whether it is possible. I think it is possible, but without a carefully monitored trial that question is very difficult to answer. In terms of injecting rooms, places like Cabramatta and Kings Cross are different to other parts of Sydney or, indeed, of the State, in that in a broader sense people tend to die of heroin overdoses in their own home. In those areas there is the street-based injecting, congregation of users and street-based death. If I were planning to trial injecting rooms, I would be looking at hot spots where we know there is a problem with street-based deaths, so I think the honey pot is already there for those places* (Darke, Evidence 30 September 1997).

The provision of a mobile service was suggested by some as a possible means by which the difficulty of choosing a location could be overcome or the stigmatisation of any one particular location could be avoided.

One Wollongong resident said:

> *It is important that the location should be near the source of supply, and that might change from time to time ... Maybe a movable facility should be considered, something like a bus* (Wollongong, 11 September 1997).

The President of the AIDS Council of New South Wales, Mr Gration said:

> *We already have models, for instance, for vans which move around particular areas at known times to provide syringe exchange. It is possible that a large-enough van could provide a safe injecting space in known locations at particular times. Clearly, it would have less capacity than a facility set up for a particular purpose, but it might provide the sort of flexibility that is needed in a particular area* (Gration, Evidence 1 October 1997).

Reference to the inability of some injecting drug users to access a fixed injecting room facility was also made. Ms Chaperlin, Co-ordinator Youth Services, Penrith Barnardos Centre made the following points to the Committee:

> *I wanted to reiterate that for the Penrith area at least transport access is going to be crucial, because it is such a poorly serviced public transport area. If a person has to travel with a purchase on his or her body for an hour to get to the room, obviously that is not feasible. I would be arguing that in some respects we have to be innovative in how these places are accessed and I believe that there is scope then for a mobile outreach service ... for the women along the Great Western Highway, the sex workers, they inject when they are working and it is simply impossible for them to leave their hours of work and places of work to travel for an hour or more to inject ... I think it is essential for that group of women. They are particularly vulnerable. Their health concerns are not being addressed at all ... What I am arguing for in those instances is that we have a mobile outreach service for those women, which would include an injecting room and with appropriate medical staff or health professional staff where those other issues which affect their longevity could also be followed through* (Chaperlin, Evidence 7 October 1997).

Representatives from the NSW Health Department pointed to cost and potential civil liability as two disadvantages of a mobile injecting room service. Dr Penman told the Committee:

> *I think you would be very brave to go down the route of mobile services. As part of my recent trip overseas, one of the specific purposes for going overseas was in fact to look at mobile methadone services and these are operated very effectively in Holland and in the United States. They operate extremely well, but both of them operate within a broader service context. In Boston, for instance, patients are also going to clinics and receiving counselling services and medical services in clinics apart from the mobile dispensing van. In Holland the dispensing van is only one part of a large integrated system of methadone and people who go on the van*

> *are very carefully selected. In both places you are talking about pretty high threshold services, people who are very stable, people who are very reliable, people who have proven that they can handle that sort of arrangement.*
>
> *You are talking here about a low threshold service, people who are chaotic, people who are quite different from mobile methadones, so I think that would be weighting the die against success. It is certainly not a way to start and as far as I know no-one else has done it ... do not kid yourself that mobile services will be cheaper either. The actual costs to get the mobile on the road in Amsterdam was something in the order of half a million gilders, so it is actually a pretty expensive service, which is important to take into account* (Penman, Evidence 24 October 1997).

Ms O=Shannessy from the NSW Health Department=s Legal Branch commented:

> *A second issue that we have is in acting, so to speak, as corporate solicitors for the Department, and by extension the system, is that potential for legal liability is low to us in a civil jurisdiction ... Why it came to my mind in relation to the mobile type proposal is ... it is a very high risk type of proposal. Your first port of call to prevent any sort of civil liability is to look at the protocols and procedures that you have in place, so you anticipate the duty of care that will be owed to those people and you have guidelines in place to address them. At its most basic you have detailed guidelines about where to get medical attention and you know that medical attention is available 24 hours a day or however long this service is open. That would be the first port of call and I would have thought in a mobile service that would be more difficult to address* (O=Shannessy, Evidence 24 October 1997).

Issues surrounding council approval of an injecting room were also brought to the attention of the Committee:

Councillor Vic Smith said:

here are also several planning issues that would

have to be addressed by council.

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When asked what the role of local government would be if it were recommended that establishment or a trial of injecting rooms go ahead, Mr Tony Kohlenberg, the Senior Environmental Health Officer with Lismore City Council told the Committee:

> *We would need direction from Department of Urban Affairs and Planning guidelines in assessing drug safe-houses. I went through this yesterday with a planner as to what the council's responsibilities would be. We thought if an application for the establishment of a safe injecting room landed in our laps at the moment it is not council's responsibility as an assessor to look at the legal implications or moral obligations. My department assesses the application as to its zoning and suitability. It would then go to council, which makes the decision on whether to approve the application ...*
>
> *It is at that place where the moral debate comes in. Council will probably make a decision based on moral aspects, even though a court of law could overturn any decision based on moral grounds because that is not part of the decision-making process. The decision-making process to approve an application should be based on the legislation. We found that we could probably slot in such an application under the council's local environmental plan terminology of a clinic. I have not got that definition but it includes premises such as clinics for the benefit and wellbeing of the community. So it possibly could be approved under that guideline.*
>
> *Another alternative could be to put it on State Department-owned land, such as in hospital grounds, in which case a development application is still required by council but the zoning issue is not in question. It would go hand in hand with the existing use of that parcel of land. So there are a couple of avenues available. If that topic did come up in our council area, it would be a really interesting exercise* (Kohlenberg, Evidence 1 October 1997).

6.2.6 SETTING THE OPERATING HOURS FOR AN INJECTING ROOM

The Committee agrees with the statement made in the Ettinger House submission that ›there is no specific time of the day when people use drugs= and understands the call for a 24 hour facility. Ms Madden put the position thus:

> *Clearly, if the service is not open for 24 hours the number of people who can be serviced will be dramatically reduced, because people are going to that area to score drugs at all hours of the day and night. We all know that is how that area works. There are no time limits on people accessing the dealers. So I would think that a shooting room in particular would need to consider opening hours because trading is going on late at night and if the service were not open people would go back to what they were doing or would inject in informal spaces* (Madden, Evidence 30 September 1997).

Despite recognising that opening hours of an injecting room need to be such as to facilitate access for users as much as possible, the Committee is nonetheless of the view that there must be minimal adverse impact on the local community. The hours of operation of injecting rooms should be determined by the nature of drug use in the area and in consultation with the local community, local council, local police and user groups as 24 hour access may not be suitable in some locations, and the costs involved with staffing such a facility may be prohibitive. The cost factor was referred to by Dr van Beek:

> *I suppose ideally, given that illicit drug use is a 24 hour, seven day a week activity, ideally a service that was seeking to offer a place for people to inject should also be seven days a week, 24 hours a day, but of course there are cost considerations for such a service which I do not think I need to elaborate on further* (van Beek, Evidence 7 October 1997).

Most injecting rooms observed by the Subcommittee during the overseas study tour are open for an average of 10 hours per day. In Switzerland where hours of operation are less, an unanticipated outcome of the limited opening hours is that clients are managing their drug use in line with the opening hours and as a result have gained greater control over it.

6.2.7 ALL SERVICES OFFERED BY AN INJECTING ROOM SHOULD BE PROVIDED FREE OF CHARGE

The majority of those submissions to and witnesses appearing before the Committee in favour of the establishment or trial of injecting rooms took the view that as a means of maximising the degree to which injecting rooms would be utilised, there should be no cost involved. Dr Maher told the Committee:

> *There are issues around payment. The figures I quoted before indicate that some of the people who are perhaps the more chaotic would not be in a position to afford even a small fee. They are barely scraping enough money together to be able to use their heroin* (Maher, Evidence 8 October 1997).

Mr Bolt expressed a similar view:

> *For people who inject in public places, the problematic heroin users, a charge of, say, $5 to access an injecting room may be the difference*

> *between them going to the injecting room or going down to the creek. If they are struggling to get the $50 to buy the hit of heroin, it may be they do not have $55 in their pocket to pay a modest token fee to use the injecting room. I think it would be a mistake to impose even a small fee because that would be, in the economies of scale experienced by injecting drug users at that street level, a real disincentive to accessing the centre. The purpose of it would be to encourage as many people as possible to access the centre and that means the cost should be born by the public purse* (Bolt, Evidence 30 July 1997).

However, the New South Wales Users and AIDS Association felt that users should make a contribution to the cost of using an injecting room, where they were in a position to do so. The rationale for this position is that: many injecting drug users have already been paying to use the illegal shooting galleries; it would help assuage resentment felt by the general community that injecting drug users were always being given ›handouts=, and it would give injecting drug users rights as consumers. Ms Annie Madden, the Co-ordinator of NUAA expressed it as follows:

> *In our submission we recommended a 70% to 80% cost recovery operation. A precedent for this exists in informal shooting rooms that charge for their use ... users have clearly been willing and able to pay for the use of those rooms and, in fact, have often travelled some distance to use them when the other option was to use a free public space that was less safe. Other examples of existing services, such as the methadone program and some aspects of the needle exchange program, in which a user-pays type system is in place have obviously worked well, the pharmacy fit pack program being one of them. So there are examples of a user-pays system working. A user-pays system brings another added benefit, that is, the consumer rights issue. A degree of user-pays would discourage the continuation of a welfare-type mentality towards drug users. From our perspective, drug users are too often perceived as helpless victims and are then treated with disrespect. This in turn leads to drug users having doubts about their self-worth.*
>
> *People paying for the use of the service are seen as consumers of that service and, as consumers, can demand a high-quality service and input as to the way in which the service is run. If users pay, there is a further likelihood that the community will support the ongoing existence of the service. Often it is claimed that these sorts of services are a drain on the public purse and users should pay for their own services. This option supports the idea that it is appropriate for drug users to pay for services if they are able to ... Also, it is probably wrong to perceive that a certain set of users will never be able to pay and will constantly not pay. It is a fluid thing: sometimes users will be able to pay and at other times they will not, as has been seen in the needle exchange program. Many users are willing to give constant donations to needle exchange programs when they have the money even though they are not required to. We are not in any way suggesting that anyone should be turned away from the service for not being able to pay, but users should be encouraged to support the ongoing provision of the service* (Madden, Evidence 30 September 1997).

In light of the testimony from other witnesses that injecting drug users are unlikely to have extra money to pay for a room, and may if it were necessary to pay for the service either go back to unsafe public injecting, or engage in petty crime to raise the money, and given that the primary objective of an injecting room would be to encourage safe using practices and to limit possible barriers to their use, including financial barriers, the Committee rejects the concept of user-pays injecting rooms.

6.2.8 AN EXPERT ADVISORY GROUP SHOULD BE FORMED

An expert advisory group (reference committee) should be formed to oversee the establishment and running of an injecting room. Key stakeholders should be represented on the expert advisory group which would also be involved in conducting broad community consultation. The composition of the group would include representation from the local community, relevant government and non-government agencies such as the police, health and welfare workers, the Attorney-General=s Department and drug user groups.

Dr Penman made the following comment in relation to the composition of such a body:

> *I think the reference committee should not be narrowly based, that is I do not think it should simply be composed of doctors and nurses. I think you have got to judge the objectives of the research and the outcome sought from the service in the broadest possible terms. I would imagine it would be important to have representation for instance from the user population, representation from the local community. I would imagine it would be important to have representation from social and behavioural disciplines as much as from medical disciplines because I think there are a number of issues to be valued here. Of course you need to have people on it who are experienced in scientific research and can give some assurance to the people who are investing in this trial that there is going to be a scientifically valid result which is of use for policy within a reasonable time-frame* (Penman, Evidence 24 October 1997).

Overseas evidence demonstrates the importance of police involvement in the planning and management of injecting rooms. After establishment, ensuring that regular meetings between injecting room staff and police take place is not only a good management practice, but also gives the community the assurances it requires in safeguarding against public nuisance.

Dr van Beek emphasised to the Committee the need for community consultation:

> *In my experience, which is long with this local community [Kings Cross], I have found through talking in public meetings and making people aware of the situation, that in fact people will, by and large, be able to put their immediate concerns to the side ... I suppose what I am saying is that the local community is, I think, by and large, very cognisant of the social issues in the area and is very constructive in its approach ... I think that through discussion and through continuing consultation, and also being able to give the community an opportunity further down the line to also*

> *have its say, so that as long as something like this was done on a kind of trial basis, people would be probably willing I think to look-see and certainly not reject it out of hand* (van Beek, Evidence 7 October 1997).

The expert advisory group would be best placed to determine many of the operational aspects related to the establishment or trial of an injecting room, the two most critical being the scope of the undertaking (that is, the number, type and location of the facilities) and the evaluation process.

The Committee heard various views as to the scope considered necessary if a trial were to be recommended. Ms Cregan from the Hepatitis C Council was of the view that more than one injecting room should be trialled and that the scope of the trial should be determined by the expert advisory group:

> *One of the advantages from a researcher's point of view of conducting trials at different sites, is that different populations can be compared, or different methods of providing a service can be compared. The best possible opportunity to interpret whatever results come out of a trial is to have more than one trial and compare variables that differ across the different trials ... [as to how many] I think that is a question for the people who set up the trial Protocol after this Committee has made its decision* (Cregan, Evidence 7 October 1997).

Dr Manderson and Professor Carney were asked to outline what they saw as suitable parameters of a trial. Dr Manderson said:

> *I think this is a question for the people who are formulating the trial, as to what will be an effective trial. There is no particular limit. However, if it was open-ended I think that people would be sceptical about whether it was actually a trial. As long as it is a trial, you could have 50 rooms or as many rooms as you wanted. The question about what would be an effective trial is something that I am not in a position to answer* (Manderson, Evidence 24 October 1997).

Professor Carney told the Committee:

> *I agree with that. It is a scientific question ... the longer the duration of the trial the more likely the scientists in us are to say it is a genuine and proper trial rather than a charade to try and get in under the international law exception ... On your question of how many rooms ... you need enough rooms ... to ensure that you have a reasonably representative sample, not a skewed sample, of a particularly hardened and chronic and unresponsive drug user on the one hand, or a particularly novice population in your geographic area ... the answer to the number of centres question is answered by looking at the demographics of the distribution of heroin users in this State ... and ensuring that you had, so far as you could afford it, at least four or five rooms, where the trial was being conducted.*
>
> *You might also want that, I might say, because if it is going to be properly rigorous trial you might sensibly want to build in some real science. You*

> *might well want to build in some variation in the manner of operation, manner of accessing, publicity, who is the gatekeeper, how rigorous is the policing, all of these things ideally should vary if you are going to get reliable information, not only about whether as a broad generalisation injecting rooms are better or worse than not having them, but of the various kinds of injecting room regimes which is the best regime* (Carney, Evidence 24 October 1997).

Both qualitative and quantitative data would need to be collected not only on the clients of any injecting room which may be set up, but also on drug users choosing not to attend, residents and businesses in the proximate vicinity and staff involved in its day to day operation. The expert advisory group would contract an independent body not involved in the running of the injecting room to carry out the actual evaluation, and the specific methodology to be used would be determined by the expert advisory group in consultation with the body contracted to do the research. There must be careful planning and thorough consultation with key stakeholders such as the NSW Health Department, the local community, the local police, existing local drug and alcohol agencies, and drug user groups to determine what the baseline evaluation should contain. The final research proposal would then need to be approved by an Ethics Committee. Given that the evaluation will be an integral component of any trial, it is important to ensure that sufficient resources are made available to allow this to be conducted in a thorough and professional manner. The evaluation needs to address both short term and long term effects. Associate Professor Mattick told the Committee:

> *I think you would want short term answers pretty quickly. You would want some answers within three to six months. I think that could be achieved looking at the attendance, looking at the health status, untoward events occurring in the facility, reports on criminal activities, congregation, that could give you short term answers to satisfy requests for such information. In the longer term I think it would take a year or two before the intervention settled in properly; probably a year would be enough, and then you would have some longer term answers ... I think it (the evaluation) is quite difficult ... but it is achievable* (Mattick, Evidence 7 October 1997).

Professor Carney said:

> *You would want to monitor both short and long term effects. Short terms effects of such measures are often very positive. Medium to longer term effects are often regrettably very pessimistic. But you would want to be looking, as a scientist, at both the short and the long term measures* (Carney, Evidence 24 October 1997).

The NSW Health Department submission to the Committee included a proposal for a research trial of a safe injecting room put forward by the New South Wales Ministerial Advisory Committee on AIDS Strategy in 1995. That Committee identified the following objectives of such a trial:

(1) To study the feasibility and operational aspects of conducting an injecting room facility;

(2) To evaluate the capacity of the injecting room facility to:

- reduce unsafe disposal and littering of used injection equipment;
- reduce the incidence of drug injecting behaviour in public places;
- reduce morbidity and mortality associated with accidental drug overdose;
- reduce the spread of infectious disease resulting from the use of non sterile injection equipment;
- reduce other health problems resulting from hazardous drug use and injection practices and improve the knowledge, health and well being of injecting drug users; and
- facilitate access for injecting drug users to other health services and appropriate drug treatment programs

(3) To monitor and evaluate the potential negative consequences associated with the operation of the injecting room facility including:

- public nuisance and affront caused by clients in the vicinity of the facility;
- violence or harassment directed towards staff or other clients;
- overdose events on or nearby the premises;
- negative publicity and controversy; and
- deleterious effects on nearby businesses, residents or the public amenity.

In their submission to this Inquiry, Mr Bolt and Ms Henry stressed the importance of developing a standardised methodology to ensure that if more than one injecting room is trialled, appropriate comparisons can be drawn (Submission 83). They referred to the need to monitor both quantitative and qualitative aspects of the trial to assess its impact on individual injecting drug users, drug and alcohol workers and injecting room staff, as well as the broader community. Under their proposal the following general data would be gathered:

The **quantitative evaluation** would cover assessment of the measurable aspects of risk associated with injecting drug use. Data would be collected from existing data collections and sources, as well as via specifically designed collection instruments such as self-completion questionnaires, structured interviews and medical examination. (These would be determined by the expert advisory group in consultation with the evaluation consultants.)

- The health of individual injecting drug user clients accessing the injecting room would be assessed (general health, nutritional status, immune function, use of alcohol, tobacco and other drugs, and general well being) in order to monitor any changes associated with using the facility.
- Psychiatric co-morbidities will be examined to identify whether access to a safe injecting space reduces anxiety, stress and depression in injecting drug users, and the potential

impact this has on improvements in lifestyle, social functioning and ability to conduct activities of daily living.

- The post code and town of usual residence will be closely monitored to evaluate any potential ›honey-pot‹ effect.

- Frequency of needle distribution will also be recorded to observe any larger than expected increase in demand for injecting equipment that could be due to an influx of injecting drug users.

- Other indicators of community risk associated with any potential increase in the injecting drug user population will also be monitored such as burglary rates, public disturbances, dealing offences and telephone complaints.

The Tables below summarise the data items that they suggest should be monitored together with the rationale for their collection. The first Table relates to measures of harm to the community, the second to measures of harm to the injecting drug user.

Quantitative Evaluation Measures - Community Measures of Harm

Indicator Type	Rationale for collection
Number of needles distributed	Injecting drug use activity
Proportion of needles discarded unsafely: • Time (month) • Location (roadside, park, school etc)	Community risk of needle-stick injury
Number of overdoses treated at hospital	Cost of drug related illness
Motor vehicle accidents post injection	Measure of driving under the influence
Arrests for street injecting drug use	Public nuisance
Street disturbances, assaults, telephone complaints	Public nuisance
Burglary rates	Public nuisance
Referrals to other services (rehabilitation, detoxification, GP, counselling etc)	Health promoting impacts of injecting room
Methadone referrals	Measure of cessation of injecting

and

Quantitative Evaluation Measures - Individual Injecting Drug User Measures of Harm

Indicator Type	Rationale for Collection
Previous overdose (ever)	Impact of injecting room on frequency of overdose
5+ overdoses in the past	Same
Place of injection, frequency in the past month: • alone or in a group • location (home, car, toilet, park etc)	Assessment of unsafe injecting practice

Sharing of any drug injection equipment during the last month (by type of equipment shared)	Impact of injecting room on sterile injecting practice
Place of disposal in past month	Influence of injecting room on unsafe disposal
Frequency of injecting	Evaluate whether the injecting room is encouraging injecting
Hepatitis B and C virus infections	Impact of the injecting room on spread of blood-borne viral diseases
Infection related to injecting (abscess, septicaemia, endocarditis etc)	Impact of the injecting room on use of sterile techniques
Time period between injecting and driving a motor vehicle	Assessment of driving under the influence
General Health Status	Impact of injecting room on health of injecting drug users
Use of alcohol and other drugs whilst injecting (link with overdoses)	Indicator of harm
Frequency of visits to doctor in past year	Indicator of health status
Access to methadone, drug counselling, rehabilitation services etc	Impact of injecting room on referral patterns
Ability to conduct activities of daily living	Normalisation of injecting drug user=s lifestyle
Postcode and Town of usual residence	Assessment of honey-pot effect

As well as the quantitative indicators of harm, various qualitative indicators of community, professional and injecting room clients perceptions regarding the trial would be gauged. A series of qualitative techniques such as community surveys, focus group discussions and interviews with key informants (police, health workers, NSEP staff) would be used to assess these qualitative effects of the program. (These would be determined by the expert advisory group in consultation with the evaluation consultants.) The Table below lists a number of the components of the qualitative evaluation.

Qualitative Evaluation Indicators

Indicator Type	Rationale for collection
Injecting drug users fear of arrest whilst using	Hurried injecting leading to unsafe practice
Injecting drug users satisfaction with the injecting room	Acceptance and viability of the injecting room
Ease of use and referral to ancillary support services	Harm reduction potential of the injecting room
Street scene ›feel= and disturbances	Impact of the injecting room on street disturbances, public injecting etc
Access to toilets and other amenities	Impact of injecting room on public nuisance

Mr Bolt and Ms Henry refer to the need to collect baseline data on various aspects of harm prior to the introduction of the injecting room so that a comparison could be made with any changes which may result after its establishment. Information on individual aspects of harm would need to be collected by questionnaire or interview with injecting drug users. This could be done with needle and syringe exchange program clients prior to introduction of the injecting room and with the injecting room clients after its establishment. A coding system could be utilised for the purposes of conducting a repeat survey to allow pre-post linkage and assessment of individual changes. Wherever possible, routinely collected information such as police and hospital records would need to be accessed for assessing the community aspects of risk.

The actual quantitative and qualitative details to be included in any evaluation would of necessity be determined by the expert advisory group and the researchers contracted to carry out the evaluation.

In addition to determining the scope and evaluation of the trial, the expert advisory group could also resolve questions concerning: staffing requirements; whether other restrictions or entry criteria should be introduced (for example, will those who smoke drugs be permitted to use the injecting room facility?, should there be a separate space for those who inject drugs other than heroin?); and whether there should be a specific injecting room for Aboriginal injecting drug users. Some witnesses appearing before the Committee felt that separate facilities would be beneficial. NUAA referred in its submission to the need for such a facility and Ms Carrington, a Redfern resident, when asked whether she thought a separate Koori specific injecting room would be of use said:

> *I think, just as a personal opinion, it would probably be a good thing to - obviously you would liaise with the Koori community - but I would see that there would probably be a leaning towards a Koori one and then another one* (Carrington, Evidence 9 October 1997).

Further research would be needed before a separate injecting room for Aboriginal injecting drug users were set up.

6.3 PROPOSED MODELS

The Committee was presented with information on a number of injecting room models and modes of delivery. The main ones being: the creation of a specific new service; the incorporation of an injecting room into a pre-existing service; or the licensing of existing but illegal services. Funding and management could be either: wholly by government; funded by government but run by a non-government agency; or government involvement could be limited to licensing and regulatory functions only. Costings presented in this section are indicators of potential costs only, and the Committee is not in a position to confirm their accuracy. It should be kept in mind that costing of any model will be dependent on a range of key variables related to size, hours of operation, location and range of services to be provided.

The Committee heard differing opinions as to the appropriate atmosphere for an approved injecting room. On the one hand, there was support for a clinical or medical approach to de-emphasise any glamour which may be associated with injecting drug use and from a practical point of view such a setting would be necessary to facilitate the premises being kept clean and hygienic. On the other hand, the view was put that if the setting was too sterile people would not be encouraged to use the injecting room. A balance between a user-friendly space which is not seen as too welcoming needs to be struck. Dr van Beek alluded to this tension in her testimony to the Committee:

> *I think at the same time that it would be very necessary for such a service to also be very flexible and responsive to the needs of drug users and for it not to be too clinical and sort of medical (if I might use that in a pejorative sense) to be acceptable to drug users. To maximise the number of people who would be willing to use such a service I think it is necessary for such a service not to appear to be just hell-bent on providing a very sterile medical sort of treatment-based service. In that way I think, yes, it would need to be a very friendly relaxed sort of an atmosphere.*

She later added

> *The important thing would be that that place does not then become somewhere that those people use in lieu of a home. It would certainly be a challenge* (van Beek, Evidence 7 October 1997).

6.3.1 MODEL ONE: ESTABLISH A NEW SERVICE OR FACILITY

This model requires the establishment of a new facility, which would be managed by the NSW Health Department or contracted out to an appropriate non-government organisation. As with all the models, there are advantages and disadvantages associated with this proposal. On the one hand, a purpose built injecting room facility could be designed and constructed to service the clients= needs, and to cater for the requirements of the staff. Some of these requirements would be specific to an injecting room and they might best be met by establishing a new facility. Certain harm reduction strategies, such as methadone treatment, might not be compatible with an injecting room and providing a new facility would mean that interference with other health and

drug services, their staff and clients could be avoided. On the other hand, the initial expense of establishing a new injecting room might exceed that of adding an injecting room to an already existing service. A new facility may take time to acquire experienced staff and to develop the referral connections to other services.

The establishment of a new facility was suggested in the proposal by the NSW Ministerial Advisory Committee on AIDS Strategy in 1995. The rationale behind the proposal was that a 12 month trial would provide information on the feasibility and potential positive and negative effects of operating an injecting room. It estimated the project would cost in the vicinity of $410,000 with the breakdown as indicated in the table below:

Item	Annual Cost
Lease premises	$80,000
Equipment and fit out	$22,000
Consumables	$15,000
Staffing: 5.6 full time @ $25,000 + 27% shift loading + 15% salary on costs	 $140,000 $37,800 $26,670 $204,470
Evaluation and Research	$90,000
TOTAL	**$411,470**

In correspondence to the Committee, the New South Wales Treasury provided the following estimates of establishing an injecting room facility:

Item	Cost
Set up costs: Project cost (excluding land) Furniture, Fittings and Equipment	 $200,000 $50,000 $250,000
On-going costs: Employee-related Other operating costs	 $266,000 $150,000 $416,000
TOTAL	**$666,000**

In calculating these estimates :

- NSW Health Guidelines were used to determine an area requirement of 92 square metres at a cost of $1,763 per square metre for a new building;
- The allowance for furniture, fittings and equipment was based on the Department=s cost guidelines;
- The project capital cost includes a standard 20% allowance on top of the construction cost for

fees, contingencies and site specifics;

- The staff costing includes three Health Education Officers ($132,000) and three Nurse Practitioners ($134,550). Other operating costs are primarily medical supplies; and
- No estimates have been made for property acquisition or rental costs as there is significant variability in costs. It is pointed out in the correspondence that the above costings should be regarded as only indicative estimates (Mr John Pierce, Correspondence to the Committee, undated).

Dr Alex Wodak provided the Committee with a series of costings if an injecting room were set up in premises already owned by the NSW Health Department with a minimum of four staff on duty. These costings ranged from $306,440 per annum for a service operating for eight hours a day to $993,430 per annum for a 24 hour a day service (Correspondence to the Committee, 3 November 1997).

Item	1st Shift 7am to 3pm (8 hours)	2nd Shift 3pm to 11pm (8 hours)	16 Hours Subtotal	3rd Shift 11pm to 7am (8 hours)	24 Hours Total
Salaries	$269,491	$303,177	$572,668	$309,915	**$882,583**
Administration - Goods and Services	$26,949	$26,949	$53,898	$26,949	**$80,847**
Clinical - Goods and Services	$10,000	$10,000	$20,000	$10,000	**$30,000**
Total	**$306,440**	**$340,126**	**$646,566**	**$346,864**	**$993,430**

Dr Wodak noted that this budget is based on three service time frames. The first is a seven days a week, eight hours a day service at a time when penalty rates are not incurred, Monday to Friday, nominally commencing at 7am. The second set of figures is for an eight hour period commencing nominally at 3pm with penalties of 12.5% incurred. the third set of figures is for an eight hour period commencing at 11pm with penalties of 15%. A further 15% allowance for on-costs has been factored into the salary costing.

The budget also only accounts for salaries, goods and services and other consumables. It is based on the presumption that NSW Health Department or other premises that do not require payment of rent will be used. If such premises are not available, market rental and outgoings will need to be allowed for.

Final estimation would require information regarding staffing levels, the hours and duration of operation for the service, with penalties to be adjusted accordingly. These figures are based on an estimated minimum level for each eight hour shift. Clerical functions would be undertaken by the Enrolled Nurses who would be hired on the basis of inclusion of this function in their job description. Staffing complement per shift: Nurse Unit Manager; Registered Nurse; and 2 Enrolled Nurses.

6.3.2 MODEL TWO: INCORPORATE AN INJECTING ROOM INTO AN EXISTING HEALTH OR DRUG SERVICE

Incorporating an injecting room into an existing health or drug service also has certain advantages and disadvantages. On the one hand, the initial expense could be minimised if an existing facility were extended to incorporate an injecting room, and by adapting an existing facility an injecting room service may be able to gain access to already established health and drug services, thus avoiding the need to gradually build up a resource base. On the other hand, it would probably be necessary to physically adapt the premises to accommodate the needs of different staff and user groups. Otherwise, the adapted facility might interfere with other health and drug services, their staff and clients. A careful choice as to an appropriate mix of services would also need to be made. In submissions and testimony to the Committee those in favour of establishing an injecting room in conjunction with another service tended to be of the view that expanding needle and syringe exchange outlets to include an injecting room would be more appropriate than making an injecting room available in methadone clinics.

Dr Penman said:

> *I do not think I would like to see a large methadone clinic have an injecting room attached for a couple of reasons. There is the community perception issue which has been so powerful or so difficult to handle in relation to the association of the needle and syringe exchange and methadone. There is a perception that the people who are receiving methadone are then using needle and syringe exchange to administer the methadone or divert the methadone in illegal ways, so there is a community perception problem, but I think there is another issue and that is that to link it to the methadone clinic is to focus on a very narrow range of the services you are providing. I do not think we are offering an injecting mill here. We would like to see a low threshold service, part of which is injection. That does not mean I would rule it out and I would think it would be quite positive to provide access to methadone to some people who are clients of the injecting room if that is their preferred way of receiving methadone maintenance treatment* (Penman, Evidence 24 October 1997).

In his testimony to the Committee, Mr Bolt said: ›I think there should be co-location of existing needle exchange services and injecting rooms. That would be ideal‹ (Bolt, Evidence 30 July 1997). Details of how such a service would operate and estimated costs were provided in a submission by Mr Bolt and Ms Henry (Submission 83). Their suggested injecting room would operate 12 hours per day, 7 days per week. With only one staff member rostered, this service was calculated to cost $168,200 per year. The costing was recalculated to cover the rostering of at least two staff on any one shift. This adjustment brought the cost to $265,085 per year. Given that some costs would only be incurred in the first year, averaged over two years the service would cost $246,085 per year. The point was also made that:

> *There will be some cost offsets from the transfer of the NSEP outlet services to the approved injecting room. These offsets are estimated at $60,000 per year, which includes existing staff wages, on-cost and*

injecting equipment. There would be some savings in equipment costs because there would be less waste of needles and fewer Fit Packs distributed (Bolt and Henry, Submission 83).

Item	Cost
Recurrent Costs • Wages (2 staff only) • Team leader • Relief • On-Costs • Rent • Injecting Equipment • Administration • Training • Committee Management Fee	 $132,800 $16,450 $5,670 $18,590 $7,800 $25,000 $3,500 $10,000 $7,275
Capital Purchases (First year only)	$13,000
Evaluation Costs (Over 2 years)	$25,000
TOTAL	**$265,085**

Similarly in the submission from Ettinger House the view was expressed that:

> *There is a perception in the community that a needle exchange program should be complemented by a safe injecting facility. These people reason that safe disposal of needles is a very important issue for the community more generally and that a safe injecting facility would enable this* (Santos, Submission 56).

Other witnesses suggested providing an injecting room in a hospital may have certain advantages:

Mr Prowse was of the view:

> *If it is ever going to be implemented Statewide there would need to be places in each of those places and the most logical place would be hospitals because they already have methadone clinics; the people who go to the methadone clinics are usually the same category of people who would be utilising these safe injection rooms and it would seem to me that hospitals, given the spread of hospitals across the State - small towns to cities have them - obviously have all the attendant benefits of trained nurses, doctors, administrators on the spot dealing in drugs every hour of the day every day of the week* (Prowse, 24 October 1997).

Mr Perrin, the Acting Commander Local Area Command, based in Redfern said:

> *Talking about this with our committee at Redfern, the suggestion mainly from them was they could see it as part of a hospital program because of the availability of medical assistance 24 hours a day, emergency medical teams on site. There are a lot of things that may indicate a hospital as an appropriate site* (Perrin, Evidence 9 October 1997).

In the New South Wales Treasury costing referred to in relation to the first model, the following information was provided regarding the incorporation of an injecting room in a pre-existing service: ›a new clinic incorporated into existing medical services would have the same on-going cost but would have a lower set up cost of around $200,000 based on refurbishment costs of around $1,300 per square metre=.

6.3.3 MODEL THREE: LICENCE AND REGULATE EXISTING COMMERCIAL PREMISES

The Committee heard evidence that existing commercial illegal injecting rooms provided some of the stated benefits of injecting rooms, in particular intervention into overdoses, easy accessibility for ambulance officers, co-operation of the police and distribution and collection of needles and syringes. The New South Wales Health Department representative raised the possibility that an existing commercially operated injecting room could be included in the trial for comparative purposes, provided certain conditions could be met (Document tabled by NSW Health Department at public hearing, 24 October, 1997).

Regulation of at least one commercial premises could be trialled. These rooms may be attractive to those injecting drug users who wish to remain anonymous and not be associated with the ›drug scene=. These premises might also be a way of reaching people suspicious of Health Department services. Additional measures would be necessary to ensure that these premises operate within NSW Health Department guidelines. These measures would include a Code of Practice, staff training, inclusion in the evaluation process and establishment as a satellite service of a suitable Government agency with referral to the parent agency and other treatment agencies to be an essential part of the operation. If these premises were restricted premises, they would also exclude people under 18 years of age.

There would be advantages and disadvantages of licencing or regulating existing commercial premises. On the one hand, a licensed commercial injecting room could be relatively inexpensive to operate, recovering a significant proportion of its operating costs. The NSW Health Department noted in information provided to the Committee that:

> *It is anticipated that if the Government were to decide to permit the operation of commercial premises within a regulatory framework, such establishments would derive all or most of their income from paying customers. Under this model it would not appear to be necessary for the Government to incur any costs, and potentially there could be a net income to Government from the payment of licence fees and taxes*.

The licensed commercial service may be able to operate 24 hours a day, 7 days a week. These premises could be a way of reaching people reluctant to use health department services and if the licensed service was incorporated into an existing business it may be possible to avoid the problems with commercial and other

neighbours associated with locating a new service. A commercially operated injecting room could be implemented and trialled in a relatively short period and still provide referral to other services.

On the other hand, a licensed commercial injecting room might have difficulties providing suitably skilled and qualified staff; data collection may be more difficult in a commercial setting; such a facility would most likely have few relevant services on site and the monitoring necessary by the relevant government agency to ensure that such an establishment met minimum standards and complied with the Code of Practice would be at the government=s expense.

Despite the generally negative description of those associated with the illegal shooting galleries, a more positive view of those involved in the day to day operation was put to the Committee by some witnesses. Dr Wodak told the Committee:

> *Some years ago I was contacted by a lady who works at an unofficial injecting room in Darlinghurst Road. She invited me to visit the premises where she worked because she wanted to explain to me what goes on there. I was very very impressed with what I saw. I was impressed by the fact that she provided a very caring service, she knew the names of all the people who came in. She treated them with great dignity and respect and that is a very important plus in this area. She had worked out a system of estimating the risk based on whether they were injecting heroin or cocaine, and the heroin users were at much greater immediate risk and anyone who was injecting heroin on her premises was told that they could rent the cubicle and within three minutes she would knock on the door and if they did not answer she would barge in and be ready to resuscitate them. She would tell them that in advance. She had developed a very sensible and rational way of dealing with a very difficult problem, which I commend her for. I think she was doing this entirely out of public interest and she led me to believe that the owners of the premises had strenuously discouraged her from continuing this operation.*
>
> *I went back a second time with a distinguished doctor from Puerto Rico who was visiting Australia and who has an interest in this in his own country, and he was astonished at the civilised way in which this problem was being dealt with. This particular facility, and one other facility, I understand are the only facilities we have of that kind at the moment in that part of Sydney which has a huge drug injecting population, whether we like it or not and however much law enforcement we seem to apply in that area ... It seems to me that we really do not have an option but to sanction what has gone on and make a facility that actually does a lot of public good, make that a legal facility rather than have it run by criminals* (Wodak, Evidence 9 October 1997).

6.4 SUMMARY

This Chapter examines many of the operational aspects which would be involved in the establishment or trial of an injecting room, and those assessed as being minimum mandatory requirements are outlined. In deliberating the issues surrounding the establishment or trial of such facilities, the Committee is mindful of the fact that it must

consider both the needs of the potential user group and those who may be affected by the operation of the injecting room.

The minimum mandatory requirements identified are:

- only those over the age of 18 with a history of injecting drug use would be able to gain access to the injecting room;
- the full range of sterile injecting equipment should be available in the injecting room as well as a means to ensure appropriate and safe disposal of used equipment;
- the injecting room should be operated by trained staff and include appropriately trained health workers;
- a registration system and strict entry criteria should be in place;
- an injecting room should be located in an area where public injecting is currently a problem, and the area chosen must be on an accessible public transport route;
- the hours of operation of the injecting room need to have minimal impact on the local community;
- all services offered by an injecting room need to be provided free of charge;
- an expert advisory group consisting of key stakeholders needs to be set up to oversee the establishment and running of any injecting room; and to pursue the issues integral to both the short-term and long-term monitoring and evaluation of injecting rooms.

Three possible injecting room models were presented, and their advantages and disadvantages discussed. The first model is a new service or facility managed by the NSW Health Department or contracted out by the Department to a suitable non-government organisation; the second model is an injecting room incorporated into an existing health or drug treatment service; and the third model is the licensing and regulating of an existing commercial premises.

If the trial or establishment of injecting rooms is to proceed, the expert advisory group would be best placed to determine on a case by case basis the operating details of any particular injecting room which may be created. This would be done in close consultation with the local community.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATION

CONCLUSION

The major focus of this Inquiry, as specified in the Terms of Reference, has been to advise Parliament of the costs and benefits to the public of the establishment or trial of safe, sanitary injecting rooms and of amendments to the *Drug Misuse and Trafficking Act 1985* required; and to make recommendations as to whether or not such establishment or trial should proceed. During the course of the Inquiry process a number of broader issues, such as alternative treatments, pertaining to drug use, prevention and treatment were raised. These were, however, outside the scope of the Inquiry and thus have not been pursued in any detail in this Report, although the Committee acknowledges the need for a broad range of treatment options and prevention and education measures which an integrated drug program should reflect.

A Subcommittee of the Select Committee visited five injecting rooms and held discussions with key stakeholders in Europe. The Committee also visited Wollongong, Newcastle, a number of rural areas in New South Wales and various Sydney suburbs to speak with concerned members of the community and drug users. In addition to its own research, the Committee received 103 submissions and took formal evidence from 89 witnesses. Amongst the witnesses were parents whose sons or daughters had died because of drug abuse.

Some witnesses and submissions were opposed to the establishment and even trial of injecting rooms in New South Wales. Their opposition stemmed mainly from concern that such a service would encourage drug use, send the wrong message, encourage drug dealing and take funds away from other drug services. The Committee also heard from a number of individual drug users, legal and medical experts, academics and organisations which supported the establishment or trial of injecting rooms. Their support was predicated on the possibility that such facilities may prevent fatal drug overdoses, reduce the transmission of blood-borne viral infections and assist in the re-integration of drug users into society.

In making recommendations in relation to the establishment or trial of injecting rooms, the task of this Committee is ultimately one of weighing up the competing costs and benefits, advantages and disadvantages, to those individuals who are injecting drug users as well as to the broader community. The Committee is well aware that drug use is a community problem for which there is no immediate solution, only better or worse outcomes, and that any proposal to deal with the problem will be perceived as positive or negative depending on the individual=s personal attitude towards injecting drug use. It is evident from the material put to the Committee that issues about the values of society were often central to arguments both for and against the establishment or trial of safe injecting rooms, and that in a number of cases personal experiences were the key informing factor in determining individual attitudes. It is important to recognise that values and value systems inevitably enter the debate and bear on our personal choices of favoured solutions.

RECOMMENDATION

The Joint Select Committee into Safe Injecting Rooms was established to Aadvise the Parliament of the costs and benefits to the public of the establishment or trial of safe, sanitary injecting rooms under the licence or supervision of the Department of Health and of amendment of the Drug Misuse and Trafficking Act 1985 accordingly@ (Committee Terms of Reference 1(a), at p 3 of the Report).

The Committee undertook extensive consultation both overseas and in New South Wales with health professionals, non-government service providers, users, local community representatives and law enforcement agencies in order to ascertain the viability of trialing safe injecting rooms in New South Wales.

The Committee was presented with detailed professional advice and anecdotal evidence which both supported and opposed the establishment or trial of safe injecting rooms.

After close consideration of all the material presented the Committee recommends that the establishment or trial of injecting rooms <u>not</u> proceed. Reasons for this recommendation include:

(a) <u>Safety concerns associated with administering and operating injecting rooms</u>

AInjecting rooms can never be safe when users are injecting heroin which is an illegal and uncontrolled substance@. (Long, Submission 87)

(b) <u>Impact on the local community</u>

Another concern expressed to the Committee by Local Government representatives, residents and drug and alcohol workers was that injecting rooms could lead to an increase in drug dealing in the nearby vicinity and confirm a local community as a drug ghetto.

ACan it seriously be denied that the provision of legal facilities for the use of drugs and safe from police interference will not generate a supply to meet the demands for the substances? These places will become a AMecca@ for dealers and pushers. They will not only be supplying the existing demands, they will be stimulating and expanding their markets@ (Watters, Submission 93)

(c) <u>Increased crime risks associated with injecting rooms</u>

When asked whether injecting drug users travelling to a particular location where an injecting room was situated were likely to perpetrate property crime in that community, Dr Weatherburn replied:

AI think the answer is yes. If more heroin users are drawn to Cabramatta, there will be more crime in Cabramatta, simply because people tend to commit crime when they need a fix. They are not going to say AI need a fix, I think I had better travel back to Double Bay@. (Weatherburn, Evidence 1 October, 1997)

(d) <u>Impact on attitudes to drug use</u>

Witnesses said that the establishment or trial of injecting rooms could be interpreted as condoning illicit drug use. Sending the wrong message to young people was of particular concern.

"The provision of formal support for illegal activity and hard drug addiction sends the message to our youth that hard drug use is condoned by our community leaders." (Ubrihien, Submission 50)

(e) Question of resource allocation

Material presented to the Committee indicated that resources would be better directed to expanding the range and capacity of drug treatment programmes.

"The current initiatives by the Council, State Government and non-government agencies are targeting the drug problems by positive measures based on education, detoxification, rehabilitation and control. ... Drug dependent persons urgently need access to these facilities and it is imperative that other issues do not result in funds or the priority of providing rehabilitation and detoxification facilities be reduced or delayed. (Long, Submission 87)

Given the concerns as mentioned the Committee does not see the establishment or trial as part of a harm reduction strategy.

This recommendation reflects the majority opinion of the Committee as moved by Ms Meagher, seconded by Mr Thompson, and supported by Ms Isaksen, Mr Jobling, Mr Kerr and Mr Rixon. The members who dissent from the majority view present their alternative conclusions in the reports appended below.

DISSENTING OPINION OF ANN SYMONDS, JOHN MILLS, CLOVER MOORE AND IAN COHEN - 16 FEBRUARY 1998

After consideration of the evidence and opinion expressed during the conduct of the Inquiry, and having regard to Commissioner Wood=s recommendation, four Members of the Committee concluded and recommended the following:

RECOMMENDATION 1

> THAT a scientifically rigorous trial of safe injecting rooms be conducted in New South Wales as part of an integrated public health and safety approach to injecting drug use as proposed by Commissioner Wood in the Royal Commission into the New South Wales Police Service.

In response to the request from Commissioner Wood to advise on the amendments to the *Drug Misuse and Trafficking Act 1985* required to enable the legal conduct of any trial, we recommend:

RECOMMENDATION 2

> THAT the *Drug Misuse and Trafficking Act 1985* be amended to enable the legal conduct of a trial by the introduction of a new Part which would define exemptions from prosecution for activities occurring in the approved injecting room for the period of the trial.

To ensure that the trial of safe injecting rooms can be evaluated and acted upon reliably, we recommend

RECOMMENDATION 3

> THAT any trial should include at least three injecting rooms in appropriate locations as determined by a consultative and open planning process which includes the community, the police service and health and welfare representatives; and
>
> THAT any consideration of the establishment of safe injecting rooms should only proceed after an evaluation of the trial.

Detailed consultative planning is essential to the success of any trial of safe injecting rooms. We therefore recommend:

RECOMMENDATION 4

> THAT an expert advisory group be established to determine the parameters of the trial including: the number and type of facilities; location; staffing; length of the trial; and indicators to be measured.

THAT the expert advisory group must include key stakeholders including representatives of the NSW Police Service, NSW Health Department, Attorney-General=s Department (including the Bureau of Crime Statistics and Research), health workers, user groups, and community representatives. The support and co-operation of police, health workers and the local community are essential to the success of any trial.

RECOMMENDATION 5

Notwithstanding the deliberations of the expert advisory group, we recommend:

THAT any injecting room conform to minimum standards of operation which provide:

- that participation in the trial only be open to those over the age of 18 years, who have a history of injecting drug use;
- that a location chosen for the trial have the support of the community, the police, and local government representatives and be in an area where a high profile drug trade already exists;
- that an injecting room be a multi-purpose facility which has an education and information role, offers some primary health care, and acts as a gateway into treatment;
- that a registration system of those using the injecting room be in place to permit a proper evaluation and ensure the number of participants is kept at a manageable level;
- that the evaluation design monitor and demonstrate both short term and long term effects; and
- that an intensive education campaign be undertaken in those areas seen as appropriate for trialing an injecting room well in advance of the commencement of the trial.

RECOMMENDATION 6

To confirm the need for continuing support for harm minimisation we recommend:

THAT the Parliament reaffirm its commitment to harm minimisation as an appropriate strategy in the management of illicit drug use.

In reaching these conclusions and recommendations we have been convinced by the evidence presented to the Committee from the health and legal professions as well as the pleas of parents and members of the community for new approaches to illegal drug use. We agree with Commissioner Wood=s reasoning that:

> *At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances to shrink from the provision from safe, sanitary premises where users can safely inject is somewhat shortsighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour (*Final Report, *Vol II: Reform*, 1997 p226).

The provision of safe injecting rooms potentially allows for the safe disposal of syringes and needles; reduces the risk of the spread of infectious diseases by making sterile equipment readily available; reduces the risk of theft and violent assaults on drug users; allows for immediate medical attention in the event of an overdose; and provides a gateway to other treatment programs.

It is alarming to note that according to the Australian Institute of Health and Welfare the increase in deaths attributable to illicit drugs reached 778 deaths in 1995 (Australian Illicit Drug Report, 1996-97:1) and according to the Alcohol and other Drugs Council of Australia (ADCA), there is around one death per day from overdose in New South Wales. It would seem imperative that increased measures to reduce harm should be trialled.

In a recent Report the National Drug Strategy again confirmed that the harm minimisation strategy had been a hallmark of Australia-s drugs policy and had provided an important contribution to international understanding of options in drug policy. A key aspect of harm minimisation has been explained as follows:

> *that harm minimisation remains neutral in terms of the long-term goals of intervention. This involves formulating priorities for goals and focusing on the immediate, realisable goals. This notion does not conflict with the long-term goal of abstention* (Single (1995) in Australian Illicit Drug Report 1996-97:6).

The principle of harm minimisation is not obstructive to law enforcement, and we agree with the recommendation in the Australian Illicit Drug Report:

> *that the police and the courts continue to give high priority to the enforcement of laws aimed at traffickers rather than those aimed at consumers* (Single and Rohl, in Australian Illicit Drug Report, 1996-97:5).

Harm minimisation takes account of reducing harm to injecting drug users and the community. The reduction of overdose deaths, reduction in the transmission of blood-borne diseases, and the reduction of public nuisance, crime and corruption are of equal importance. **We can and must harmonise the goals of public health with the goals of public safety and security**.

As Commissioner Wood said in his Report:

> *A co-ordinated effort by government, police and health professionals is required to properly implement the harm minimisation program that they have all espoused. A progressive but careful move towards dealing with personal use of narcotics primarily as a medical problem, would also have considerable potential to reduce the opportunities for police corruption and the conflict faced by police*

> *officers forced to deal with intravenous drug users as both law breakers and people in need of help* (Wood, 1997:17).

Finally, the success of Australia=s harm minimisation approach to illegal drug use has relied on the bipartisan political commitment to the National Drug Strategy. We earnestly entreat all parties to continue to support the principle of harm minimisation. Lives depend on it.

DISSENTING COMMENT FROM THE HON JOHN JOBLING, MR MALCOLM KERR MP AND MR BILL RIXON MP

CHAPTER TWO:

2.3 SERVICES FOR INJECTING DRUG USERS

This section of the Report deals with the Needle and Syringe Exchange Program; Methadone Maintenance Treatment; Detoxification and other treatment options.

During the debate in the Legislative Assembly establishing the Joint Select Committee Upon Injecting Rooms of 19 June, 1997, the Shadow Minister for Health, Jillian Skinner, proposed amendments to the Government=s motion which would extend and broaden the Committee=s terms of reference to include among other matters, an assessment of the management of the Needle and Syringe Exchange Program and an investigation of alternatives to injecting illegal drugs including the methadone maintenance program.

These amendments were rejected by the Government and the terms of reference given to the Committee remained with a narrow focus on the costs and benefits to the public of the establishment of safe injecting rooms and on amendments to the *Drug Misuse and Trafficking Act 1985*.

Therefore, it is our view that the sections in Chapter 2 relating to these other programs are beyond the scope of the Committee=s terms of reference. The Committee did not investigate these issues and this is confirmed in the conclusion of the Report:

> *During the course of the inquiry process a number of broader issues, such as alternative treatments, pertaining to drug use, prevention and treatment were raised. These were, however, outside the scope of the Inquiry and thus have not been pursued in any detail in this Report.*

Thus, these sections and any conclusions reached about these programs are outside the terms of reference and should not be included in the report.

DISSENTING COMMENT FROM THE HON JOHN JOBLING

CHAPTER THREE: TRAVEL EXPERIENCE

As a member of the Subcommittee which visited the Pauluskerk in Rotterdam, I do not believe that the report adequately reflects the views of Reverend Hans Visser, the Co-ordinator of that Church=s Drugs Centre.

Having met with Reverend Visser and carefully analysed the publications and programs which this Church supports, I believe that the Pauluskerk fully endorses the use of dangerous drugs and challenges the already liberal law in the Netherlands to adopt a more permissive attitude:

> *AIt is the task of government to develop a drug policy that is based on the risks involved.@* (*Regulation of the Drugs Scene in the Pauluskerk in Rotterdam,* Hans Visser, Rotterdam, 30 September, 1996, p 1).

Rev Visser is totally opposed to the prohibition of drugs. Indeed, I quote *Athis is why I advocate the legalization of drugs@. (Drugs Policy in the Netherlands*, Hans Visser, p5). He champions the development of a uniform drugs policy in Europe where hard drugs are distributed on a medical-social basis which would not interfere with work projects.

> *AMan is a creature that has an urge for excitement. He wants to cross barriers in his search for happiness and fulfilment. Drugs enable people to deepen and expand their experiences and consciousness. Furthermore drugs are seen as a means of healing and cure. In youth cultures drugs sometimes play a role on the road to adulthood@*. (*Regulation of the Drugs Scene in the Pauluskerk in Rotterdam*, Hans Visser, Rotterdam, 30 September, 1996, p 1).

Rev Visser regrettably believes *that drugs cannot be effectively controlled by criminal justice measures*.

The *other marginalised groups* referred to in the report (p54) which are supported and given shelter by the Pauluskerk include *Apaedophiles, transsexuals, transvestites etc@* (*Regulation of the Drugs Scene in the Pauluskerk in Rotterdam*, Hans Visser, Rotterdam, 30 September, 1996, p1).

The quote given in Chapter 3.1.1 of the Report concerning dealers is further expanded in Visser=s *Regulation of the Drugs Scene*, p 9:

AWe Dutch have committed ourselves to the principle of opportunity. This makes it possible for us to regulate the drug trade in the church... Considering the law, the police must keep a low profile... but they cannot interfere with the trade, the law being what it is. For this reason, no trading takes place at times when police officers on their rounds pay a visit to the church.@

If, as the English Court of Appeal held Athe chief function of the police is to enforce the law@, then I concur with the view of the former Attorney General and Minister for Crime Prevention for South Australia, the Hon C Sumner A*the Dutch system is not feasible for*

a number of reasons, one of which would be the Australian justice system=s ability to tolerate the systematic ambiguity between law and criminal justice practice which is inherent in the Dutch system.

DISSENTING COMMENT FROM THE HON JOHN JOBLING, MR MALCOLM KERR MP AND MR BILL RIXON MP

CHAPTER THREE: STUDY TOUR

As members of the Committee, we dissent from the view that the study tour undertaken by the Subcommittee visited countries with a broad range of policies on the drugs issue.

By only visiting Switzerland, the Netherlands and Germany, we believe the Subcommittee was only exposed to groups that favour the introduction of safe injecting rooms. No specific appointments were made with groups or organisations with a contrary view or opinion in these countries.

We can understand the financial and time constraints on the Committee=s visits, however, by not including visits to other jurisdictions such as Sweden, we believe the Subcommittee did not have an opportunity to speak with groups and organisations who not only disagree with the establishment of safe injecting rooms but have decided not to establish them following exhaustive debate and research. That is why Mr Jobling chose to also make a comprehensive visit to Stockholm at his own expense.

Whilst the Report in its summary of Chapter 3 indicates that the European centres visited by the Subcommittee need to be viewed in terms of their specific cultural and legal context, it is our belief that such facilities could not possibly translate successfully to an Australian setting.

APPENDIX 1 ADVERTISEMENT

JOINT SELECT COMMITTEE INTO SAFE INJECTING ROOMS

A parliamentary committee has been established to

(a) advise the Parliament of the costs and benefits to the public of the establishment or trial of safe, sanitary injecting rooms under the licence or supervision of the Department of Health and of amendments of the Drug Misuse and Trafficking Act 1985 accordingly; and

(b) make recommendations to the Parliament as to whether or not such establishment or trial should proceed.

The Committee consists of 10 members of Parliament who will consider submissions and conduct public hearings and site visits.

Interested individuals or organisation are invited to make a submission to assist the inquiry.

The Committee is particularly interested to hear what users think about injecting rooms. Users can make a submissions in writing or, alternatively, give evidence directly to the Committee. If you would like to arrange a confidential meeting with the Committee, at an agreed location, please contact Susan Want on 9230 3054. The Committee will also visit needle exchanges and treatment centres to take evidence from interested people.

If requested, contents of submissions may be kept strictly confidential. Evidence can be given in private and individuals will be subject to the protection of parliamentary privilege which ensures that no information they provide can be used against them.

Written submissions (in writing, typed, or on disk) should be addressed to:
Senior Project Officer
Joint Select Committee into Safe Injecting Rooms
Parliament House
Macquarie Street
SYDNEY NSW 2000

or FAX to (02) 9230 3052

Closing date for submissions is **12th August, 1997.**

For further information and copies of the full terms of reference contact Susan Want on (02) 9230 3054.

Patricia Staunton MLC

Chairman

APPENDIX 2 LIST OF SUBMISSIONS

Submission 1	Mr Joseph Deguara
Submission 2	Ms Denese Harrington
Submsision 3	Detective Senior Constable Nick Bingham
Submission 4	Mr John Holmes
Submission 5	Mr Vince George
Submission 6	Mr Michael Smith
Submission 7	Mrs Elda Quinton
Submission 8	Mr H E Smith
Submission 9	Mr Tony Kohlenberg, Senior Environmental Health Officer Lismore City Council
Submission 10	Ms Judy Crane
Submission 11	Ms Jacquie Sands
Submission 12	Mr Tim Sladden, Epidemiologist North Coast Public Health Unit Northern Rivers Area Health Service
Submission 13	Professor Laurence Mather Professor of Anaesthesia and Analgesia (Research) University of Sydney
Submission 14	Names Unclear
Submission 15	Mr M and Mrs G Ellen
Submission 16	Mr and Mrs R J Wilde
Submission 17	Karl
Submission 18	Petition of Nimbin Residents
Submission 19	Dr Shane Darke, Senior Lecturer National Drug and Alcohol Research Centre
Submission 20	Dr Tony Sherbon, Chief Executive Officer Northern Rivers Health Service
Submission 21	Mr E S Harris
Submission 22	Ms Rae Owen
Submission 23	Mr Stephen Lang
Submission 24	Mr Phil O'Grady, President

	Fairfield City Chamber of Commerce Inc
Submission 25	Mr Donald S Johnston
Submission 26	Mr Peter Connie, Executive Director Network of Alcohol and Other Drug Agencies Inc
Submission 27	Ms Annie Madden, Co-ordinator NSW Users and Aids Association Inc
Submission 28	Mr Phillip Nash, Eastern Regional Director Christian Community Schools Limited
Submission 29	Mr M Butcher
Submission 30	Ms Margaret McKay
Submission 31	Mr Phillip Utting
Submission 32	Mr E and Mrs M Bazzana
Submission 33	Mr Scott D Sledge
Submission 34	Mr A Brown
Submission 35	Mr Bruce Shearman, Chairman Nimbin Branch of the National Party of Australia (NSW)
Submission 36	Mr Peter O'Meagher
Submission 37	Mr W and Mrs N Nugent
Submission 38	Mr Hal Baker
Submission 39	Mr Wayne Hodges
Submission 40	Ms Katherine Rynne, Acting Centre Manager The Langton Centre
Submission 41	Ms Maria Walsh
Submission 42	Patricia Baker, Mary Baddock, Patricia Sawonga
Submission 43	Mr Reginald Lee, Lifestyles Unit Long Bay Correctional Centre
Submission 44	Mr Bill Hoyles Director, Youth Services and After Care Barnardos Australia
Submission 45	The Co-ordinator Newtown Needle Exchange
Submission 46	Mr J MacNeill
Submission 47	Mr Stuart Loveday, Executive Officer

	Hepatitis C Council of NSW
Submission 48	Ms Jan Cregan, Researcher National Centre in HIV Social Research
Submission 49	Dr Alex Wodak Director, Alcohol and Drug Service St Vincent's Hospital Sydney Limited
Submission 50	Mr T and Mrs K Ubrihien and Family
Submission 51	Dr John Smart Ethel Street Family Medical and Dental Practice
Submission 52	Ms Jenny Iversen, Disposal Project Officer Drug Intervention Service Cabramatta (DISC)
Submission 53	Dr Michael Dawson Senior Lecturer, Department of Chemistry University of Technology
Submission 54	Mr Gary Gahan, Manager, HIV and Sexual Health Promotion Unit Northern Sydney Area Health Service
Submission 55	Mr John Malouf Australian Pharmacists Against Drug Abuse
Submission 56	Adrine Santos, Co-ordinator Ettinger House Inc
Submission 57	Mr B Schutz and Mr S Stubbs, Cabramatta Youth Team Cabramatta Community Services Centre
Submission 58	Ms Geraldine Mullins, Co-convenor Fremantle Local Drug Action Group Australian Parent Movement, Family Council of WA
Submission 59	Binna Pownall Nimbin Neighbourhood Centre
Submission 60	Sonia
Submission 61	Kerry Darcovich
Submission 62	Kevin Ko, Co-ordinator Dunlea
Submission 63	Gayle Stannard, Co-ordinator South West Alternative Programme
Submission 64	Mr Steve Bolt, Solicitor Northern Rivers Community Legal Centre
Submission 65	Mr Brad Soward

Submission 66	Ms Margaret Orr
Submission 67	Mr Chris Lawrence
Submission 68	Mr Tony Trimingham Damien Trimingham Foundation
Submission 69	Mr Craig Thompson, Magistrate Bankstown Local Court
Submission 70	Mr G E Priest, State President The Returned and Services League of Australia
Submission 71	Mr James Brecse
Submission 72	Mr Collis Parrett
Submission 73	Mr John Medich, President Cabramatta Chamber of Commerce and Industry
Submission 74	Mr George Selvanera Criminal Justice Coalition
Submission 75	Dr Margaret Sargent
Submission 76	Mr Keith King Hunter Needle and Syringe Exchange Program
Submission 77	Mr Chris Lawrence Hepatitis C and IV Drug Advocate
Submission 78	Ms Karen Henry
Submission 79	Mr Graham Parry
Submission 80	Mr Timothy Moore
Submission 81	Mr Chris Puplick, Chairman Australian National Council on AIDS and Related Diseases
Submission 82	Ms Karen Graham, Project Officer HIV/NSEP Hunter Centre for Health Advancement
Submission 83	Steve Bolt and Karen Henry
Submission 84	Sarah Nielsen, Solicitor Redfern Legal Centre
Submission 85	Kevin Swift, Manager The Exchange Services, Manly
Submission 86	Ms Amanda Burfitt, Manager The Exchange Services, Ryde
Submission 87	Mr Brian Long, Special Projects Manager Fairfield City Council

Submission 88	Mr Henry Bartnik, Community Relations Church of Scientology
Submission 89	Mr Mark Benjamin
Submission 90	Mr Nigel Pierce, Secretary Nimbin Neighbourhood and Information Centre Inc
Submission 91	Mr Warren Woodley, President Forum for the Prevention of Drug Abuse
Submission 92	Mr Chris Gration, President AIDS Council of NSW
Submission 93	Major Brian Watters Commander, Rehabilitation Services Command The Salvation Army
Submission 94	Ms Margaret Duckett
Submission 95	Ambulance Service of New South Wales
Submission 96	Ms Helen Simpson, Secretary Nimbin Health & Welfare Association Inc.
Submission 97	Mrs Gail Slade
Submission 98	Sandy Wolfenden
Submission 99	W J Hensen
Submission 100	Stephen Jurd, Head, Department of Drug and Alcohol Services Royal North Shore Hospital
Submission 101	Mr Michael Reid, Director-General NSW Dept of Health
Submission 102	Katherine Brown, Director Illawarra Sexual Health Service
Submission 103	Assisting Drug Dependants Inc

APPENDIX 3 LIST OF WITNESSES

Mr Dick Bennett	Member 2011 Residents Group (Sydney: 8 October 1997)
Mr Phil Berry	Policy Officer, Criminal Law Review Division NSW Attorney General=s Department (Sydney: 24 October 1997)
Mr Steve Bolt	Solicitor Northern Rivers Community Legal Centre (Nimbin: 30 July 1997) (Sydney: 9 October 1997)
Mr Richard Button	Director, Criminal Law Review Division NSW Attorney General=s Department (Sydney: 24 October 1997)
Professor Terry Carney	Faculty of Law University of Sydney (Sydney: 24 October 1997)
Ms Betty Carrington	Resident, Redfern (Sydney: 9 October 1997)
Ms Erica Chaperlin	Co-ordinator, Youth Services Penrith Barnardos Centre (Sydney: 7 October 1997)
Ms Jan Cregan	Social Researcher Hepatitis C Council (Sydney: 1 October 1997) (Sydney: 7 October 1997)
Dr Shane Darke	Senior Lecturer, National Drug & Alcohol Research Centre University of New South Wales (Sydney: 30 September 1997)
Mr Jamie Dunbar	Resident, Redfern (Sydney: 9 October 1997)
Ms Sonia Fenton	Councillor South Sydney City Council (Sydney: 8 October 1997)
Dr Gordian Fulde	Director St. Vincent=s Hospital Emergency Department (Sydney: 7 October 1997)
Dr Roger Garsia	Chair Ministerial Advisory Committee on AIDS Strategy (Sydney: 8 October 1997)

Major Kevin Goldsack	Manager, William Booth Insitute The Salvation Army (Sydney: 30 September 1997)
Mr Chris Gration	President AIDS Council of NSW (Sydney: 1 October 1997)
Mr Don Griffin	Health Education Officer Hepatitis C Council (Sydney: 7 October 1997)
Ms Fiona Haines	Resident, Redfern (Sydney: 9 October 1997)
Professor Wayne Hall	Executive Director, National Drug & Alcohol Research Centre University of New South Wales (Sydney: 24 October 1997)
Ms Christine Harcourt	Deputy Mayor South Sydney City Council (Sydney: 1 October 1997)
Mr James Harrison	Director, Planning and Building South Sydney City Council (Sydney: 1 October 1997)
Dr David Helliwell	General Practitioner (Nimbin: 30 July 1997)
Ms Karen Henry	Needle Syringe Exchange Worker (Nimbin: 30 July 1997)
Mr Bill Hoyles	Director, Youth Services and After Care Barnardos (Sydney: 7 October 1997)
Professor John Kaldor	Deputy Director National Centre in HIV Epidemiology and Clinical Research (Sydney: 7 October 1997)
Mr Garry Keep	Health Services Manager South Sydney City Council (Sydney: 1 October 1997)
Mr Bruce Kemp	Chairman, Crosswise Kings Cross Residents Action Committee (Sydney: 8 October 1997)
Mr Tony Kohlenberg	Senior Environmental Health Officer Lismore City Council (Sydney: 1 October 1997)

Mr Brian Long	Manager Fairfield City Council (Sydney: 9 October 1997)
Mr Stuart Loveday	Executive Officer Hepatitis C Council (Sydney: 7 October 1997)
Ms Margaret MacDonald	Senior Research Assistant National Centre in HIV Epidemiology and Clinical Research (Sydney: 7 October 1997)
Ms Annie Madden	Co-ordinator New South Wales Users and AIDS Association (Sydney: 30 September 1997)
Dr Lisa Maher	Research Fellow, Department of Community Medicine University of New South Wales (Sydney: 8 October 1997)
Dr Desmond Manderson	Senior Lecturer, School of Law Macquarie University (Sydney: 24 October 1997)
Detective Sergeant John Maricic	Kings Cross Police (Sydney: 9 October 1997)
Associate Professor Richard Mattick	Director of Research National Drug & Alcohol Research Centre University of New South Wales (Sydney: 7 October 1997)
Ms Robyn Maurice	Co-ordinator, Gay and Lesbian Injecting Drug Use Project AIDS Council of NSW (Sydney: 1 October 1997)
Mrs Margaret McKay	(Sydney: 7 October 1997)
Dr Winifred Mitchell	Secretary Nimbin Older Women's Forum and Nimbin Health and Welfare Association (Nimbin: 30 July 1997)
Mr Phuong Ngo	Councillor Fairfield City Council (Sydney: 9 October 1997)
Mrs Nancy Nugent	Enrolled Nurse and Nimbin Resident (Nimbin: 30 July 1997)
Mr Phil O=Grady	President, Chamber of Commerce Fairfield (Sydney: 1 October 1997)

Mr Rory O'Halloran	Chairperson Byron Bay Community Safety Committee (Nimbin: 30 July 1997)
Mrs Margaret Orr	(Sydney: 30 September 1997)
Ms Leanne O=Shannessy	Deputy Director, Legal and Legislative Services Branch NSW Health Department (Sydney: 24 October 1997)
Ms Denise Owens	Damian Trimingham Foundation (Sydney: 30 September 1997)
Dr Andrew Penman	Director, Disease Prevention and Health Promotion NSW Health Department (Sydney: 24 October 1997)
Superintendent Dave Perrin	Redfern Police (Sydney: 9 October 1997)
Mr Nigel Pierce	Secretary Management Committee of the Nimbin Neighbourhood and Information Centre (Nimbin: 30 July 1997)
Mr Jim Porter	Ambulance Officer Paddington & Kings Cross Area (Sydney: 30 September 1997)
Mr Roger Prowse	Chair, Criminal Law Committee NSW Law Society (Sydney: 24 October 1997)
Major Bill Redwood	General Secretary, Rehabilitation Services Command The Salvation Army (Sydney: 30 September 1997)
Ms Diana Roberts	Councillor Lismore Council (Nimbin: 30 July 1997)
Mr Miles Rooke	Community Advocacy Co-ordinator New South Wales Users and AIDS Association (Sydney: 30 September 1997)
Mr George Salvanera	Member Prisons & Blood-Borne Communicable Diseases Working Group (Sydney: 1 October 1997)
Mr Vic Smith	Mayor South Sydney City Council (Sydney: 1 October 1997)
Mr Gregory Soward	President Nimbin Agricultural Industrial Society

	(Nimbin: 30 July 1997)
Mr Kevin Soward	President Nimbin Ratepayers and Progress Association Inc (Nimbin: 30 July 1997)
Mr Robert Toner	Secretary Bar Council NSW (Sydney: 24 October 1997)
Mr Tony Trimingham	Damian Trimingham Foundation (Sydney: 30 September 1997)
Major Ray Tunstall	Community Relations Secretary The Salvation Army (Sydney: 30 September 1997)
Dr Ingrid van Beek	Director Kirketon Road Centre (Sydney: 7 October 1997)
Dr Don Weatherburn	Director, NSW Bureau of Crime Statistics and Research. NSW Attorney General=s Department (Sydney: 1 October 1997)
Professor Ian Webster	Professor of Public Health, Department of Community Medicine University of New South Wales (Sydney: 8 October 1997)
Ms Jo-ann West	(Nimbin: 30 July 1997)
Mr Douglas Whitlen	Treasurer Nimbin Chamber of Commerce (Nimbin: 30 July 1997)
Dr Alex Wodak	Director, Alcohol and Drug Service St. Vincent=s Hospital (Sydney: 9 October 1997)
Mr Peter Zahra	Public Defender NSW Attorney General=s Department (Sydney: 24 October 1997)

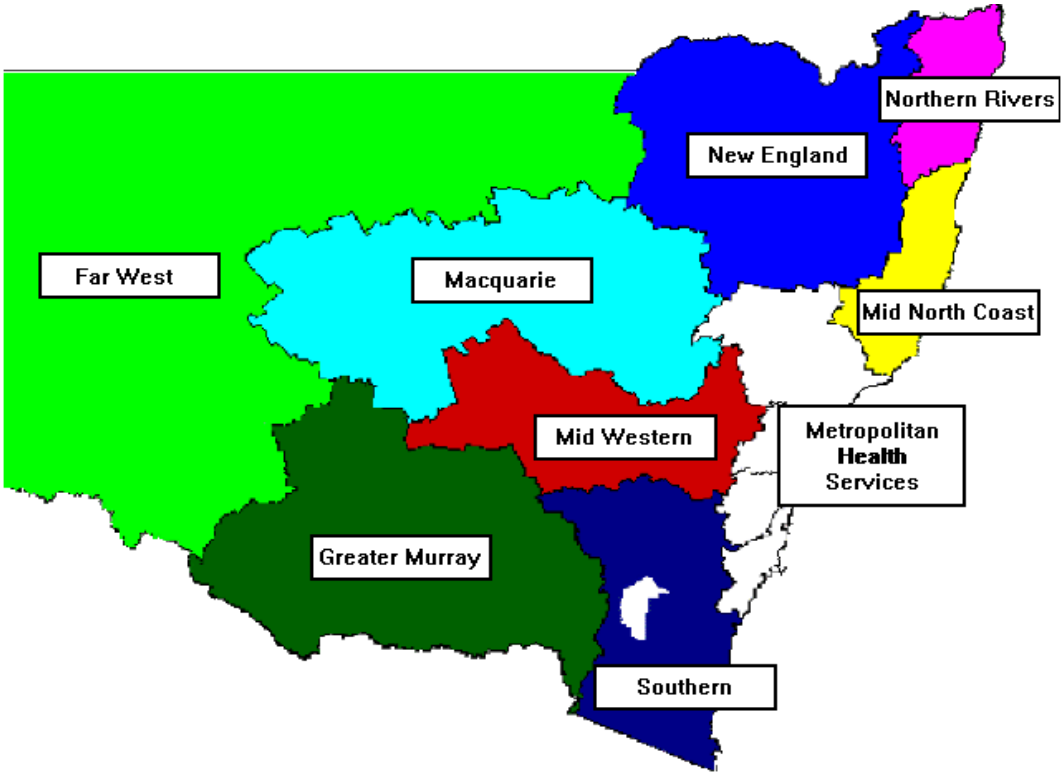
APPENDIX 4 LIST OF SITE VISITS

23 July, 1997	Kirketon Road Centre, Kings Cross Shooting-gallery - Kings Cross
30 July, 1997	Nimbin - Public Hearing
31 July, 1997	Byron Bay - Meeting with Byron Bay Safety Committee ›The Buttery= Therapeutic Community - Binna Burra
6 August, 1997	Cabramatta Community Centre - Meeting with key stakeholders
12 August, 1997	Newcastle East Community Centre - Meeting with key stakeholders
13 August, 1997	New South Wales Users and AIDS Association (NUAA) - Meeting with NUAA and injecting drug users
11 September, 1997	HIV Prevention Service, Illawarra Area Health Service, Wollongong - Meeting with key stakeholders
September, 1997	Redfern

APPENDIX 5 STUDY TOUR OF INJECTING ROOMS IN EUROPE

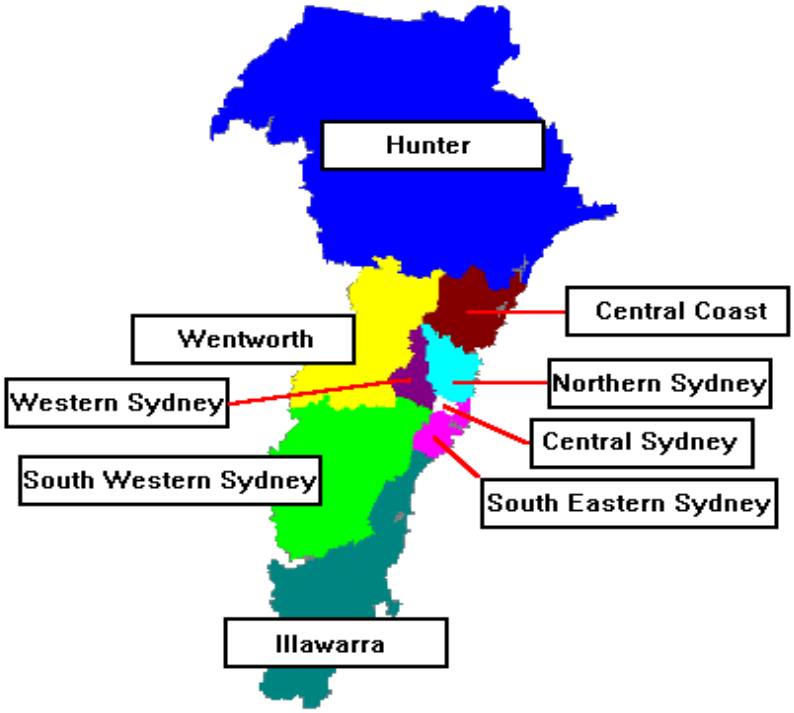
London	The Subcommittee met with Professor Gerry Stimson from the Centre for Research on Drugs and Health Behaviour (22 August 1997)
Rotterdam	The Subcommittee met with Reverend Hans Visser from the Paulus Kerk (25 August 1997)
Arnhem	The Subcommittee met with Mr Max Daniel, Head of Police, Dr Don Olthof, Director of the Stichting Gelders Centrum Voor Verslavingszorg, and Dr Ype Schat, Head of General Health Care in Arnhem (26 August 1997)
Utrecht	The Subcommittee met with Mr Franz Trautmann, Co-ordinator of the Netherlands Institute of Mental Health and Education, and Mr Hans Roerink from the Ministry for Health (26 August 1997)
Berne	The Subcommittee met with Mr Christian Buschan, a Forensic Expert in the Swiss Federal Office of Justice and Police, Dr Margaret Rihs-Middel, Head of Research in the Swiss Federal Office of Public Health (27 August 1997)
Basel	The Subcommittee met with Mr Vosser, Public Prosecutor, Mr Luc Saaner MP and Mr Thomas Kessler from the Ministry of Justice, (28 and 29 August 1997)
Frankfurt	The Subcommittee met with Dr Harald Körner, Chief Prosecutor from the Prosecutor=s Office, Mr Peter Frerichs, Vice - President from the Police Department, Mrs Ernst from the Drug Policy Co-ordination Office, Mr Jurgan Weimer, Professor Hans Happel and Ms Susan Schardt from the European Cities on Drugs Policy Group, Mr Barth from the Drogermotdieust Crisis Centre and Mr Messer (1 September 1997)

APPENDIX 6 NSW HEALTH DEPARTMENT AREA AND RURAL



HEALTH SERVICES

Metropolitan Health Services


Hunter
Central Coast
Wentworth
Northern Sydney
Western Sydney
Central Sydney
South Western Sydney
South Eastern Sydney
Illawarra

APPENDIX 7 RELEVANT CLAUSES IN THE DRUG MISUSE AND TRAFFICKING REGULATION 1994

CLAUSE 4 APPROVAL BY DIRECTOR-GENERAL OF HEALTH OF NEEDLE EXCHANGE PROGRAMS

(1) The Director-General of the Department of Health may authorise a specified person or specified class of persons to participate in a program approved by the Director-General to facilitate:

(a) the supply to intravenous drug users of sterile hypodermic syringes and sterile hypodermic needles to prevent the spread of contagious disease; and

(b) the giving out of information concerning hygienic practices in the use of hypodermic syringes and hypodermic needles to prevent the spread of contagious disease.

(2) An authorisation under this clause is to be granted, and may be revoked, in the same manner as an authorisation under the Act.

CLAUSE 5 EXEMPTION FOR PHARMACISTS WITH RESPECT TO THE POSSESSION OF ITEMS OF EQUIPMENT FOR DRUG ADMINISTRATION

(1) A pharmacist is exempt from the provisions of sections 11, 19 and 20 of the Act, but only to the extent necessary to authorise the pharmacist to have in his or her possession items of equipment for use in the administration of a prohibited drug capable of being so administered.

(2) The exemption applies only for the purpose of enabling the pharmacist to participate in an approved needle exchange program.

CLAUSE 6 EXEMPTION FOR AUTHORISED PERSONS WITH RESPECT TO THE POSSESSION OF SYRINGES AND NEEDLES AND THE GIVING OUT OF INFORMATION

(1) An authorised person is exempt from the provisions of sections 11, 19 and 20 of the Act, but only to the extent necessary to authorise the person:

(1) to have in his or her possession hypodermic syringes and hypodermic needles for use in the administration of a prohibited drug capable of being so administered; and

(2) to give out information concerning the administration of any such prohibited drug.

(2) The exemption applies only for the purpose of enabling the authorised person to participate in an approved needle exchange program.

APPENDIX 8 LIST OF INTERNATIONAL CONVENTIONS

(Taken from the Premier=s Drug Advisory Council, *Drugs and Our Community*, Victoria, April 1996, p29.)

The Australian Government is a signatory to a wide range of international treaties. Several of these relate to illicit drugs. International treaties related to illicit drugs reflect the concerns of many nations about the impact of these drugs. They are also a recognition of the fact that controlling the supply of these drugs requires international cooperation. The extent and nature of the International treaties has evolved over many years. The first such agreement was the 1912 Hague Convention controlling the manufacture of opium.

A number of conventions were signed after 1912 and included:

- The 1925 International Opium Convention.
- The 1931 International Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs.
- The 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs.
- The 1946 Geneva Protocol that transferred functions exercised by the League of Nations under various narcotic treaties to the United Nations.
- The 1948 Paris Protocol that authorised the World Health Organisation to place under international control any dependence-producing drug, synthetic or natural.
- The 1953 New York Opium Protocol that limited the use of opium and international trade in it to medical and scientific needs.

The major treaties involving illicit drugs are:

- The 1961 Single Convention on Narcotic Drugs that Australia ratified in 1967. The convention defines the drugs covered (consistent with those that are the subject of the Council=s terms of reference) and details the agreement that the trade and use of these drugs should remain illegal.
- The 1972 Protocol attaches to the 1961 Convention. The importance of this protocol is that it places greater emphasis on treatment, education and rehabilitation for abusers who commit minor offences as an alternative or adjunct to imprisonment.
- The 1971 Convention on Psychotropic Substances added synthetic hallucinogens, stimulants and sedatives to the list of banned drugs, and provided improved structures to distinguish medical use of drugs from other purposes.
- The 1988 Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances was ratified by Australia in 1993. This convention enhanced the provisions relating to inter-jurisdictional cooperation in the detection and prosecution of drug trafficking. It sets standards for signatories in such matters as dealing with possession and purchase of illicit drugs.

APPENDIX 9 - LEGISLATIVE MODELS FOR ›APPROVED PLACES:

CHILDREN (PROTECTION AND PARENTAL RESPONSIBILITY) ACT 1997

SECTION 14 ›OPERATIONAL AREA:

(1) The council for an area may request the Attorney General to declare the area to be an operational area for the purposes of Division 2 of this Part.

(2) The Attorney General may, by order, declare an area described in the order to be an operational area for the purposes of Division 2 of this Part in accordance with a request under subsection (1), or may declare a portion only of that area to be an operational area.

(3) The Attorney General must not make an order declaring an area (or portion of an area) to be an operational area unless the Attorney General is satisfied that adequate crime prevention or youth support initiatives will be available in the area before the order takes effect.

(4) In considering a request under subsection (1) to declare an area (or a portion of an area) to be an operational area, the Attorney General is to have regard to the following:

(1) whether the council has adequately informed and consulted with the local community concerned, including young people and the Aboriginal community, and the views expressed,

(2) the extent and nature of crime in the area,

(3) the nature of any crime prevention or youth support initiatives that have been undertaken in the area, including whether any local crime prevention plan or safer community compact is in force for the area, or is in the course of being prepared by the council for the area, and the contents or proposed contents of that plan or compact,

(4) the effect of making the declaration on young people in the area, including the availability of safe and appropriate recreational amenities for young people in the area,

(5) the practicality of applying Division 2 of this Part in the area, including (but not limited to) any advice given by the Commissioner of Police relating to the operational capacity of police to carry out functions under the Division in the area,

(6) without limiting paragraph (e), whether appropriate arrangements have been made, or are able to be made, to cater for the needs of young people who are removed from public places in the area under Division 2 of this Part and who are not able to be taken home, including culturally appropriate arrangements for Aboriginal and Torres Strait Islander young people,

(7) whether the council has undertaken steps to include young people's needs in its local planning processes.

(5) The Attorney General is to consult with the Minister for Community Services and the Minister for Police before declaring an area (or a portion of an area) to be an operational area.

INTOXICATED PERSONS ACT 1979

SECTION 3 DEFINITIONS

(1) In this Act, except in so far as the context or subject-matter otherwise indicates or requires:

"proclaimed place":

(1) in relation to persons of or above the age of 18 years, means any place that is declared by the Governor, by proclamation published in the Gazette, to be a proclaimed place for adults for the purposes of this Act, and any place belonging to a class of places that is so declared to be a class of proclaimed places for adults for the purposes of this Act; or

(2) in relation to persons under the age of 18 years, means any place that is declared by the Governor, by proclamation published in the Gazette, to be a proclaimed place for juveniles for the purposes of this Act, and any place belonging to a class of places that is so declared to be a class of proclaimed places for juveniles for the purposes of this Act;

(2) A place or a class of places may, under a proclamation made for the purposes of paragraph (a) or (b) of the definition of ›proclaimed place‹ in subsection (1), be declared to be a proclaimed place or a class of proclaimed places, as the case may be, for both adults and juveniles.

(3) The Governor may, by proclamation, vary or revoke any proclamation made for the purposes of paragraph (a) or (b) of the definition of ›proclaimed place‹ in subsection (1).

APPENDIX 10 LEGISLATIVE MODELS FOR LICENSING PROVISIONS

CASINO CONTROL ACT 1992

SECTION 4 GAMING IN LICENSED CASINO DECLARED LAWFUL

(1) Despite the provisions of any other Act or law, the conduct and playing of a game and the use of gaming equipment is lawful when the game is conducted and the gaming equipment is provided in a casino by or on behalf of the casino operator (that is, the holder of the licence for that casino under this Act).

(2) The Gaming and Betting Act 1912 and the Lotteries and Art Unions Act 1901 do not apply to the conduct and playing of a game and the use of gaming equipment when the game is conducted and the gaming equipment is provided in a casino by or on behalf of the casino operator, except to the extent (if any) that the regulations otherwise provide.

(3) This section does not operate to validate or render enforceable a contract relating to gaming that would, apart from this section, be invalid or unenforceable.

(4) Despite subsection (3), a contract to which that subsection refers and to which a casino operator is a party is enforceable against the casino operator.

(5) The conduct of operations in a casino in accordance with this Act and the conditions of the casino licence is not of itself a public or private nuisance.

SECTION 7 MINISTERIAL DIRECTIONS AS TO REQUIREMENTS FOR CASINO

(1) The Minister may from time to time give a direction in writing to the Authority as to any of the following matters:

(1) the permissible location for a casino,

(2) the required size and style of a casino,

(3) the development required to take place in conjunction with the establishment of a casino, such as the development of a hotel or other complex of which a casino is to form part,

(4) any other prescribed matter concerning the establishment of a casino.

(2) Before giving a direction on any matter to the Authority, the Minister is to call for a report on the matter from the Authority and is to consider the Authority's report.

(3) A direction as to the permissible location for a casino must not specify a particular site unless the site is vested in the Crown or the Crown has the exclusive right of occupation of the site.

(4) The Minister may vary or revoke a direction by a further direction in writing to the

Authority.

(5) The Authority must exercise its functions under this Act in respect of the grant of a casino licence, the conduct of negotiations and the entering into of agreements in a manner that is consistent with the directions of the Minister under this section.

GAMING AND BETTING ACT 1912

SECTION 20B TWO-UP ON ANZAC DAY

(1) A game of two-up played on Anzac Day is not an unlawful game, if:

(1) no payment or other benefit is, for the purpose of participating in the game, given or sought for the right to enter the public or private place where the game is or is to be played, and

(2) no payment or other benefit is given or sought for the right to participate in the game (otherwise than by the placing of money by way of a bet), and

(3) no commission on, percentage of or fee for bets or winnings is given or sought by any person, whether or not a participant in the game.

(2) A game of two-up played on Anzac Day in the premises of a registered club and involving the giving or seeking of such a payment, benefit, commission, percentage or fee is not an unlawful game, if:

(1) the playing of the game is authorised by the club, and

(2) all payments or other benefits involved are authorised by the club to be disposed of in their entirety for the benefit of a charity or for a charitable purpose and are not to form part of the funds of the club, and

(3) such other requirements (if any) as are prescribed by the regulations for the purposes of this subsection are complied with.

(3) Nothing in:

(1) this Act (including, but not limited to, sections 5, 7 and 42), the Liquor Act 1982, the Registered Clubs Act 1976 or the Charitable Collections Act 1934 or any regulation under any of those Acts, or

(2) any condition of any licence, approval or other instrument under any such Act or regulation, or

(3) such provisions of any other Act or statutory instrument as are prescribed by the regulations for the purposes of this subsection, prevents or applies in relation to the playing of a game of two-up in any public or private place on Anzac Day where the game is (because of this section) not an unlawful game, unless the place is prescribed by the regulations as being excluded from this subsection.

(4) Nothing in this section prevents payment of an entrance fee or charge to a licensed racecourse or other ground, so long as the fee or charge is not directly related to the game of two-up.

(5) This section does not apply to a game of two-up played on Anzac Day in a place

that is otherwise a gaming-house.

(6) This section does not affect any offence involving betting or wagering by or with a person under the age of 18 years.

(7) If a game of two-up played on Anzac Day is an unlawful game because any of the matters mentioned in subsection (1) or (2) are not satisfied, a participant in the game is not guilty of an offence in relation to the game, unless it is proved that the participant knew or, in the circumstances, should have known or suspected that the game was an unlawful game.

(8) For the purposes of this section, reference to the game of two-up extend to the betting and side betting associated with the game, and references to participants in the game are to be construed as including persons engaged in such betting.

SECTION 20C TWO-UP IN BROKEN HILL

(1) A game of two-up played in the City of Broken Hill is not an unlawful game for the purposes of this Act or any other law if the game is conducted in accordance with Part 3A.

(2) For the purposes of this Act or any other law, it is declared that two-up premises (within the meaning of Part 3A) are not a gaming-house.

APPENDIX 11 LEGISLATIVE MODELS FOR ›SUNSET CLAUSES:

SPECIAL COMMISSIONS OF INQUIRY AMENDMENT ACT 1997

SECTION 33H EXPIRY OF PART

This Part expires at the end of the period of 6 months commencing on the date on which this Part commences.

SUBORDINATE LEGISLATION ACT 1989

SECTION 10 STAGED REPEAL OF STATUTORY RULES

(2) Unless it sooner ceases to be in force, a statutory rule published on or after 1 September 1990 is repealed:

(1) on the fifth anniversary of the date on which it was published (in the case of a statutory rule published on 1 September in any year); or

(2) on 1 September following the fifth anniversary of the date on which it was published (in any other case).

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APPENDIX 13 MINUTES OF PROCEEDINGS

No 1

MINUTES OF COMMITTEE PROCEEDINGS

TUESDAY 8 JULY 1997

AT 9.30 AM, COMMITTEE ROOM 1043, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Meagher, MP	**The Hon. John Jobling, MLC**
Ms Moore, MP	**The Hon. Pat Staunton, MLC**
Mr Thompson, MP	**The Hon. Ann Symonds, MLC**

Opening of the Meeting

The Clerk-Assistant (Procedure), on behalf of the Clerk of the Legislative Assembly, opened the meeting and advised of the Committee membership and that apologies had been received from Mr Mills, MP and Mr Rixon, MP.

The Clerk-Assistant (Procedure) circulated the terms of reference of the Committee from the following extracts of the Legislative Assembly *Votes and Proceedings* and Legislative Council *Minutes of Proceedings*:

***Entry no. 37, *Votes and Proceedings* (no. 72), Thursday 19 June 1997:**

(1) That in the light of the Royal Commission into the New South Wales Police Service recommendation concerning safe and sanitary injecting rooms a joint select committee be appointed to:

  (1) advise the Parliament of the costs and benefits to the public of the establishment or trial of safe, sanitary injecting rooms under the licence or supervision of the Department of Health and of amendments of the Drug Misuse and Trafficking Act 1985 accordingly; and

  (2) make recommendations to the Parliament as to whether or not such establishment or trial should proceed.

(2) That the Legislative Assembly members comprise:

  (1) three Government members nominated in writing to the Clerk of the House by the Leader of the House;

(2) two Opposition members nominated in writing to the Clerk of the House by the Leader of the Opposition; and

(3) one Independent member nominated in writing to the Clerk of the House by the Independent members.

(3) That notwithstanding anything to the contrary in the standing orders of either House:

(1) the committee is to elect as chairman a government member;

(2) the chairman of the committee have a deliberative vote and, in the event of an equality of votes; a casting vote; and

(3) at any meeting of the committee four members will constitute a quorum, provided that the committee meet as a joint committee at all times.

(4) That the committee have leave to sit during any adjournment of either or both Houses; to adjourn from place to place; to make visits of inspection within the State of New South Wales and Australia; and have powers to take evidence and to send for persons, records and things; and to report from time to time.

(5) That the committee report by 30 November 1997.

(6) That should either or both Houses stand adjourned and the committee agree to any report before the Houses resume sitting:

(1) the committee have leave to send any such report, minutes and evidence taken before it to the Clerks of the respective Houses;

(2) the documents be printed and published and the Clerks forthwith take such action as is necessary to give effect to the order of the House; and

(3) the documents be laid on the table of the Houses at their next sittings.

(7) That a Message be sent requesting the Legislative Council to appoint 4 of its Members (being 2 Government and 2 Non-Government) to serve on the Committee and to nominate the time and place for the first meeting of the Committee.@

***Entry no. 47, *Votes and Proceedings* (no. 72), Thursday 26 June 1997, a.m.:**

AMr Speaker reported the following message from the Legislative Council:

Mr SPEAKER

The Legislative Council having had under consideration the Legislative Assembly=s Message, dated 19 June 1997 relating to the appointment of a Joint Select Committee upon Injecting rooms, informs the Legislative Assembly that it has this day agreed to the following Resolution:

(1) That this House agrees to the Legislative Assembly=s Message of 19 June 1997 for the appointment of a Joint Select Committee into Injecting Rooms.

(2) That the Legislative Council Members of the Committee comprise:

(1) 2 Government Members nominated in writing to the Clerk of the House by the Leader of the Government;

(2) 1 Opposition Member nominated in writing to the Clerk of the House by the Leader of the Opposition; and

(3) Mr Cohen.

(3) That the time and place of the first meeting of the Committee be 9.30am on Tuesday 8 July 1997 in Room 1043.

Legislative Council
24 June 1997

MAX WILLIS
President@

***Entry no. 22, *Minutes of Proceedings* (no. 85), Friday 27 June 1997:**

AThe President informed the House that the Clerk had received the following nominations for membership of the Joint Select Committee upon Injecting Rooms in accordance with the Resolution of the House of 24 June 1997:

Government Members - Ms Staunton and Mrs Symonds
Opposition Member - Mr Jobling@

***Entry no. 74, *Votes and Proceedings* (no. 72), Friday 27 June 1997, p.m.:**

AMr Speaker reported the following message from the Legislative Council:

Mr SPEAKER

The Legislative Council desires to inform the Legislative Assembly that it has this day agreed to the following Resolution:

That, with the approval of the President and the Speaker, the Joint Select Committee upon Injecting Rooms have leave to travel overseas to make visits of inspection.

The Legislative Council invites the Legislative Assembly to adopt a similar Resolution.

Legislative Council
27 June 1997

MAX WILLIS
President@

***Entry no. 87, *Votes and Proceedings* (no. 72), Friday 27 June, p.m.:**

(a) That the Joint Select Committee upon Injecting Rooms have leave to travel

overseas to make visits of inspection; and

(b) That a message be sent to the Legislative Council acquainting it of this resolution.@

Election of Chairman

The Clerk-Assistant (Procedure) called for nominations of the office of Chairman.

The Hon. Pat Staunton was nominated by Mr Thompson and seconded by the Hon. Ann Symonds.

There being no further nomination the Hon. Pat Staunton was declared elected.

The Hon. Pat Staunton took the Chair and made her acknowledgements to the Committee.

Procedural Motions

Resolved, on the motion of Mr Thompson, seconded by the Hon. Ian Cohen:

That the following motions be adopted *in globo* -

(1) That arrangements for the calling of witnesses and visits of inspection be left in the hands of the Chairman and the Clerk to the Committee, after consultation with members of the Committee.

(2) That, unless otherwise ordered, parties appearing before the Committee shall not be represented by any member of the legal profession.

(3) That, unless otherwise ordered, when the Committee is examining witnesses, the press and public (including witnesses after examination) be admitted to the sitting of the Committee.

(4) That persons having special knowledge of the matters under consideration by the Committee may be invited to assist the Committee.

(5) That press statements on behalf of the Committee be made only by the Chairman after approval in principle by the Committee or after consultation with Committee members.

(6) That, unless otherwise ordered, access to transcripts of evidence taken by the Committee be determined by the Chairman and not otherwise made available to any person, body or organisation: provided that witnesses previously examined shall be given a copy of their evidence and that any evidence taken *in camera* or treated as confidential shall be checked by the witness in the presence of the Clerk to the Committee or an officer of that Committee.

(7) That the Chairman and the Clerk to the Committee be empowered to negotiate with the Presiding Officers through the Clerk of the Legislative Assembly for the provision of

funds to meet expenses in connection with advertising, operating and approved incidental expenses of the Committee.

(8) That the Chairman be empowered to write to advertise and/or write to interested parties requesting written submissions.

(9) That upon the calling of a division or quorum in either House during a meeting of the Committee, the proceedings of the Committee shall be suspended until the Committee again has a quorum.

(10) That the Chairman and the Clerk make arrangements for visits of inspection by the Committee as a whole and that individual members wishing to depart from these arrangements be required to make their own arrangements.

Call for submissions

A draft advertisement calling for submissions was circulated for discussion.

The Committee discussed the working and placement of the advertisement.

Media Release

A draft media release under the name of the Chairman was circulated for comment and was noted by the Committee.

Reference Material

Preliminary reference material was circulated to Committee members.

Letter to Deputy Premier

The Chairman canvassed writing to the Deputy Premier and Minister for Health about the appointment of a liaison officer, a background paper and a briefing on the Drug Misuse and Trafficking Act.

The Committee discussed the proposed correspondence.

Inspections

The Committee discussed possible visits of inspections that should be undertaken.

The Committee adjourned at 10.37 am until 10.00 am on Friday 11 July 1997.

No 2

MINUTES OF COMMITTEE PROCEEDINGS

FRIDAY, 11 JULY 1997

AT 9.30 AM, COMMITTEE ROOM 1043, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Ms Meagher, MP	**The Hon. John Jobling, MLC**
Ms Moore, MP	**The Hon. Ann Symonds, MLC**
Mr Rixon, MP	
Mr Thompson, MP	

The Hon. Ian Cohen, MLC, participated by way of a telephone hook-up to the meeting room.

Apologies were received from Mr Kerr, MP and Mr Mills, MP.

Minutes

The minutes of the meeting held on Tuesday 8 July 1997, as amended, were confirmed.

Call for Submissions

The Chair informed the Committee that the advertisement calling for submissions would be published in The Sydney Morning Herald on 12 July 1997 and that the Speaker=s approval had been obtained for the advertisement to be placed in various other regional and specific newspapers.

Working Name for the Committee

The Chair informed the Committee that the Parliamentary Committees Enabling Amendment Act 1997 gave the Committee the legal name of AJoint Select Committee upon Injecting Rooms@.

The Committee deliberated.

Resolved, on the motion of Ms Moore, seconded by Mr Thompson:

That the Committee have the working name of AJoint Select Committee into Safe Injecting Rooms.@

Briefing by Pharmacologist

The Chair informed the Committee that arrangements were being made for a pharmacologist to brief the Committee.

The Committee discussed a suitable time and date.

Visits of Inspection

The Committee discussed arrangements and dates for various visits of inspection.

Senior Project Officer

The Chair informed the Committee of a proposed timetable for recruitment for the position of Senior Project Officer to the Committee and that an advertisement for the position would appear in The Sydney Morning Herald on 12 July 1997.

The Committee adjourned at 11.05 am until 11.00 am on Wednesday 23 July 1997.

No 3

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY, 23 JULY 1997

AT 11.00 AM, COMMITTEE ROOM 1043, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP

Ms Meagher, MP

Mr Mills, MP

Ms Moore, MP

Mr Rixon, MP

Mr Thompson, MP

The Hon. Ian Cohen, MLC

The Hon. John Jobling, MLC

The Hon. Ann Symonds, MLC

Minutes

The minutes of the meeting held on Friday 11 July 1997, as amended, were confirmed.

Visits of Inspection

The Chair deliberated on arrangements for the proposed study tour to Germany, Switzerland, The Netherlands and possibly Sweden.

Resolved, on the motion of Mr Rixon, seconded by Mr Thompson.

1. That the Committee approve of a delegation to undertake a study tour to Germany, Switzerland, The Netherlands and possibly Sweden;

2. That the delegation consist of the Chair, an Opposition Member and a Cross-bench Member; and

3. That any other Committee Member prepared to meet any up front airfare costs be invited to join the delegation and be assisted with accommodation and on ground costs and any funds remaining from the total budget be used to offset their airfares.

Resolved, on the motion of Mr Mills, seconded by the Hon. Ian Cohen:
That the Chair be authorised to prepare a submission on the proposed study tour for

presentation to the Speaker and Clerk of the Legislative Assembly.

The Committee then discussed arrangements for the visit of inspection to Kings Cross later this day.

The Committee then discussed arrangements for the visit of inspection to Nimbin and Byron Bay on Wednesday and Thursday, 30 and 31 July 1997.

The Committee then discussed arrangements for the visit of inspection to Cabramatta on Wednesday 6 August 1997.

Media

The Committee noted correspondence from Ms Sue Daniel, of ABC Radio National, requesting permission to accompany the Committee on visits to either Kings Cross or Nimbin.

The Committee discussed in general terms the issue of the presence of the media.

Submissions

Arrangements were discussed for the most convenient way of distributing submissions to Members.

Briefings

Mr Ross O=Donoughue, Director - AIDS and Infectious Diseases Branch, of the Department of Health, was admitted and briefed the Committee on matters such as the needle exchange program and other services provided by the Department for injecting drug users, relevant provisions of the Drug Misuse and Trafficking Act and other statistical background information.

Briefing concluded and Mr O=Donoughue withdrew.

Associate Professor Macdonald Christie, Department of Pharmacology at the University of Sydney, was admitted and briefed the Committee on the pharmacology of heroin, cocaine, amphetamines, prescription drugs and use of Narcan to counter the effects of a heroin overdose.

Briefing concluded and Associate Professor Christie withdrew.

The Committee adjourned at 1.45pm until 2.00pm this day.

No 4

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY 23 JULY 1997

AT 2.00 PM, KIRKETON ROAD CENTRE, KINGS CROSS

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP

Ms Meagher, MP

Mr Mills, MP

Ms Moore, MP

Mr Rixon, MP

Mr Thompson, MP

The Hon. Ian Cohen, MLC

The Hon. John Jobling, MLC

The Hon. Anne Symonds, MLC

Briefing

Dr Ingrid van Beek, Director of the Kirketon Road Centre, briefed the Committee on the operation of the Centre, on harm reduction, counselling and other services in relation to injecting drug users.

Inspections

Dr van Beek then took Committee Members to inspect the facilities at the Centre, a nearby car park and of an illegal injecting room.

Inspections concluded the Committee adjourned at 4.30pm until 1.00pm on Wednesday 30 July 1997.

No 5

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY 30 JULY 1997

AT 10.15 AM, TOWN HALL, NIMBIN

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Mr Mills, MP	**The Hon. Ann Symonds, MLC**
Mr Rixon, MP	

Apologies were received from Ms Meagher, MP, Ms Moore, MP and Mr Thompson, MP.

Hearings

The press and public were admitted.

By direction of the Chair, the Clerk read the Committee terms of reference and Legislative Assembly Standing Orders 332 and 333 relating to the examination of witnesses and the recording of evidence.

Mr Stephen Lawrence Bolt, Solicitor of the Northern Rivers Community Legal Centre, Lismore, affirmed and examined.

Evidence concluded, the witness withdrew.

Mr Nigel Kelly Nelson Pierce, Secretary, Management Committee of the Nimbin Neighbourhood and Information Centre, affirmed and examined.

Evidence concluded, the witness withdrew.

Mr Rory O=Halloran, Chairperson of the Byron Bay Community Safety Committee, affirmed and examined.

Evidence concluded, the witness withdrew.

Dr Winifred Joyce Mitchell, Secretary of the Nimbin Older Women=s Forum and Nimbin Health and Welfare Association, affirmed and examined.

Evidence concluded, the witness withdrew.

Dr David Andrew Helliwell, General Practitioner and Methadone Prescriber at Nimbin, sworn and examined.

Evidence concluded, the witness withdrew.

Councillor Diana Jane Roberts, Herbalist, affirmed and examined.

Evidence concluded, the witness withdrew.

Mr Kevin William Soward, President of the Nimbin Ratepayers and Progress Association Inc, sworn and examined.

Evidence concluded, the witness withdrew.

Mr Douglas Whitlen, Treasurer of Nimbin Chamber of Commerce, affirmed and examined.

Evidence concluded, the witness withdrew.

Mrs Nancy Georgina Nugent, Enrolled Nurse, sworn and examined.

Evidence concluded, the witness withdrew.

Mr Gregory Wayne Soward, President of the Nimbin Agricultural Industrial Society, sworn and examined.

Evidence concluded, the witness withdrew.

Mr Karen Ann Henry, Needle Syringe Exchange Worker, affirmed and examined.

Evidence concluded, the witness withdrew.

Ms Jo-ann Lyn West, TAFE Student, affirmed and examined.

Evidence concluded, the witness withdrew.

The press and public withdrew to enable the Committee to take further evidence from four witnesses in camera.

The Committee adjourned at 5.20pm until Thursday 31 July 1997 at 9.30am.

No 6

MINUTES OF COMMITTEE PROCEEDINGS

THURSDAY 31 JULY 1997

AT 9.00 AM, BYRON BAY HOSPITAL, BYRON BAY

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Mr Mills, MP	**The Hon. John Jobling, MLC**
Mr Thompson, MP	**The Hon. Ann Symonds, MLC**

Apologies were received from Ms Meagher, MP, Ms Moore, MP and Mr Rixon, MP.

Briefing and Discussions

Briefings and discussions were held with members of the Byron Bay Safety Committee.

Briefing and discussions concluded the Committee adjourned at 11.15am until 1.00pm on Wednesday 6 August 1997.

No 7

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY 6 AUGUST 1997

AT 1.00 PM AT THE CABRAMATTA COMMUNITY CENTRE

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Meagher, MP	**The Hon. John Jobling, MLC**
Ms Moore, MP	**The Hon. Ann Symonds, MLC**
Mr Thompson, MP	

Apologies were received from Mr Mills, MP and Mr Rixon, MP.

Briefing and Discussions

Briefings and discussions were held with injecting drug users and service providers.

Inspections

Ms Sue Heard, Acting Co-ordinator, Drug Intervention Service, Cabramatta, took Committee Members to inspect sites in the Cabramatta area.

Inspections concluded the Committee adjourned at 4pm until 10.00am 12 August, 1997.

No 8

MINUTES OF COMMITTEE PROCEEDINGS

TUESDAY 12 AUGUST 1997

AT 10.30 AM AT THE NEWCASTLE EAST COMMUNITY HEALTH CENTRE

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP

Mr Mills, MP

Mr Thompson, MP

The Hon. Ann Symonds, MLC

Apologies were received from the Hon John Jobling MLC, the Hon Ian Cohen MLC, Ms R Meagher MP, Ms C Moore, MP and Mr B Rixon, MP.

Briefing and Discussions

Briefings and discussions were held with service providers and injecting drug users.

Discussions concluded the Committee adjourned at 1.30pm until 11.30am 13th August 1997.

No 9

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY 13 AUGUST 1997

AT 11.30 AM AT THE NEW SOUTH WALES USERS AND AIDS ASSOCIATION, BONDI JUNCTION

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Mr Mills, MP	**The Hon. John Jobling, MLC**
Ms Moore, MP	**The Hon. Ann Symonds, MLC**

Apologies were received from Ms R Meagher MP, Mr B Rixon, MP and Mr G Thompson, MP.

Briefing and Discussions

Briefings and discussions were held with representatives of the New South Wales Users and AIDS Association.

Discussions concluded the Committee proceeded to take evidence.

Hearings

By direction of the Chair, the Clerk read the Committee terms of reference and Legislative Assembly Standing Orders 332 and 333 relating to the examination of witnesses and the recording of evidence in camera.

Mr Khaled Sabsabi, Artist and Community Worker, sworn and examined.

Mr Mark Phillips, Vice President, New South Wales Users and AIDS Association Management Committee, sworn and examined.

Ms Maria Patricia Samios, sworn and examined.

Mr John Justin Carey, Artist, affirmed and examined.

Ms Felicity Anne Norman-Elliott, affirmed and examined.

Ms Jo Anne Lancaster, affirmed and examined.

Mr William Lachlan Robertson, Manager, Foley House, affirmed and examined.

Evidence concluded, the witnesses withdrew.

By direction of the Chair, the Clerk read the Committee terms of reference and Legislative Assembly Standing Orders 332 and 333 relating to the examination of witnesses and the recording of evidence in camera.

Mr Miles Rooke, Health Educator, sworn and examined.

Mr Stanley Chatfield, sworn and examined.

Ms Carol Ann Charles, sworn and examined.

Mr Sam Hook, sworn and examined.

Ms Leslie Townsley, Health Educator, sworn and examined.

Mr Andrew Joseph Pearce, sworn and examined.

Mr Ronald James Beckett, sworn and examined.

Mr Lesley Davidson, sworn and examined.

Mr Kenneth John Irvine, sworn and examined.

Mr Tony James McNaughton, Health Worker, affirmed and examined.

Evidence concluded the witnesses withdrew.

The Committee adjourned at 3.40pm until 9.30am Friday 15th August, 1997.

No 10

MINUTES OF COMMITTEE PROCEEDINGS

FRIDAY 15TH AUGUST, 1997

AT 9.30 AM AT LEVEL 3, 111 ELIZABETH ST, SYDNEY

MEMBERS PRESENT

The Hon. Pat Staunton, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Moore, MP	**The Hon. John Jobling, MLC**
Mr Thompson, MP	**The Hon. Ann Symonds, MLC**

Apologies were received from Mr J Mills MP, and Mr B Rixon, MP.

Briefing and Discussions

Briefings and discussions were held with The Hon Justice JRT Wood, Commissioner, Royal Commission into the New South Wales Police Service.

Discussions concluded the Committee adjourned at 10.40am until 10.00am on 20 August, 1997.

No 11

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY 20 AUGUST, 1997

AT 10.00 AM IN ROOM 1043, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Patricia Staunton, MLC (Chair)

Mr Kerr, MP **The Hon. Ann Symonds, MLC**

Mr Mills, MP

Mr Thompson, MP

The Hon. Ian Cohen MLC participated by way of a telephone hook-up to the meeting room.

Apologies were received from the Hon John Jobling MLC, Ms R Meagher MP, Ms C Moore MP, Mr B Rixon MP.

Minutes

Resolved on the motion of Ms Symonds and seconded by Mr Mills that the minutes of the meetings held 23 July (No. 3) and 23 July (No. 4), 30 July (No. 5), 31 July (No. 6), 6 August (No. 7), 12 August (No. 8), 13 August (No. 9) and 15 August (No. 10) be taken as read and confirmed.

Submissions

The Committee discussed the submissions received, possible dates for public hearings and proposed witnesses.

Briefings

Mr Richard Button, Director, Criminal Law Review Division and Mr Phil Berry, Policy Officer, Criminal Law Review Division, were admitted and briefed the Committee on the relevant provisions of the Drug Misuse and Trafficking Act 1985.

Briefing concluded Mr Button and Mr Berry withdrew.

The Committee adjourned at 11.20am, sine die.

No 12

MINUTES OF COMMITTEE PROCEEDINGS

THURSDAY 11TH SEPTEMBER, 1997

AT 10.00 AM AT THE HIV PREVENTION SERVICE, ILLAWARRA AREA HEALTH SERVICE

MEMBERS PRESENT

Mr Mills, MP	**The Hon. Ian Cohen, MLC**
Mr Thompson, MP	**The Hon. Ann Symonds, MLC**

Apologies were received from Mr Kerr MP, Ms Meagher MP, Ms C Moore MP, Mr Rixon MP, and the Hon John Jobling MLC.

Briefing and Discussions

Briefings and discussions were held with service providers and injecting drug users.

Discussions concluded the Committee adjourned at 1.30pm, sine die.

No 13

MINUTES OF COMMITTEE PROCEEDINGS

TUESDAY 23RD SEPTEMBER, 1997

AT 1.10 PM IN ROOM 1043, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Mr Mills, MP	**The Hon. Dorothy Isaksen, MLC**
Ms Meagher, MP	**The Hon. John Jobling, MLC**
Ms Moore, MP	**The Hon. Ann Symonds, MLC**
Mr Thompson, MP	

Apologies were received from Mr B Rixon MP.

Election of Chair

The Clerk-Assistant (Procedure) called for nominations for the office of Chair left vacant by the resignation of the Hon. Patricia Staunton.

The Hon. Ann Symonds was nominated by the Hon. Ian Cohen and seconded by Ms Moore.

There being no further nominations the Hon. Ann Symonds was declared elected.

Minutes

Resolved on the motion of Mr Kerr and seconded by the Hon. Ann Symonds that the minutes of the meeting held 20 August, 1997 be taken as read and confirmed.

Acceptance of late submissions

Resolved on the motion of Ms Moore and seconded by the Hon. John Jobling that the Committee accept the late submissions received by the Committee.

Public hearings

The Committee discussed the public hearings to be held on 30th September, 1997 and 1st October, 1997 including witnesses, questions and media coverage.

Visits of Inspection

The Committee discussed arrangements for visits of inspection to Redfern.

The Committee adjourned at 1.30pm until 9.30am 30th September, 1997.

No 14

MINUTES OF COMMITTEE PROCEEDINGS

TUESDAY 30 SEPTEMBER 1997

AT 9.30 AM IN THE JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Meagher, MP	**The Hon. Dorothy Isaksen, MLC**
Mr Rixon, MP	**The Hon. John Jobling, MLC**
Mr Thompson, MP	

Apologies were received from Mr Mills MP

Hearings

The press and public were admitted.

The Chair read the Committee terms of reference and Legislative Assembly Standing Orders 332 and 333 relating to the examination of witnesses and the recording of evidence.

Mr James William Porter, Paramedic Station Officer, Ambulance Service of New South Wales, affirmed and examined:

Evidence concluded, the witness withdrew.

Dr Shane Darke, Senior Lecturer, National Drug and Alcohol Research Centre, University of New South Wales, affirmed and examined:

Evidence concluded, the witness withdrew.

Mrs Margaret Joan Orr, sworn and examined:

Evidence concluded, the witness withdrew.

Major William Roy Redwood, General Secretary, Salvation Army Rehabilitation Services Command,

Major Kevin John Goldsack, Manager, William Booth Institute, and

Major Raymond Maurice Tunstall, Salvation Army Community Relations Secretary,sworn and examined:

Evidence concluded, the witnesses withdrew.

Mr Anthony Trimingham, Trustee, Damien Trimingham Foundation.

Mrs Denise Owen, Member, Families and Friends for Drug Law Reform.

The press and public withdrew to enable the Committee to take further evidence in camera from four witnesses.

Evidence concluded, the witnesses withdrew.

Ms Anne Gabrielle Madden, Co-ordinator, New South Wales Users and AIDS Association, affirmed and examined:

Mr Miles Gavin Rooke, Community Advocacy Co-ordinator, New South Wales Users and AIDS Association, sworn and examined:

Evidence concluded, the witnesses withdrew.

The press and public withdrew to enable the Committee to take further evidence in camera from three witnesses.

Evidence concluded the witnesses withdrew.

The Committee adjourned at 4.25 p.m. until 9.30am 1st October, 1997.

No 15

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY 1 OCTOBER 1997

AT 9.30 AM IN THE JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Meagher, MP	**The Hon. Dorothy Isaksen, MLC**
Mr Mills, MP	**The Hon. John Jobling, MLC**
Ms Moore, MP	
Mr Thompson, MP	

Apologies were received from Mr Rixon MP

Hearings

The press and public were admitted.

Mr George Robert Selvanera, Member of the Prisons and Blood-Borne Communicable Diseases Working Group, and

Ms Jan Cregan, Member of the Hepatitis C Council of New South Wales, both affirmed and examined:

Evidence concluded, the witnesses withdrew.

Mr Victor John Smith, Mayor, South Sydney City Council,

Mr James Robert Harrison, Director Planning and Building, South Sydney City Council, and

Mr Garry John Keep, Health Services Manager, South Sydney City Council, sworn and examined:

Ms Christine Lillian Harcourt, Deputy Mayor, South Sydney City Council, affirmed and examined:

Evidence concluded, the witnesses withdrew.
Mr Philip Michael O'Grady, President, Fairfield City Chamber of Commerce, sworn

and examined:

Evidence concluded, the witness withdrew.

Mr Anthony Owen Kohlenberg, Senior Environmental Health Officer, Lismore City Council, sworn and examined:

Evidence concluded, the witness withdrew.

Mr Chris Gration, President, AIDS Council of New South Wales, and

Ms Robyn Maurice, Gay and Lesbian Injecting Drug Use Project Co-ordinator, AIDS Council of New South Wales, affirmed and examined:

Evidence concluded, the witnesses withdrew.

Dr Donald James Weatherburn, Director, New South Wales Bureau of Crime Statistics and Research, affirmed and examined:

Evidence concluded, the witness withdrew.

The Committee adjourned at 4.20 p.m. until 7th October, 1997.

No 16

MINUTES OF COMMITTEE PROCEEDINGS

TUESDAY 7 OCTOBER, 1997

AT 9.30 AM, JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Mr Mills, MP	**The Hon. Dorothy Isaksen, MLC**
Ms Moore, MP	**The Hon. John Jobling, MLC**
Mr Thompson, MP	

Apologies were received from Ms Meagher MP and Mr Rixon MP.

Hearings

The press and public were admitted.

Dr Gordian Ward Oscar Fulde, Director, Emergency Department, St Vincent's Hospital, sworn and examined:

Evidence concluded, the witness withdrew.

Associate Professor Richard Philip Mattick, Director of Research, National Drug and Alcohol Research Centre, University of New South Wales, sworn and examined, and

Dr Ingrid Alida van Beek, Director, Kirketon Road Centre, affirmed and examined:

Evidence concluded, the witnesses withdrew.

Professor John Martin Kaldor, Professor of Epidemiology, and

Ms Margaret Anne Macdonald, Senior Research Assistant, National HIV Centre, sworn and examined:

Evidence concluded, the witnesses withdrew.

Mr Donald Hollis Griffin, Health Education Officer at St George Hospital and Canterbury Hospital, sworn,
Ms Jan Cregan, Social Researcher, Hepatitis C Council of New South Wales, sworn,

and

Mr Stuart Kinnoch Loveday, Executive Officer, Hepatitis C Council New South Wales, affirmed and examined:

Evidence concluded, the witnesses withdrew.

Mr William Richard Hoyles, Director of Youth Services and Aftercare, Barnardos Australia, sworn and

Ms Erica Lavinia Chaperlin, Co-ordinator, Youth Services, Penrith Barnardos Centre, affirmed and examined:

Evidence concluded, the witnesses withdrew.

Mrs Margaret June McKay, school teacher, sworn and examined:

Evidence concluded, the witness withdrew.

The Committee adjourned at 4.15 p.m until 9.30 8th October, 1997.

No 17

MINUTES OF COMMITTEE PROCEEDINGS

WEDNESDAY 8 OCTOBER, 1997

AT 9.30 AM, JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Meagher, MP	**The Hon. Dorothy Isaksen, MLC**
Mr Mills, MP	**The Hon. John Jobling, MLC**
Ms Moore, MP	
Mr Thompson, MP	

Apologies were received from Mr Rixon MP.

Hearings

The press and public were admitted.

Professor Ian William Webster, Professor of Public Health at the University of New South Wales, and

Dr Lisa Maher, Research Fellow in the School of Community Medicine, University of New South Wales, sworn and examined:

Evidence concluded, the witnesses withdrew.

Dr Roger Jonathon Garsia, Medical Practitioner, Department of Clinical Immunology, Royal Prince Alfred Hospital, sworn and examined:

Evidence concluded, the witness withdrew.

Mr Bruce Raymond Kemp, Chair, Crosswise Residents Action Committee, sworn and examined:

Evidence concluded, the witness withdrew.

Mrs Sonia Joyce Fenton, Councillor with South Sydney Council, sworn and examined:

Evidence concluded, the witness withdrew.

Mr Richard Leland Bennett, Company director, sworn and examined:

Evidence concluded, the witness withdrew.

The press and public withdrew to enable the committee to take further evidence in camera from one witness.

Evidence concluded the witness withdrew.

The Committee adjourned at 2.30 p.m. until 9.30am Thursday 9th October, 1997.

No 18

MINUTES OF COMMITTEE PROCEEDINGS

THURSDAY 9 OCTOBER 1997

AT 9.30 AM, JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Meagher, MP	**The Hon. Dorothy Isaksen, MLC**
Ms Moore, MP	**The Hon. John Jobling, MLC**

Apologies were received from Mr Mills MP, Mr Rixon MP and Mr Thompson MP

Hearings

The press and public were admitted.

Dr Alexander David Wodak, medical practitioner, affirmed and examined:

Evidence concluded, the witness withdrew.

Mr Phuong Ngo, Councillor, Fairfield City Council,

Mr Brian John Long, Manager, Fairfield City Council, sworn and examined:

Evidence concluded, the witnesses withdrew.

Mr James Macdonald Dunbar, registered nurse,

Ms Berenice Naidi Ilona Carrington, corporate development officer, South Sydney City Council, and

Ms Fiona Diane Haines, computer technician student, affirmed and examined:

Evidence concluded, the witnesses withdrew.

Superintendent David Perrin, Superintendent of Police, Acting Commander, Local Area Command, Redfern Police Station, and

Detective Sergeant John Maricic, Detective Sergeant of Police, Kings Cross, NSW Police Service, sworn and examined:

Evidence concluded, the witnesses withdrew.

Mr Stephen Laurence Bolt, Solicitor, Northern Rivers Community Legal Centre, affirmed and examined:

Evidence concluded, the witness withdrew.

The Committee adjourned at 4.25 p.m. until Friday 24th October, 1997.

No 19

MINUTES OF COMMITTEE PROCEEDINGS

TUESDAY 24 OCTOBER, 1997

AT 9.30 AM, JUBILEE ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP	**The Hon. Ian Cohen, MLC**
Ms Meagher, MP	**The Hon. Dorothy Isaksen, MLC**
Mr Mills, MP	**The Hon. John Jobling, MLC**
Mr Rixon, MP	
Mr Thompson, MP	

Apologies were received from Ms Moore MP.

Hearings

The press and public were admitted.

Professor Wayne Dennis Hall, Professor and Executive Director of the National Drug & Alcohol Research Centre, affirmed and examined.

Evidence concluded, the witness withdrew.

The press and public withdrew to enable the Committee to take evidence in camera from two witnesses.

Mr Robert Stephen Toner, Barrister at Law, Secretary New South Wales Bar Association, affirmed and examined.

Evidence concluded, the witness withdrew.

Mr Roger David Prowse**,** Solicitor and Barrister, Councillor and Chair of Criminal Law Committee, Law Society of New South Wales, affirmed and examined.

Evidence concluded, the witness withdrew.
Mr Peter Zahra**,** Public Defender, affirmed and examined.

Evidence concluded, the witness withdrew.

Mr Richard James Button**,** Barrister and Director of Criminal Law Review Division, Attorney General's Department of New South Wales, affirmed and examined, and

Mr Philip Peter Berry, Solicitor and Policy Officer, Criminal Law Review Division, Attorney General's Department of New South Wales, sworn and examined.

Evidence concluded, the witnesses withdrew.

Professor Terry Ross Carney, Professor of Law, University of Sydney, Sydney, and

Dr Desmond Robert Alexander Manderson, Senior Lecturer, School of Law, Macquarie University, affirmed and examined.

Evidence concluded, the witnesses withdrew.

Dr Andrew Graham Penman, Director, Centre for Disease Prevention & Health, sworn and examined:

Ms Leanne O'Shannessy, Deputy Director, Legal Branch, New South Wales Department of Health, affirmed and examined.

Evidence concluded, the witness withdrew.

The Committee adjourned at 4.55 pm, sine die.

No 20

MINUTES OF COMMITTEE PROCEEDINGS

MONDAY 10 NOVEMBER, 1997

AT 10.05 AM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP

Ms Meagher, MP

Mr Mills, MP

Ms Moore, MP

Mr Rixon, MP

Mr Thompson, MP

The Hon. Ian Cohen, MLC

The Hon. Dorothy Isaksen, MLC

The Hon. John Jobling, MLC

The Committee considered minutes previously circulated.

Resolved, on the motion of Mr Mills and seconded by Mr Thompson that the minutes of the meeting held on the 11th September, 1997 (No. 12) be taken as read and confirmed.

Resolved, on the motion of Mr Thompson and seconded by Hon Dorothy Isaksen that the minutes of the meeting held on the 23rd September, 1997 (No. 13) be taken as read and confirmed.

Resolved, on the motion of Hon Dorothy Isaksen and seconded by Mr Mills that the minutes of the meeting held on 30th September 1997 (No. 14), be taken as read and confirmed.

Resolved, on the motion of Hon John Jobling and seconded by Mr Thompson that the minutes of the meeting held on 1st September, 1997 (No. 15) be taken as read and confirmed.

Resolved, on the motion of Mr Mills and seconded by Hon Dorothy Isaksen that the minutes of the meeting held on 7th September, 1997 (No. 16) be taken as read and confirmed.

Resolved, on the motion of Mr Mills and seconded by Mr Thompson that the minutes of the meeting held on 8th September, 1997 (No. 17) be taken as read and confirmed.

Resolved, on the motion of Hon John Jobling and seconded by Mr Mills that the minutes of the meeting held on 9th September, 1997 (No. 18) be taken as read and confirmed.

Resolved, on the motion of Mr Mills and seconded by Mr Thompson that the minutes of the meeting held on 24th September, 1997 (No. 19) be taken as read and confirmed.

The Chair sought comment on the draft report previously circulated.

The Committee considered the draft report and deliberated on amendments to be addressed before being re-circulated to the Members.

The Committee adjourned at 3.10pm until 10.00am on Monday 17th November, 1997.

No 21

MINUTES OF COMMITTEE PROCEEDINGS

MONDAY 17 NOVEMBER, 1997

AT 10.00 AM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP

Mr Mills, MP

Ms Moore, MP

Mr Rixon, MP

Mr Thompson, MP

The Hon. Ian Cohen, MLC

The Hon. Dorothy Isaksen, MLC

The Hon. John Jobling, MLC

Apologies were received from Ms Meagher.

Minutes

Resolved, on the motion of the Hon John Jobling and seconded by Mr Thompson that the minutes of the meeting held on the 10th November, 1997 (No. 20) be taken as read and confirmed.

The Chair sought comment on the draft report previously circulated.

The Committee considered the draft report and deliberated on further amendments and issues to be addressed before being circulated again to the Members.

Resolved on the motion of Mr Mills and seconded by Mr Cohen that the first sentence of the third paragraph of Chapter Seven, page 7, read ACommittee members met Reverend Hans Visser, whose church (Pauluskerk) has catered for drug users and other marginalised groups@.

The Hon John Jobling, Mr Kerr, and Mr Rixon voted against the motion.

The Committee adjourned at 4.00pm until 1.00pm on Thursday 20th November, 1997.

No 22

MINUTES OF COMMITTEE PROCEEDINGS

THURSDAY 20TH NOVEMBER, 1997

AT 1.00 PM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP

Ms Meagher, MP

Mr Mills, MP

Ms Moore, MP

Mr Rixon, MP

Mr Thompson, MP

The Hon. Ian Cohen, MLC

The Hon. Dorothy Isaksen, MLC

The Hon. John Jobling, MLC

The Chair opened the meeting and sought comment on Chapter Four of the draft report which had been previously circulated.

The Committee deliberated on amendments to be addressed before being circulated again to the Members. As further consideration of this chapter was necessary the Committee agreed to reconvene at 9pm, 20th November, 1997.

The Committee adjourned at 2.05pm until 9.00pm, that day.

No 23

MINUTES OF COMMITTEE PROCEEDINGS

THURSDAY 20TH NOVEMBER, 1997

AT 9.00 PM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Ms Meagher, MP

Ms Moore, MP

Mr Rixon, MP

Apologies were received from the Hon Ian Cohen MLC, Hon Dorothy Isaksen MLC, Hon John Jobling MLC, Mr Kerr MP, Mr Mills MP, and Mr Thompson MP.

The Chair sought comment on Chapter Four: Costs of the draft report which had been previously circulated and which had been partially considered at a meeting earlier that day.

The Committee considered Chapter Four and amendments needed to be addressed before being circulated again to the Members.

A revised Chapter Four would be circulated to the Committee prior to the meeting to be held on Monday 24th November, 1997.

The Committee adjourned at 10.45pm until 2.30pm Monday 24th November, 1997.

No 24

MINUTES OF COMMITTEE PROCEEDINGS

MONDAY 24 NOVEMBER, 1997

AT 2.30 PM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Ms Meagher, MP	**The Hon. Ian Cohen, MLC**
Mr Mills, MP	**The Hon. Dorothy Isaksen, MLC**
Ms Moore, MP	**The Hon. John Jobling, MLC**
Mr Rixon, MP	

Apologies were received from Mr M. J. Kerr MP, and Mr G. E. Thompson MP

The Chair opened the meeting and sought the agreement of the Committee to ask for an extension of the tabling date for the report. The Chair expressed the view that additional evidence and statistical data needed to be added to the report.

Resolved On the motion of Ms Meagher and seconded by the Hon John Jobling that the Committee=s reporting date be extended to 23 December, 1997 and that the Chair write to the Leader of the House asking that an appropriate motion be prepared.

The Chair advised that Ms Marie Swain, a researcher from the Parliamentary Library who prepared the chapter on legal aspects of the reference, had been seconded to provide additional material and re-drafting of the report.

Consideration of the new draft would be held at a meeting on the 8th or 9th of December (depending on the sitting dates of the Legislative Assembly) and be finalised on the 12th or 15th of December.

The Chair asked members of the Committee to note any extra information they thought should be included in the draft report.

The Chair advised that draft recommendations would be circulated to members once the draft report had been considered.
The Chair advised that on the date of tabling all members would receive a copy of the report, an executive summary and a copy of the press release.

The Committee considered the draft chapters and deliberated on changes.

The Committee adjourned at 3.50pm until the 8th December.

No 25

MINUTES OF COMMITTEE PROCEEDINGS

MONDAY 8 DECEMBER, 1997

AT 10.30 AM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Ms Meagher, MP

Mr Mills, MP

Ms Moore, MP

Mr Thompson, MP

The Hon. Dorothy Isaksen, MLC

The Hon. John Jobling, MLC

Apologies were received from the Hon Ian Cohen MLC, Mr M. J. Kerr MP, and Mr B. W. Rixon MP.

The Chair opened the meeting and sought the agreement of the Committee to ask for a further extension of the tabling date for the report.

Resolved on the motion of Ms Moore and seconded by the Hon John Jobling that the Committee's reporting date be extended to 27 February, 1998.

The Chair proposed that a revised copy of the full report be sent to Members by the end of January 1998.

The Committee would meet on Monday 9th February, 1998 at 10.00am to consider the report, and re-convene on Monday 16th February, 1998 at 10.00am to give final consideration to the report.

The Committee adjourned at 10.38am until the 9th February, 1998.

No 26

MINUTES OF COMMITTEE PROCEEDINGS

MONDAY 9 FEBRUARY, 1998

AT 10 AM, IN THE WARATAH ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon. Ann Symonds, MLC (Chair)

Mr Kerr, MP

Ms Meagher, MP

Ms Moore, MP

Mr Rixon, MP

Mr Thompson, MP

The Hon. Ian Cohen, MLC

The Hon. Dorothy Isaksen, MLC

The Hon. John Jobling, MLC

Apologies were received from Mr Mills MP.

Minutes

The Chair opened the meeting and circulated minutes. Consideration of the minutes deferred.

The Chair advised that the Select Committee into Misuse of Drugs Act 1981, Western Australia would be in Sydney on the 18th February 1998 at 2.30pm and that all members were invited to meet the Committee.

The Committee deliberated upon the revised draft report previously circulated. The Chair advised that in accordance with her earlier letter members were to circulate their dissenting views by Friday 13 February.

The Committee considered the Executive Summary. Mr Kerr advised that he might be circulating a minority view regarding Australia's international treaty obligations.

The Committee considered Chapter 1.

Resolved on the motion of Ms Moore and seconded by Mr Cohen, that Chapter 1 stand as a chapter of the Report.

The Committee considered Chapter 2.
Resolved on the motion of Ms Moore and seconded by Mr Cohen that, Chapter 2, as

amended, stand as a chapter of the report with the understanding that Mr Jobling would provide a dissenting opinion.

The Chair informed the Committee that dissenting remarks of up to 7 to 10 lines would be included at the end of a chapter. Larger texts of dissent would be included as an appendix to the report following Chapter 7 (Recommendations).

The Committee considered Chapter 3.

Resolved on the motion of Mr Cohen and seconded by Ms Moore, that Chapter 3, as amended, stand as a chapter of the report with the understanding that Mr Jobling would provide a dissenting opinion.

Discussion ensued.

The Committee considered Chapter 4.

Resolved on the motion of Ms Meagher and seconded by Mr Thompson, that Chapter 4, as amended, stand as a chapter of the Report.

The Committee considered Chapter 5.

Consideration of section 5.4.1 (regarding international treaties) and section 5.6 (Summary) were deferred.

The Chair advised that she would be bringing a redrafted recommendation in relation to this chapter to the Committee at the next meeting on 16 February, 1998.

Resolved on the motion of Mr Thompson and seconded by Ms Isaksen, that the balance of Chapter 5, as amended, stand as a Chapter of the report.

The Committee considered Chapter 6.

The Chair advised that she had requested additional material to be included in this Chapter. The new Chapter 6 would be circulated on Wednesday 11 February 1998. This material would be considered at the meeting to be held on Monday 16th February, 1998.

The Committee considered Chapter 7.

The Chair circulated copies of the draft recommendations.

(Luncheon adjournment)

The Committee considered the minutes of the meeting previously circulated.

Resolved on the motion of Mr Thompson and seconded by Mr Jobling, that the minutes of the meeting No. 21 held 17 November, 1997 be taken as read and confirmed.
Resolved on the motion of Mr Thompson and seconded by Mr Rixon, that the minutes of the meeting No. 22 held at 1.00pm on Thursday 20th November, 1997 be taken as read and confirmed.

Resolved on the motion of Mr Rixon and seconded by Ms Meagher, that the minutes of the meeting no. 23 held at 9.00pm on Thursday 20th November, 1997 be taken as read and confirmed.

Resolved on the motion of Mr Rixon and seconded by Ms Isaksen, that the minutes of the meeting no. 24 held 24 November, 1997 be taken as read and confirmed.

Resolved on the motion of Mr Jobling and seconded by Mr Thompson, that the minutes of the meeting No. 25 held 8 December, 1997 be taken as read and confirmed.

The Committee resumed deliberation on Chapter 7.

The Committee agreed that p167 stand part of the report and that pages 168 and 169 be deleted.

The Chair referred to the draft recommendations for consideration and the Committee agreed not to formally vote on the recommendations until the next meeting.

The Committee adjourned until Monday 16 February 1998 at 10.00am.

No 27

MINUTES OF COMMITTEE PROCEEDINGS

MONDAY 16 FEBRUARY, 1998

AT 10 AM. IN THE WARATAH ROOM, PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

The Hon Ann Symonds, MLC (Chair)

Mr Kerr, MP

Ms Meagher, MP

Mr Mills, MP

Ms Moore, MP

Mr Rixon, MP

Mr Thompson, MP

The Hon. Ian Cohen, MLC

The Hon. Dorothy Isaksen, MLC

The Hon. John Jobling, MLC

The Chair opened the meeting.

The Committee considered draft Chapter 6, previously circulated.

Resolved on the motion of Mr Cohen and seconded by Mr Mills, that Chapter 6, as amended, stand as a chapter of the report.

The Committee considered the Executive Summary, previously circulated.

Resolved on the motion of Mr Mills and seconded by Mr Thompson, that the Executive Summary stand as a chapter of the report.

The Committee concurred with the amendments to the Report drafted as a result of previous deliberations.

The Project Officer provided further information on trends in heroin use in Australia and overseas.

Resolved on the motion of Mr Rixon and seconded by Mr Thompson, that the minutes of the meeting No. 26 held 9th February, 1998, as amended, be taken as read and confirmed.

The Committee deliberated on the draft recommendations and dissenting views

previously circulated.

Mr Kerr and Mr Rixon indicated that they supported Mr Jobling's dissenting view and requested that their names be appended to the dissenting views to Chapter 2 and Chapter 3.

The Committee considered the draft recommendation circulated by Ms Meagher.

It was moved by Ms Meagher, seconded by Mr Thompson that the recommendation be the recommendation of the Committee.

The Committee divided:

Ayes: Ms Meagher, Mr Thompson, Ms Isaksen, Mr Jobling, Mr Kerr, Mr Rixon.

Noes: Mr Cohen, Mr Mills, Ms Moore, Ms Symonds

and so it was carried.

The Committee agreed to insert, at the end of the recommendation, a paragraph stating:

"This recommendation of the Committee reflects the majority opinion as moved by Ms Meagher, seconded by Mr Thompson and supported by Ms Isaksen, Mr Jobling, Mr Kerr and Mr Rixon. The members who dissent from the majority view present their alternative conclusions in the reports appended below."

The Chair's foreword was circulated to members of the Committee.

Resolved on the motion of Ms Moore and seconded by Mr Rixon, that the Report, as considered and amended, be the Report of the Committee and tabled with the Clerks.

General Business

The Chair advised that she intended to table the report on Wednesday 18th February, 1998, and until then members of the Committee were free to comment on the Committee's deliberations.

Resolved on the motion of Ms Isaksen and seconded by Ms Meagher that the Committee Report record the Committee's particular gratitude to Ms Marie Swain.

The Committee adjourned at 11.25am.