The Present and Future of Harm Minimisation in Australia

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As outlined in Australia's *National Drug Strategy 2017–2026*, harm minimisation/reduction is a key component of the Australian government's response to the public health issue of illicit drug use. Being a federation, Australia has a constitution that empowers constituent States to legislate on drug issues independently. The absence of a nationally uniform drug law means that the legal bases of approval for harm minimisation programs differ across Australian jurisdictions. This paper critically analyses the legal bases on which harm minimisation programs are allowed to operate in different Australian States and Territories. It also examines whether the legal implementations can be improved further. Specifically, analysis and evaluation are conducted on four widely used harm minimisation strategies for illicit drug use, those being opioid pharmacotherapy, needle and syringe programs, supervised injection rooms and substance testing services. This paper demonstrates that most Australian jurisdictions' legal implementation of harm minimisation programs can be improved. It identifies and advocates for specific legislative changes that can be made to maximise the benefits delivered by harm minimisation programs. Finally, the paper advocates for more national coordination in drugs policymaking and cautions against the role of political influences in the process.

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I. Introduction

Australia first began to move away from strictly criminalising illicit drug use following the rise of the HIV epidemic in the early 1980s.[1] Harm minimisation, the policy that replaced strict criminalisation, continues to be recognised and endorsed in Australia's *National Drug Strategy 2017–2026* ('*National Drug Strategy*') several decades later.[2] Conceptually, harm minimisation, also known as harm reduction, involves offering specialised

1 See generally Paul Sendziuk, 'Harm Reduction and HIV-Prevention among Injecting Drug Users in Australia: An International Comparison' *Canadian Bulletin of Medical History* (2007) 24(1) 113, 114–7.

2 Department of Health (Cth), *National Drug Strategy 2017–2026* (2017) 1 ('*National Drug Strategy*').

services to people who use drugs with the aim of reducing the harm caused by drugs to them and the wider society.[3]

The significance of harm minimisation is two-tiered. At an ideological level, the implementation of harm minimisation programs requires an acknowledgement that illicit drugs will be used despite legislative and policing attempts to limit their availability.[4] Thus, the establishing of harm minimisation programs reflects a society's acceptance that there are circumstances in which the strict criminalisation of illicit drug use is inappropriate. Such an acceptance is a significant departure from the long-held position on illicit drugs, which is often summarised as fighting a 'war on drugs'.[5] For this reason, the shift to harm minimisation represents a major ideological change in Australia's drug policy.

At a pragmatic level, harm minimisation strategies address a pertinent social and public health issue – drug use – which is prevalent in society. According to the Australian Government-commissioned *National Drug Strategy Household Survey 2019*, 43% of Australians aged 14 and over (9.0 million people) had illicitly used a drug at some point in their lifetime.[6] Furthermore, 16.4% of Australians aged 14 and over (3.4 million people) had illicitly used a drug in the 12 months leading up to the 2019 survey.[7] The high prevalence of drug use in Australia has public health ramifications. Relevantly, burden of disease is used to measure a population's current state of health by reference to the ideal situation where every person lives free of disease.[8] Burden of disease is calculated by reference to the estimated years of life lost due to premature deaths and the estimated years of life lived in ill health or with disability (ie with reduced quality).[9] In 2018, the Australian population had a burden of

3 G Alan Marlatt, Mary E Larimer and Katie Witkiewitz, *Harm Reduction, Second Edition: Pragmatic Strategies for Managing High-Risk Behaviors* (2nd ed, 2011) 6.

4 Tibor Brunt, *Drug Checking as a Harm Reduction Tool for Recreational Drug Users: Opportunities and Challenges*, European Monitoring Centre for Drug Addiction (2017) 3.

5 See generally Dan Werb, 'Post-War Prevention: Emerging Frameworks to Prevent Drug Use after the War on Drugs' *International Journal of Drug Policy* (2018) 51 160, 160.

6 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2019* (Report, 2020) 28.

7 Ibid.

8 Australian Institute of Health and Welfare, *Australian Burden of Disease Study: Impact and Causes of Illness and Death in Australia 2018* (2021) 1.

9 Ibid.

disease attributable to illicit drug use of 149,535 years of healthy life.[10] This represented 3.0% of the total burden of disease in that year.[11] Evidently, illicit drug use is a public health issue which affects major parts of the Australian society. Thus, harm minimisation strategies are pragmatically significant as they have the potential to improve the social and physical wellbeing of those affected by illicit drug use.

The central purpose of this paper is to provide an overview and evaluation of the ways in which harm minimisation strategies are integrated in the Australian legal system. Currently, no such overview is readily available in the literature, most likely due to the fact that Australia, being a federation, does not have a single uniform drug law. This paper critically analyses the legal bases on which harm minimisation strategies are allowed to operate and examines the legal obstacles that may be present. Furthermore, the paper examines possible reform options to improve the legal integration of harm minimisation strategies.

Part II of this paper introduces the *Australian National Drug Strategy 2017–2026* and critically analyses its implications for Australia's implementation of harm minimisation measures. Parts III-VI explore the four most common harm minimisation measures in relation to drug use, being opioid pharmacotherapy, needle and syringe programs, substance testing, and supervised injection centres, in detail.[12] Each harm minimisation measure is introduced with a brief overview about the state of the scientific evidence and the measure's availability in Australian jurisdictions. Then, the paper analyses the legal frameworks that allow the harm minimisation measure to operate and presents specific suggestions about the measure's future. Finally, Part VII considers the way forward for harm minimisation in Australia generally, in light of the findings from the previous Parts.

10 Ibid 66.

11 Ibid.

12 Katie Stone and Sam Shirley-Beavan, *The Global State of Harm Reduction 2018* (2018) 20–2.

II. The Australian National Drug Strategy 2017 – 2026

Australia operates under a federal system of government consisting of States and (self-governing) Territories.[13] The regulation of drugs and medicines is not included in the Commonwealth Parliament's legislative powers.[14] Consequently, Australian States and Territories legislate independently to regulate drug issues within their own jurisdiction.[15]

Despite each State and Territory having independent drug legislations, a national framework to minimise the harms associated with alcohol, tobacco, illicit drug and pharmaceutical drug use was introduced in 1985.[16] The latest iteration of this framework, the *National Drug Strategy 2017 – 2026*, adopts a three-pillar strategy consisting of demand, supply and harm reduction.[17] Demand reduction refers to the reduction of the population's need for drugs, by preventing or delaying drug uptake, and by supporting people to recover from drug use.[18] Supply reduction refers to the reduction of illicit drugs' availability through policing actions.[19] Harm reduction (ie minimisation) refers to the reduction of risk behaviour associated with drug use.[20]

The *National Drug Strategy* appears to be ideologically consistent with the implementation of harm minimisation measures outlined in Part I. Overall, the strategy is expressed in language focusing on the improvement of public health and minimisation of harms associated with drug use.[21] It also specifically identifies the reduction of 'adverse health, social and economic consequences associated with … [drug] problems' as a priority focus area.[22] Furthermore, the strategy states that the use of evidence-informed responses is an underpinning principle,[23] and endorses opioid

13 *Australian Constitution.*
14 Ibid s 51.
15 See, eg, *Drugs Misuse Act 1986* (Qld).
16 *National Drug Strategy* (n 2) 3.
17 Ibid 7.
18 Ibid 8 – 10.
19 Ibid 11 – 12.
20 Ibid 13 – 14.
21 Andrew Groves, 'Worth the Test?' Pragmatism, Pill Testing and Drug Policy in Australia' *Harm Reduction Journal* (2018) 15 12:1, 3.
22 *National Drug Strategy* (n 2) 23.
23 Ibid 15.

pharmacotherapy, needle and syringe programs, and supervised injection centres as particular 'examples of evidence-based … approaches to harm minimisation'.[24]

As a policy document, the *National Drug Strategy* does not provide any legal basis for the implementation of harm minimisation measures. To allow for national coordination and cooperation, the Ministerial Drug and Alcohol Forum was inaugurated in December 2016 to oversee the governance of issues outlined in the *National Drug Strategy*.[25] The forum consisted of health and justice portfolio ministers from every Australian jurisdiction, who would have been responsible for the implementation of harm minimisation measures in their home jurisdiction.[26]

The forum appears to be practically ineffective as it was disbanded in 2020 following a review.[27] The review found that the forum failed to meet at least two of three objectives, the three objectives being (1) enabling national cooperation and consistency on enduring strategic issues, (2) addressing issues requiring cross-border collaboration, and (3) performing regulatory policy and standard setting functions.[28] The ongoing governance arrangements of the *National Drug Strategy* are still being reviewed at the time of writing.[29]

Ultimately, the Australian *National Drug Strategy* is in principle supportive of the implementation of harm minimisation measures. The governance of issues relating to illicit drugs, which is a central focus of the strategy, appears to be hindered by a lack of national coordination at present. The following Parts of this paper examine the status of each harm minimisation measure in individual Australian States and Territories.

24 Ibid 51.

25 *National Drug Strategy* (n 2) 35; Ministerial Drug and Alcohol Forum, *Ministerial Drug and Alcohol Forum Communiqué* (16 December 2016).

26 *National Drug Strategy* (n 2) 35. See generally Gabrielle Appleby, Alexander Reilly and Laura Grenfell, *Australian Public Law* (3rd ed, 2019) 295–6.

27 Department of Health (Cth), *Department of Health Annual Report 2020–21* (2021) 63 ('*DoH Annual Report*').

28 Peter Conran, *Review of COAG Councils and Ministerial Forums* (2020) 5, 23–5.

29 *DoH Annual Report* (n 27) 63.

III. Opioid Pharmacotherapy

1. Introduction and Purpose

Opioid pharmacotherapy is a medical treatment which involves providing users of illicit opioids such as heroin with a medically controlled substitute.[30] The purpose of this treatment is to manage a client's opioid dependence in a controlled way, which reduces their reliance on the illegal drug market and improves their social functioning.[31] Although the use of all drugs, including of substitute medication, carries the risk of negative health consequences, drugs supplied under an opioid pharmacotherapy program do not have the risks specifically associated with street-bought illicit drugs. These risks include the unintentional contamination of the illicitly produced drug, as well as the intentional cutting of the illicitly produced drug with other drugs, chemicals, or fillers.[32]

In Australia, the medications used for opioid pharmacotherapy are methadone, buprenorphine, or buprenorphine-naloxone.[33] Methadone is a full opioid agonist, meaning that it elicits a maximal response from a person's opioid receptors.[34] Buprenorphine is a partial opioid agonist and elicits only a partial functional response from a person's opioid receptors.[35] Finally, naloxone is an opioid antagonist, meaning that it elicits no response in the opioid receptors and prevents other opioid agonists from binding to the same receptor.[36] The pharmacological goals of opioid pharmacotherapy is achieved through methadone or buprenorphine.[37] The

30 Laura Amato et al, 'An Overview of Systematic Reviews of the Effectiveness of Opiate Maintenance Therapies: Available Evidence to Inform Clinical Practice and Research' *Journal of Substance Abuse Treatment* (2005) 28(4) 321, 322; Louisa Degenhardt et al, 'Mortality among Clients of a State-Wide Opioid Pharmacotherapy Program over 20 Years: Risk Factors and Lives Saved' *Drug and Alcohol Dependence* (2009) 105(1) 9, 9.

31 Amato et al (n 30) 322.

32 See generally Claire Cole et al, 'Adulterants in Illicit Drugs: A Review of Empirical Evidence' *Drug Test Analysis* (2011) 3(2) 89, 90.

33 Australian Institute of Health and Welfare, *National Opioid Pharmacotherapy Statistics Annual Data Collection* (2022) 4 ('*National Opioid Pharmacotherapy Statistics Report*').

34 Hasan Pathan and John Williams, 'Basic Opioid Pharmacology: An Update' *British Journal of Pain* (2012) 6(1) 11, 11–12.

35 Ibid.

36 Ibid.

37 See, eg, *National Opioid Pharmacotherapy Statistics Report* (n 33) 28.

purpose of naloxone in buprenorphine-naloxone is to discourage injecting use of the medication, which is designed to be taken orally.[38]

2. The Scientific Evidence

In the literature, the effectiveness of opioid pharmacotherapy is assessed generally either by reference to behavioural changes of its clients or by reference to mortality. Both methadone and buprenorphine-based pharmacotherapies have been shown to be effective at retaining opioid users in treatment and suppressing illicit opioid use.[39] Furthermore, participation in opioid pharmacotherapy treatment is correlated to an improvement in the client's physical and mental health status.[40] In terms of mortality, a 2009 review suggested that methadone treatment had no statistically significant impact on the mortality of opioid-dependent people.[41] This is in contrast to a 2017 review, which suggested that the retention in either methadone or buprenorphine treatment is associated with substantial reductions in the risk of mortality in opioid-dependent people.[42]

As an additional qualification, it should be noted that the existing body of research on the efficacy of harm minimisation measures discussed in this paper is mostly focused on and conducted in high-income countries.[43] Thus, while the relevant research findings are likely applicable to Australia, attempts to generalise them to other countries must be done with care. This is because the implications of differing cultural and socio-

38 Ibid.

39 Richard P Mattick et al, 'Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence' *Cochrane Database of Systematic Reviews* (2014) 2 CD002207; Richard P Mattick et al, 'Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence' *Cochrane Database of Systmatic Reviews* (2009) 3 CD002209.

40 Peter Lawrinson et al, 'Key Findings from the WHO Collaborative Study on Substitution Therapy for Opioid Dependence and HIV/AIDS' *Addiction* (2008) 103(9) 1484, 1489.

41 Mattick et al, 'Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence' (n 39).

42 Luis Sordo et al, 'Mortality Risk during and after Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies' *British Medical Journal* (2017) 357 j1550:1, 7.

43 Ibid 12.

economic backgrounds to the effectiveness of harm minimisation, are not yet fully known in the literature.[44]

3. Legal Implementations

The use of methadone or buprenorphine for treating addiction is available,[45] and requires legal approval, in all Australian States and Territories.[46] The jurisdictions' regulatory frameworks differ predominantly in two ways.

The first point of difference is how each jurisdiction classifies methadone and buprenorphine as medications. At the federal level, Australia has a national *Standard for the Uniform Scheduling of Medicines and Poisons* ('*SUSMP*'), which categorises both substances as Schedule 8 Controlled Drugs.[47] Generally, Schedule 8 contains substances with an elevated risk of dependence.[48] However, this federal standard is not adopted by all Australian States and Territories. Australian jurisdictions may be separated into three groups depending on the extent to which the jurisdiction's opioid pharmacotherapy legislation adopts the *SUSMP*. The first group, comprising of Victoria only, adopts the *SUSMP* directly without modifications.[49] Jurisdictions in the second group, comprising of Queensland, Western Australia, Tasmania, Australian Capital Territory and Northern Territory, adopt the *SUSMP* indirectly in the sense that the

44 See generally Joseph Henrich, Steven J Heine and Ara Norenzayan, 'Most People are Not WEIRD' *Nature* (2010) 466(7302) 29.

45 *National Opioid Pharmacotherapy Statistics Report* (n 33) 16.

46 *Poisons and Therapeutic Goods Act 1966* (NSW) ss 28(3), (6); *Poisons and Therapeutic Goods Regulation 2008* (NSW) reg 123; Department of Health (Cth), *Standard for the Uniform Scheduling of Medicines and Poisons* (No 35, February 2022) pt 4 sch 8 ('*SUSMP*'); *Drugs, Poisons and Controlled Substances Act 1981* (Vic) ss 4(1), 34(1); *Drugs Misuse Act 1986* (Qld) s 6; *Drugs Misuse Regulation 1987* (Qld) sch 2; *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) ss 10–11, 25–26; *Medicines, Poisons and Therapeutic Goods Act 2012* (NT) ss 7, 10(2), 14, 85; Northern Territory, *Northern Territory Government Gazette*, No G10, 11 March 2020, 2–3; *Poisons Act 1971* (Tas) ss 3, 14, 59C; *Poisons* (*Adoption of Uniform Standard*) *Order 2012* (Tas); *Controlled Substances Act 1984* (SA) ss 4, 18A(1); *Controlled Substances* (*Controlled Drugs, Precursors and Plants*) *Regulations 2014* (SA) sch 1; *Medicines and Poisons Act 2014* (WA) ss 3, 14; *Medicines and Poisons Regulations 2016* (WA) reg 114.

47 *SUSMP* (n 46) sch 8.

48 Ibid x.

49 *Drugs, Poisons and Controlled Substances Act 1981* (Vic) ss 4(1) (definition of 'Schedule 8 Poison' and 'Poisons Standard'), 34A.

standard is allowed to be modified by subordinate legislation.[50] Finally, jurisdictions in the third group, consisting of New South Wales and South Australia, do not adopt the *SUSMP* and instead use a different scheduling system.[51]

The second point of difference is whether opioid pharmacotherapy is approved on a per-patient or per-practitioner basis. In all jurisdictions except Queensland, a separate treatment approval is required for each person receiving opioid pharmacotherapy (i. e. approval is issued on a 'per-patient' basis).[52] In Queensland, opioid pharmacotherapy treatments under specialists are approved on a per-practitioner basis, and treatments under a shared care arrangement with community doctors are approved on a per-patient basis.[53]

50 *Medicines and Poisons Act 2019* (Qld) ss 11, 67, sch 1 (definition of 'Poisons Standard'); *Medicines and Poisons Regulations 2016* (WA) regs 6, 117; *Medicines and Poisons Act 2014* (WA) ss 3 (definition of 'Schedule 8 Poison'), 4; *Poisons Act 1971* (Tas) ss 3 (definition of 'Narcotic Substance' and 'Poisons List'), 59E; *Poisons* (*Adoption of Uniform Standard*) *Order 2012* (Tas); *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) ss 10 – 11, 15, 25, 78; *Medicines, Poisons and Therapeutic Goods Act 2012* (NT) ss 7, 14, pt 2.4 div 1 sub-div 2.

51 *Poisons and Therapeutic Goods Act 1966* (NSW) ss 28(3)-(4), (6), 29; *Poisons and Therapeutic Goods Regulation 2008* (NSW) reg 123; *Controlled Substances Act 1984* (SA) ss 4 (definition of 'controlled drug' and 'drug of dependence'), 18A(3)-(4); *Controlled Substances* (*Controlled Drugs, Precursors and Plants*) *Regulations 2014* (SA) sch 1 pt 2.

52 *Poisons and Therapeutic Goods Act 1966* (NSW) s 29(3); *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 34(4); *Drugs, Poisons and Controlled Substances Regulations 2017* (Vic) reg 129, sch 2 item 3; *Medicines, Poisons and Therapeutic Goods Regulation 2008* (ACT) reg 560(2)(a); *Medicines, Poisons and Therapeutic Goods Act 2012* (NT) s 143; Department of Health (NT), *Schedule 8 code of practice* (14 November 2019) pt 4A s 4.1; *Poisons Act 1971* (Tas) s 59E(3)(a); *Controlled Substances Act 1984* (SA) s 18A(4); *Medicines and Poisons Regulations 2016* (WA) reg 114 (definition of 'prescribing code'), 139; Department of Health (WA), *Schedule 8 Medicines Prescribing Code* (September 2018) cl 3.4.3.2 ('*WA S8 Code*').

53 Queensland Health, *Application for a Prescribing Approval for Approved Opioids* (*QOTP – Patient Class*) (2021); Queensland Health, *Application for a Prescribing Approval for Approved Opioids* (*QOTP – Shared Care*) (2021); Queensland Health, *Queensland Medication-Assisted Treatment of Opioid Dependence* (2018) 91.

4. Analysis and Critique

4.1 Treatment Approval on Per-Practitioner Basis

The authorisation of opioid pharmacotherapy treatment on a per-practitioner, rather than a per-patient, basis allows prospective opioid pharmacotherapy patients to access the service more quickly. In jurisdictions that implement a per-patient approval system, a prospective patient must have an individual application approved before treatment could commence. In contrast, Queensland, which is the only jurisdiction that allows per-practitioner approvals, allows an approved practitioner to commence treating a patient immediately.[54] Long waiting times have been identified as a treatment accessibility barrier that renders opioid pharmacotherapy less effective.[55]

The benefits of quick access should be balanced against the legitimate need to restrict the public's access to the opioid pharmacotherapy medications. Such a need arises due to the potential for these medications to be abused.[56] In Queensland, regulations are in place to require a prescriber to notify the authorities whenever they start or stop treating a patient with opioid pharmacotherapy.[57] Additionally, the prescription of medicine in Queensland is subject to a general requirement that it must reasonably be necessary for therapeutic treatment.[58] Combined, these legal requirements allow authorities to take administrative action against any medical practitioner who prescribes opioid pharmacotherapy inappropriately.[59]

Ultimately, the availability of opioid pharmacotherapy treatment approvals on a per-practitioner basis is more practically suitable for harm minimisation, as it allows prospective patients to access the service quickly without needing to wait for the outcome of an individual application. Queensland's implementation of a per-practitioner treatment

54 *Medicines and Poisons* (*Medicines*) *Regulation 2021* (Qld) regs 30–1.

55 Georgios Kourounis et al, 'Opioid Substitution Therapy: Lowering the Treatment Thresholds' *Drug and Alcohol Dependence* (2016) 161 1, 3.

56 See generally Jane Carlisle Maxwell and Elinore F McCance-Katz, 'Indicators of Buprenorphine and Methadone Use and Abuse: What Do We Know?' *American Journal on Addictions* (2010) 19(1) 73.

57 *Medicines and Poisons* (*Medicines*) *Regulation 2021* (Qld) regs 30–1.

58 Ibid reg 81.

59 *Medicines and Poisons Act 2019* (Qld) s 96(1).

approval system contains appropriate safeguards to ensure a sufficient level of supervision over the public's access to opioid pharmacotherapy medications.

4.2 Lack of Uniform Classification System for Pharmacotherapy Medications

The lack of a nationally uniform classification system for methadone and buprenorphine appears to be a practical hinderance to the goals of harm minimisation. As only Victoria adopts the *SUSMP* directly, no two jurisdictions' classification systems are identical.[60] The nuances in each jurisdiction's legislations, despite often being minor, means that the legal requirements for the prescription of methadone and buprenorphine are not necessarily accessible to prescribers or the public.[61] In a small number of circumstances, including when a practitioner relocates to a different jurisdiction or when a patient attempts to use a prescription issued in another jurisdiction, the inaccessibility of the prescription requirements may delay a patient's access to opioid pharmacotherapy.[62] Thus, a nationally uniform classification system for pharmacotherapy medications would be more practically suitable for harm minimisation.

Furthermore, a uniform classification system, phrased appropriately, may be beneficial to the public's support of opioid pharmacotherapy. For example, the New South Wales legislation labels both methadone and buprenorphine as a type B (and type C) 'drug of addiction'.[63] In contrast, the *SUSMP* labels those medications as a 'controlled drug', with an additional explanation that they are 'substances which should be available for use but require restriction … to reduce abuse, misuse and physical or psychological dependence'.[64] Arguably, the prescription of a 'controlled drug' to treat a patient is significantly less stigmatising than the

60 See above Part III.3.

61 Andy C Hua, Finna Shen and Xiaoting Ge, 'State-Based Legal Requirements for Schedule 8 Prescriptions: Why So Complicated?' *Medical Journal of Australia* (2015) 203(2) 64, 64.

62 Ibid.

63 *Poisons and Therapeutic Goods Regulation 2008* (NSW) reg 123; *Poisons and Therapeutic Goods Act 1966* (NSW) s 28(6).

64 *SUSMP* (n 46) x.

prescription of a 'drug of addiction'.[65] Thus, a uniform and appropriate classification system would allow the public to view opioid pharmacotherapy patients in a less punitive way.[66] This is practically beneficial for harm minimisation, as it would lessen the effect of social stigma as a barrier to treatment.

5. Recommendations

As a harm minimisation strategy, the effectiveness of opioid pharmacotherapy programs can be furthered by allowing treatment approvals to be issued on a per-practitioner basis. A feasible reform option could be for all Australian jurisdictions to adopt the model in Queensland. For this reform option, it is important that the authorities maintain a level of supervision over the issuing of pharmacotherapy prescriptions, due to the abuse potential of methadone and buprenorphine.[67]

Additionally, the effectiveness of opioid pharmacotherapy programs may be furthered by the introduction of a nationally uniform classification system for the pharmacotherapy medications. A feasible reform option is for all Australian jurisdictions to adopt the *SUSMP* directly, as it already exists and does not associate either methadone or buprenorphine with stigmatising connotations. For this reform option, it is important that the adoption of the *SUSMP* is direct and not subject to subordinate legislation. Indirect adoptions of the *SUSMP* do not necessarily improve accessibility, as a person would still be required to search through other statutory instruments to ascertain how a drug is classified.

65 See generally John F Kelly, Sarah E Wakeman and Richard Saitz, 'Stop Talking 'Dirty': Clinicians, Language, and Quality of Care for the Leading Cause of Preventable Death in the United States' *The American Journal of Medicine* (2015) 128(1) 8.

66 Ibid 8–9.

67 See generally Maxwell and McCance-Katz (n 56).

IV. Needle and Syringe Programs

1. Introduction and Purpose

Needle and syringe programs ('NSPs') concern the provision of sterile injection equipment to people who inject drugs.[68] They aim to protect people who inject drugs from the transmission of blood-borne diseases, such as HIV and hepatitis C, through 'risk injecting behaviours' such as the sharing of injectors.[69]

A needle and syringe program may provide sterile injectors in exchange for used injectors on a 'one-for-one' basis.[70] This requires the user accessing the service to hand over a used injector for every new injector issued. Alternatively, it may hand out sterile injectors freely on a 'no questions asked' basis.[71]

2. The Scientific Evidence

In the literature, the effectiveness of needle and syringe programs is assessed generally by reference to one of three metrics. These metrics are behavioural changes, HIV transmission and hepatitis C transmission.

There is evidence supporting the effectiveness of needle and syringe programs in reducing HIV transmission among people who inject drugs.[72] However, some reviews have expressed reservations about the quality of the available evidence.[73] The reservations arise mainly because the relevant

68 Ricardo M Fernandes et al, 'Effectiveness of Needle and Syringe Programmes in People who Inject Drugs: An Overview of Systematic Reviews' *BMC Public Health* (2017) 17 309: 1, 2.

69 Ibid.

70 Susan G Sherman et al, 'Consequences of a Restrictive Syringe Exchange Policy on Utilisation Patterns of a Syringe Exchange Program in Baltimore, Maryland: Implications for HIV Risk' *Drug Alcohol Review* (2015) 34(6) 637, 637–8.

71 Ibid.

72 Fernandes et al (n 68) 13–14; Esther J Aspinall et al, 'Are Needle and Syringe Programmes Associated with a Reduction in HIV Transmission among People who Inject Drugs: A Systematic Review and Meta-Analysis' *International Journal of Epidemiology* (2014) 43(1) 235, 246; Alex Wodak and Annie Cooney, 'Do Needle Syringe Programs Reduce HIV Infection Among Injecting Drug Users: A Comprehensive Review of the International Evidence' *Substance Use and Misuse* (2006) 41 777, 802.

73 Fernandes et al (n 68) 13–14; Aspinall et al (n 72) 246.

primary studies are observational in nature, due to ethical and practical difficulties for randomised trials.[74] Subject to similar reservations about the quality of the available evidence, needle and syringe programs have also been shown to be effective in reducing injecting risk behaviours in people who inject drugs.[75]

As for the reduction of hepatitis C transmissions, Palmateer et al consider the available evidence to be 'insufficient' to support such a finding.[76] Similarly, Fernandes et al consider that the evidence in support is of 'low to moderate quality'.[77] Ultimately, while the evidence in support of needle and syringe programs' effectiveness for harm minimisation appears 'weaker than given credit for in the literature',[78] the sources agree that needle and syringe programs should be one component of a comprehensive programme of harm minimisation measures.[79]

3. Legal Implementations

Needle and syringe programs are available in all Australian jurisdictions.[80] Depending on the jurisdiction, a needle and syringe program may be given authority to operate in one of two approaches. The first approach is used in Queensland, Western Australia and the Northern Territory, which have a separate criminal offence for the supply of syringes in connection with drug use.[81] In these jurisdictions, an approved needle and syringe program is exempted from any criminal liability associated with the specific offence.[82]

74 See, eg, Fernandes et al (n 68) 12–13.

75 Norah Palmateer et al, 'Evidence for the Effectiveness of Sterile Injecting Equipment Provision in Preventing Hepatitis C and Human Immunodeficiency Virus Transmission among Injecting Drug Users: A Review of Reviews' *Addiction* (2010) 105(5) 844, 851–2; Fernandes et al (n 68) 13–14.

76 Palmateer et al (n 75) 846–7, 851.

77 Fernandes et al (n 68) 13–14.

78 Palmateer et al (n 75) 844.

79 Wodak and Cooney (n 72) 802; Fernandes et al (n 68) 14; Aspinall et al (n 72) 246.

80 Sue Heard et al, *Needle Syringe Program National Minimum Data Collection* (2020) 3.

81 *Drugs Misuse Act 1986* (Qld) s 10(3); *Misuse of Drugs Act 1981* (WA) s 7B(3); *Interpretation Act 1984* (WA) s 5 (definition of 'sell'); *Misuse of Drugs Act 1990* (NT) s 12(2).

82 *Drugs Misuse Act 1986* (Qld) s 10(3); *Misuse of Drugs Act 1981* (WA) s 7B(5); *Misuse of Drugs Regulations 1982* (WA) reg 4B(3); *Misuse of Drugs Act 1990* (NT) s 12(2).

The second approach is used in the Australian Capital Territory, New South Wales, South Australia, Tasmania and Victoria where the supply of syringes is not specifically criminalised. In these jurisdictions, it is an offence to administer illicit drugs to oneself.[83] Thus, while there do not appear to be any reported cases, a person who supplies syringes to another could technically be held liable for aiding, abetting or procuring an offence of administering illicit drugs if the recipient of the syringe commits that offence.[84] Accordingly, these jurisdictions exempt needle and syringe programs from certain criminal liability which arise as a result of extensions of criminal liability. In New South Wales, Victoria, and Tasmania, needle and syringe programs are exempted from extensions of criminal liability for specific offences.[85] In the Australian Capital Territory and South Australia, needle and syringe programs are exempted from extensions of criminal liability generally.[86]

An additional point of difference in the legal implementation of needle and syringe programs across Australia is whether a jurisdiction allows a defence for secondary distributors. Such a provision extends the legal protection given to needle and syringe programs to anyone who receives a syringe from a needle and syringe program and passes it unused to another person. Jurisdictions that implement this defence are Victoria, Tasmania, and the Northern Territory.[87] Additionally, the Australian Capital Territory implements an extended version of this defence in which the origin of the syringe is immaterial so long as the syringe is sterile.[88]

83 *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) s 37(2); *Drug Misuse and Trafficking Act 1985* (NSW) s 12(1); *Controlled Substances Act 1984* (SA) s 33L(1)(b); *Misuse of Drugs Act 2001* (Tas) s 24(b); *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 75.

84 See, eg, Victoria, *Parliamentary Debates*, Legislative Council, 25 March 1987, 568 (David Ronald White).

85 *Drug Misuse and Trafficking Regulation 2021* (NSW) regs 37, 38; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 80(5); Victoria, *Victoria Government Gazette*, No G4, 28 January 2021, 171–175; *Public Health Act 1997* (Tas) s 56K(4).

86 *Public Health Act 1997* (ACT) s 66 J; *Controlled Substances Act 1984* (SA) s 33S(b); *Controlled Substances* (*Controlled Drugs, Precursors and Plants*) *Regulations 2014* (SA) reg 12.

87 *Drugs, Poisons and Controlled Substances Act 1981* (Vic) ss 80(8)-(9); *Public Health Act 1997* (Tas) s 56K(5); *Misuse of Drugs Act 1990* (NT) s 12(3), (3 A).

88 *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) ss 37(3).

4. Analysis and Critique

4.1 Legal Basis for Authorisation

As discussed previously, the way in which a needle and syringe program is authorised to operate depends on the laws of the jurisdiction it operates in. In jurisdictions where the supply of syringes in connection with drug use is a separate offence, an authorised needle and syringe program is exempted from that specific offence. In contrast, in jurisdictions where a supplier of syringes is potentially liable for aiding, abetting or procuring the self-administration of drugs, an authorised needle and syringe program is exempted from being liable under extensions of criminal liability.

Despite the difference in the legal basis of needle and syringe programs' authorisations, a common feature of the authorisation systems in all Australian jurisdictions is that protection against the relevant criminal liability is given to official needle and syringe programs only. However, official needle and syringe programs are only one of the channels through which sterile injectors are distributed, with evidence suggesting that people who inject drugs also distribute sterile injectors amongst themselves.[89] The ultimate purpose of a needle and syringe program is to address the harms associated with the use of contaminated injectors.[90] Thus, the fact that legal protections are only given to official needle and syringe programs appears to arbitrarily limit the harm minimisation opportunities that could be had through peer-distribution of injecting equipment. Subject to the discussion below about the secondary distributors' defence, current Australian laws, which give legal protections to official needle and syringe programs only, are arguably too restrictive to allow for effective harm minimisation.

89 See, eg, Loren Brener et al, 'Patterns of Peer Distribution of Injecting Equipment at an Authorized Distribution Site in Sydney, Australia' *Substance Use and Misuse* (2018) 53(14) 2405, 2410–11; Jamee Newland, Christy Newman and Carla Treloar, '"We get by with a Little Help from Our Friends": Small-Scale Informal and Large-Scale Formal Peer Distribution Networks of Sterile Injecting Equipment in Australia' *International Journal of Drug Policy* (2016) 34 65, 69–70.

90 See, eg, Fernandes et al (n 68) 2.

4.2 Secondary Distributors' Defence

The implementation of a secondary distributors' defence appears to be practically suitable for the goals of harm minimisation. As discussed previously, one concern about the Australian laws enabling needle and syringe programs to operate is that legal protections for the distribution of injectors are only afforded to narrowly defined and officially sanctioned entities.

The 'standard' secondary distributor's defence, as implemented in Victoria, Tasmania, and the Northern Territory, extends the relevant legal protection to secondary distributors of NSP-originated injectors.[91] This makes the law significantly less restrictive and allows for peer-distribution of injectors obtained from official needle and syringe programs. Nonetheless, the 'standard' defence does not completely address the restrictiveness of the laws, as the criminal liability of people who distribute sterile injectors obtained from places other than those prescribed by legislation remains unaltered.

In contrast, the Australian Capital Territory's version of the defence extends the relevant legal protection to secondary distributors of sterile injectors irrespective of their origin.[92] This implementation appears to be most consistent with the goal of harm minimisation, as it grants protection to anyone distributing sterile injectors while not altering the legal liability of those supplying unsterile injectors.

5. Recommendations

From the harm minimisation perspective of preventing the spread of blood-borne diseases, the law should discourage the supply of contaminated injectors while not burdening any entity who distributes sterile injectors. However, except for the Australian Capital Territory which has an extended secondary distributor defence, this is not the case in Australia. In jurisdictions that implement the 'standard' secondary supplier defence, liability for the supply of syringes is effectively tied to the origin of the

91 *Drugs, Poisons and Controlled Substances Act 1981* (Vic) ss 80(8)-(9); *Public Health Act 1997* (Tas) s 56K(5); *Misuse of Drugs Act 1990* (NT) ss 12(3), (3 A).

92 *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) s 37(3).

syringe. In jurisdictions that do not have a secondary supplier defence, liability for the supply of syringes is only exempted when it is supplied by an approved entity.

Ultimately, the harm minimisation goals that needle and syringe programs seek to achieve can be furthered by allowing any entity to distribute sterile needles and syringes freely. To achieve this, a possible reform option could be to ensure that the supply of syringes only attracts criminal liability where the syringe supplied is unsterile. For jurisdictions that have a separate offence of supplying syringes in connection with drug use, the offence could be amended such that only the supply of unsterile syringes is penalised. For jurisdictions in which a syringe supplier may be liable under extensions of criminal liability, an extended secondary distributor defence could be introduced to exempt suppliers of sterile syringes from secondary criminal liability.

V. Supervised Injection Centres

1. Introduction and Purpose

Supervised injection centres provide a physical space where people can consume people the supervision of medical professionals.[93] These rooms aim to protect drug users from overdose-induced harms and reduce drug use in unhygienic conditions.[94] Other purposes of these facilities may include the delivery of drug education to people who inject drugs, the screening of viral infections, or the reduction of nuisances triggered by injecting drug use in public spaces.[95]

2. The Scientific Evidence

There is evidence supporting the effectiveness of supervised injection centres for the public health objectives of reducing unhygienic drug use and

93 Stone and Shirley-Beavan (n 12) 21.

94 Ibid 21–2.

95 Chloé Potier et al, 'Supervised Injection Services: What Has Been Demonstrated? A Systematic Literature Review' *Drug and Alcohol Dependence* (2014) 145 48, 49.

managing overdoses.[96] Furthermore, these facilities have also been shown to be effective in meeting their public order objectives of reducing instances of public drug use and publicly discarded syringes.[97]

3. Legal Implementations

There are currently two supervised injection centres in Australia. One centre is located in Sydney, New South Wales and operates on a permanent basis.[98] The second centre is located in Melbourne, Victoria and operates as part of a trial which started on 30 June 2018 and is scheduled to end on 29 June 2023.[99]

Each State has a licensing system to allow one (and only one) supervised injection centre to operate.[100] In both states, the licence permits clients to use and possess drugs inside the centre, subject to limits on the type and quantity of drugs they bring in.[101] The licence also exempts the operator from criminal liability for deemed possession and aiding and abetting.[102] Exemptions of criminal liability for both the client and the operator of the centre are necessary because the use/self-administration of drugs is criminalised in both New South Wales and Victoria.[103] This means that clients of the supervised injection centres would be potentially liable for the use, as well as the possession of drugs.[104] The operators would be

96 Ibid 65; Mary Clare Kennedy, Mohammad Karamouzian and Thomas Kerr, 'Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review' *Current HIV/AIDS Reports* (2017) 14(5) 161, 179.

97 Potier et al (n 95) 65; Kennedy, Karamouzian and Kerr (n 96) 178.

98 *Drug Misuse and Trafficking Act 1985* (NSW) s 36G.

99 *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 55F; Daniel Andrews, *Saving and Rebuilding Lives from Drug Addiction* (2020); *Victoria Government Gazette*, No S309, 29 June 2020, 1.

100 *Drug Misuse and Trafficking Act 1985* (NSW) s 36A; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 55D.

101 *Drug Misuse and Trafficking Act 1985* (NSW) s 36N, sch 1; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 55K; *Drugs, Poisons and Controlled Substances Regulations 2017* (Vic) regs 149A, 149B.

102 *Drug Misuse and Trafficking Act 1985* (NSW) s 36O; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 55L.

103 *Drug Misuse and Trafficking Act 1985* (NSW) s 12; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 75.

104 *Drug Misuse and Trafficking Act 1985* (NSW) ss 10, 12; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) ss 73, 75.

potentially liable for aiding and abetting the use of drugs, as well as for having deemed possession of drugs.[105] Finally, the licence exempts the operator from all non-negligent civil liability.[106]

Several points of difference exist between the Victorian and New South Wales legislations. First, the Victorian legislation exempts both the client and operator from the criminal liability for supplying illicit drugs.[107] In contrast, the New South Wales legislation does not exempt the client from any criminal liability for supplying illicit drugs.[108] The operator may be exempt from liability for supply, but only if the supply was 'in the conduct' of the facility.[109] Additionally, the New South Wales legislation requires the licence to be reviewed if the centre has low attendance, which is defined as less than 156 client visits per day in each month.[110] No similar provision about the economic viability of the centre exists in the Victorian legislation.

4. Analysis and Critique

4.1 Limited Availability

The availability of supervised injection centres is limited across Australia. Currently, supervised injection centres are only available in New South Wales and Victoria, and each of these States only allow one licence to be granted.[111] The numerical limit on the number of licences in New South Wales and Victoria appears to be products of political pressure.

105 *Drug Misuse and Trafficking Act 1985* (NSW) ss 7, 10, 14, 19; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) ss 5, 73, 80.

106 *Drug Misuse and Trafficking Act 1985* (NSW) s 36P; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 55N.

107 *Drugs, Poisons and Controlled Substances Act 1981* (*Vic*) ss 4(1) (definition of 'injecting centre drug'), 55K(1), 55L(1); *Drugs, Poisons and Controlled Substances Regulations 2017* (Vic) reg 149A.

108 *Drug Misuse and Trafficking Act 1985* (NSW) ss 36D (definition of 'prescribed drug'), 36N(2)(a).

109 Ibid s 36O.

110 *Drug Misuse and Trafficking Act 1985* (NSW) s 36K(2); *Drug Misuse and Trafficking Regulation 2021* (NSW) reg 40.

111 *Drug Misuse and Trafficking Act 1985* (NSW) s 36 A; *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 55D.

In both States, the numerical limit was presented as an assurance to opponents of supervised injection centres during parliamentary debates of the bill enabling supervised injection centres.[112] The numerical limit was used to emphasise that the introduction of this politically 'novel' harm minimisation measure is 'controlled', and that the political party seeking to introduce them is not 'soft on drugs'.[113] In contrast, in jurisdictions other than New South Wales and Victoria, the issue of supervised injection centres does not appear frequently in the public discourse. This is possibly due to an absence of media attention or legislative proposals on this issue. Ultimately, given the scientific evidence about their effectiveness,[114] the limited availability of supervised injection centres appears to be both ideologically and practically inconsistent with the goals of harm minimisation.

4.2 NSW's Economic Viability Requirement

The economic viability requirement was added by an amendment to s 36K of the *Drug Misuse and Trafficking Act 1985* (NSW) in 2007, when the New South Wales Government was seeking a further extension to their supervised injection centre trial (as it then was).[115] In the Second Reading Speech of the amending legislation, the Government presented the addition of this requirement as further evidence that their trial is 'cautious' and 'strictly regulated'.[116] However, no quantitative figure about either the cost of the facility or the value of its benefits was mentioned in the speech.[117] Furthermore, a government review on the operation of the supervised injection centre, referred to in the Second Reading Speech and subsequently tabled, did not recommend any changes to the pre-

112 New South Wales, *Parliamentary Debates*, Legislative Council, 21 October 1999, 1774 (John Della Bosca); Victoria, *Parliamentary Debates*, Legislative Council, 14 December 2017, 6880 (Jaclyn Symes).

113 Ibid.

114 See above Part V.2.

115 *Drug Summit Legislative Response Amendment* (*Trial Period Extension*) *Bill 2007* (NSW) sch 1 [3].

116 New South Wales, *Parliamentary Debates*, Legislative Assembly, 07 June 2007, 1090 (Reba Meagher, Minister for Health).

117 Ibid 1089–91.

amendment version of s 36K.[118] Ultimately, the introduction of the economic viability requirement in New South Wales appears to be a political compromise to win more support for the trial's extension.

4.3 Victoria's Authorisation for Supplying Drugs

The Victorian legislation's blanket authorisation for the supervised injection centre and its clients to supply illicit drugs[119] appears to be unnecessary for the centre's present functions. As a harm minimisation measure, the main purpose of a supervised injection centre is to manage overdoses safely.[120] The centre may also provide education or sterile injecting equipment for its clients.[121] In performing these functions, the centre need not to supply illicit drugs or require its clients to supply illicit drugs to any entity.[122]

A comparison with the New South Wales legislations further suggests that the Victorian legislation's authorisation for supplying illicit drugs is unnecessary. New South Wales and Victoria define the supply of illicit drugs similarly.[123] Despite this, the New South Wales legislation for supervised injection centres does not exempt a client from any criminal liability for the supply of illicit drugs.[124] While some qualified exemptions are given, the supervised injection centre's operator is not given a blanket exemption from criminal liability for the supply of illicit drugs in New South Wales.[125]

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118 Ibid 1090; Ken Moroney and Bob McGregor, *Review of the Operation and Use of the Medically Supervised Injecting Centre and Part 2A of the Drugs Misuse and Trafficking Act 1985* (2007) 4, 31.

119 *Drugs, Poisons and Controlled Substances Act 1981* (Vic) ss 4(1) (definition of 'injecting centre drug'), 55K(1), 55L(1); *Drugs, Poisons and Controlled Substances Regulations 2017* (Vic) reg 149A.

120 See above Part V.1.

121 Ibid.

122 North Richmond Community Health, 'Medically Supervised Injecting Room', (Web page, undated).

123 *Drug Misuse and Trafficking Act 1985* (NSW) s 3(1) (definition of 'supply'); *Drugs, Poisons and Controlled Substances Act 1981* (Vic) s 4(1) (definition of 'supply').

124 *Drug Misuse and Trafficking Act 1985* (NSW) ss 36D (definition of 'prescribed drug'), 36N(2)(a).

125 *Drug Misuse and Trafficking Act 1985* (NSW) s 36O.

Furthermore, the Victorian legislation's authorisation for the supply of illicit drugs does not appear to offer any political advantage. During parliamentary debates of the bill which enabled the Victorian trial, it was clear that the Victorian Government still intended to penalise drug dealing harshly.[126] The Victorian Government emphasised that the trial was 'conservative', 'controlled', and with 'strict' conditions.[127] Given these representations by the Victorian Government, the addition of a further authorisation for supply does not appear to be politically motivated. This is corroborated by the fact that the authorisation of supply was criticised by members of the opposition.[128] Ultimately, the authorisation for the supply of illicit drugs in the Victorian legislation appears to be unnecessary for the centre's present functions.

5. Recommendations

A recurring theme throughout the analysis was the effect that political pressure has on the regulatory framework governing supervised injection centres. Whether in the form of a numerical limit on licences or an 'economic viability' requirement, conditions are attached to the operation of supervised injection centres as a form of assurance to political opponents. The reluctance, of policymakers in favour of harm minimisation, to alienate opponents of supervised injection centres suggests that the opposing view is still relatively mainstream in the community.[129]

The effectiveness of supervised injection centres as a harm minimisation strategy can be furthered by making these facilities available in more locations. Evidently, any expansion of supervised injection centres will depend on the level of political support. Considering that the supervised injection centre in both New South Wales and Victoria started as time-

126 Victoria, *Parliamentary Debates*, Legislative Council, 14 December 2017 (n 112), 6880 (Jaclyn Symes), 6902 (Gavin Jennings).

127 Victoria, *Parliamentary Debates*, Legislative Council, 14 December 2017 (n 112), 6880 (Jaclyn Symes).

128 Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2017, 3872 (Bill Tilley).

129 See, eg, Hamish Goodall, 'Business Owners Furious over Location of Drug-Injecting Room in Melbourne CBD', *7News* (online), 18 May 2021.

limited trials,[130] there appears to be some political support for this type of arrangement. Hence, the most feasible option to expand the availability of supervised injection centres would be to introduce more time-limited trials of these facilities wherever sufficient political support exists. Given the existing scientific evidence, evaluation of these new trials should return favourable findings.[131] These findings can then be used to advocate for the trials to be made permanent, as has been done in New South Wales.[132]

On a separate and minor point, the Victorian legislation's authorisation for supplying drugs, applicable to both supervised injection centre clients and operators, appears to be unnecessary for the centre's functioning. Considering the then parliament's intention to continue to criminalise drug dealing,[133] the removal of the legislation's reference to authorising supply may be desirable.

VI. Substance Testing

1. Introduction and Purpose

Substance testing involves the scientific analysis of the ingredients and composition of a drug sample.[134] This initiative aims to protect people who use drugs, especially recreational drugs in tablet form, from the harmful effects of contaminants and/or cutting agents by providing information that allows them to make a more informed choice about drug use.[135] Additionally, substance testing initiatives facilitate the outreach of drugs education by engaging with people who use drugs casually and

130 *Drug Summit Legislative Response Act 1999* (NSW) sch 2; *Drugs, Poisons and Controlled Substances Amendment* (*Medically Supervised Injecting Centre*) *Act 2017* (Vic) s 7.

131 See above Part V.2.

132 New South Wales, *Parliamentary Debates*, Legislative Assembly, 23 September 2010, 25996–7 (Carmel Tebbutt).

133 Victoria, *Parliamentary Debates*, Legislative Council, 14 December 2017 (n 112), 6880 (Jaclyn Symes), 6902 (Gavin Jennings).

134 Felix Betzler et al, 'Drug Checking and Its Potential Impact on Substance Use' *European Addiction Research* (2021) 27(1) 25, 25–6.

135 Groves (n 21) 2.

recreationally, a group which has little or no contact with support otherwise.[136]

2. The Scientific Evidence

Substance testing services have been shown to influence its clients' intended behaviour.[137] The literature has consistently reported that clients are less inclined to use their samples if the analysis returns unexpected or suspicious results.[138]

Nevertheless, some gaps exist in the literature. In particular, less research is available about substance testing's effect on its clients' enacted (actual) behaviour and thus exposure to harm.[139] A person's actual behaviour may differ from what they indicate on a self-report survey as their intended behaviour.[140]

3. Legal Implementation

Officially sanctioned[141] substance testing was, as of 2021, only available in Australia in two time-limited trials, which took place at the 'Groovin the Moo' music festival in Canberra, Australian Capital Territory ('ACT'), in 2018 and 2019 (the 'music festival trials').[142] It was reported that substance testing will not be available at the 2022 'Groovin the Moo' festival, which will be the first time it is held since the COVID-19 pandemic.[143] Additionally, during the writing of this paper, the ACT Government launched a fixed-site substance testing service in July 2022 as a six-month

136 Brunt (n 4) 10.

137 Groves (n 21) 8; Nazlee Maghsoudi et al, 'Drug Checking Services for People Who Use Drugs: A Systematic Review' *Addiction* (2022) 117(3) 532, 535.

138 Ibid.

139 Groves (n 21) 7; Maghsoudi et al (n 137) 535.

140 See, eg, Betzler et al (n 134) 31.

141 Cf Andrew M Camilleri and David Caldicott, 'Underground Pill Testing, Down Under' *Forensic Science International* (2005) 151(1) 53.

142 Meegan Fitzharris, Second Pill Testing Trial Takes Place in Canberra (2019).

143 Donal Sheil and Jack Schmidt, 'Groovin the Moo Cancels Pill-Testing at Canberra Musical Festival after Insurers Pull Out', *ABC News* (online).

pilot trial (the '2022 fixed-site trial').[144] This trial is ongoing at the time of writing.

There is no legislation to authorise either the music festival trials or the 2022 fixed-site trial. For the music festival trials, the operators relied on an 'agreement and mutual understanding' with local law enforcement for their, and their clients', criminal liability.[145] This arrangement with law enforcement was necessary because under ACT law, substance testing clients would be potentially liable for the possession of drugs as well as for the supply of drugs when they submit a sample for analysis.[146] Once the sample is received, the operators of the testing service are potentially liable for possession of the drugs.[147] A similar agreement with law enforcement regarding the use of police discretion is implemented and documented in a police Better Practice Guide for the 2022 fixed-site trial.[148] It should also be noted that in all of the trials, steps were taken to conceal the identity of substance testing clients from outside observers.[149]

Finally, substance testing clients in all trials were required to sign a waiver releasing the operator from tortious liability associated with their participation in the trial.[150] It was stated in the reports of the music festival trials that, prior to signing, the client's capacity to consent was assessed by medical professionals.[151]

144 Rachel Stephen-Smith, *Australia's first fixed-site health and drug checking service opens* (2022).

145 Sarah Byrne et al, 'Australia's First Official Illicit Pill Testing at Canberra's Groovin' The Moo Music Festival: Legal Hurdles and Future Prospects' *Journal of Law and Medicine* (2018) 26(1) 54, 60.

146 *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) ss 11(2) (definition of 'controlled medicine'), 26, 35.

147 Ibid s 35.

148 Australian Federal Police, *Better Practice Guide on Fixed-Site Drug Checking Service at 1 Moore Street Canberra (ACT) (2022)* ('Better Practice Guide').

149 Safety Testing Advisory Service At Festivals and Events Consortium, *Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service* (2018) 6–7 ('*2018 GTM Pill Testing Report*'); Pill Testing Australia Consortium, *Report on the 2nd ACT GTM Pill Testing Pilot: a Harm Reduction Service* (2019) 8–9 ('*2019 GTM Pill Testing Report*'); Better Practice Guide (n 148) 4.

150 *2018 GTM Pill Testing Report* (n 149) 8; *2019 GTM Pill Testing Report* (n 149) 8–9; [s.n.] 'CANTEST – Directions' (Web page, undated).

151 *2018 GTM Pill Testing Report* (n 149) 8.

4. Analysis and Critique

4.1 Limited Availability

The availability of substance testing services in Australia is presently confined to a single location in the ACT. Evidence from New South Wales and the Australian Capital Territory suggests that the limited availability of substance testing is likely a product of political pressure.[152]

In the Australian Capital Territory, the Government, at the time led by a coalition of the Greens and the Labor Party, had approved a substance testing trial at the 2017 'Spilt Milk' music festival.[153] This festival was to be held on land belonging to the federal government, at the time led by a coalition of the Liberal Party and the National Party.[154] The land was managed by the statutory agency National Capital Authority.[155] In the end, the planned trial was cancelled.[156] While the National Capital Authority maintains that it was not involved in the decision to cancel the trial,[157] proponents of substance testing blamed the cancellation on interventions from the federal government.[158]

In New South Wales, the Greens presented a bill in 2019 with a legislative framework to enable substance testing on a continuing basis.[159] The bill was voted down, with the then governing Liberal-National Coalition refusing to provide any support outright.[160] The Labor Party, while indicating that they generally support substance testing, also refused to provide support for this bill on the basis that the bill was not framed as a

152 See, eg, Shane Rattenbury, 'To All Those Who Supported Pill Testing: Thank You' (2018); New South Wales, *Parliamentary Debates*, Legislative Council, 24 November 2021, 62 (Scott Farlow), 64 (John Graham).

153 Rattenbury (n 152).

154 Joint Standing Committee on the National Capital and External Territories, Parliament of Australia, *Biannual Public Briefing* (Transcript of Proceedings, 7 December 2017) 1.

155 Ibid.

156 See, eg, ibid.

157 Ibid.

158 Rattenbury (n 152); [s.n.] 'Pill Testing Advocates Blame Federal Intervention for Spilt Milk Trial Cancellation', *The Canberra Times* (online), 13 October 2017.

159 *Pill Testing Bill 2019* (NSW).

160 New South Wales, *Parliamentary Debates*, Legislative Council, 24 November 2021 (n 152) 62 (Scott Farlow).

time-limited trial.[161] It should also be noted that a similar bill to enable substance testing was introduced to the Victorian parliament in 2019 but has now lapsed following dissolution of parliament before a general election.[162]

In jurisdictions other than New South Wales, Victoria and the Australian Capital Territory, substance testing does not appear frequently in the public discourse. This is possibly due to an absence of media attention or legislative proposals on this issue. Ultimately, despite some gaps in the available literature, the scientific evidence is generally in favour of substance testing being an effective harm minimisation strategy.[163] Thus, the limited availability of substance testing appears to be both ideologically and practically inconsistent with the goals of harm minimisation.

4.2 Lack of Legislative Protection

The effectiveness of the ACT's substance testing trials is adversely affected by each trial's reliance on police discretion and waivers. As offences are potentially committed when a client utilises the substance testing service,[164] the success of the service depends substantially on the police cooperating and exercising their discretion to not charge people.[165] The implication of this is that a distrust of the police could deter some people from accessing the service. While no official data can be collected, anecdotal evidence suggests that, during the 2018 music festival trial, some festival attendees brought in (legally acquired) prescription medications to the testing service to confirm that the program is not a police 'set-up'.[166] Thus, it appears that the lack of legal protection is of concern among attendees and may have deterred some from utilising the service. Additionally, it should be noted that the ACT police's decision to cooperate appears to be influenced in part by the views of former senior

161 Ibid 64 (John Graham).

162 *Drugs, Poisons and Controlled Substances Amendment* (*Pill Testing Pilot for Drug Harm Reduction*) *Bill 2019* (Vic).

163 See above Part VI.2.

164 Better Practice Guide (n 148) 3–4.

165 See generally Byrne et al (n 145) 58.

166 [s.n.] 'What is the Future of Pill Testing in Australia? Australian Politics Live *Podcast' Guardian Australia* (online) 2018 0:09:35–0:10:20.

police officials.[167] This means that the ACT model is unlikely to be replicated in other jurisdictions.

Furthermore, a person must have capacity to consent in order to validly execute a waiver, which may be problematic for substance testing services at music festivals. Attendees at music festivals are often intoxicated, whether due to alcohol or drugs, which would impair their capacity to consent.[168] Even if all clients are assessed by medical professionals for their capacity to consent, a risk of tortious liability for the testing provider and the event organiser remains because a court could later override that assessment. Liability issues may affect the future availability of substance testing, through the reluctance of event organisers or insurers.[169]

Ultimately, the lack of legislative protections in the ACT substance testing trials appears to be a practical hinderance to the goals of harm minimisation. The lack of legislative protections may deter both potential clients and event organisers from adopting substance testing and makes the arrangement difficult to replicate in other jurisdictions.

5. Recommendations

The lack of legislative protections appears to be a significant barrier to substance testing programs' furtherance of harm minimisation goals. Thus, legislative protections should be introduced for future Australian substance testing initiatives.

As evidenced by the rejection of the New South Wales substance testing proposal,[170] political and ideological resistance will likely be the most significant barrier to the introduction of legislative protection for substance testing programs. Again, the presence of political reluctance appears to indicate that opposition to substance testing is still relatively mainstream in the community.

167 Byrne et al (n 145) 58.
168 Ibid 57–8.
169 See, eg, Sheil and Schmidt (n 143).
170 *Pill Testing Bill 2019* (NSW).

Considering the stance taken by the Labor Party regarding the New South Wales Bill,[171] there appears to be some political support for time-limited trials of substance testing. Hence, the most feasible reform option appears to be the introduction of legislative protections for substance testing services on a time-limited, trial basis. Given the existing scientific evidence, evaluation of these trials should return favourable findings.[172] These findings can then be used to advocate for the trials to be made permanent.

VII. Conclusion

In conclusion, the Australian legal implementations of all four harm minimisation strategies relating to drug use can be improved further.

For opioid pharmacotherapy, the need for individual treatment approvals in all jurisdictions except Queensland and the associated delay can constitute an entry barrier to pharmacotherapy treatment.[173] A potential reform option could be for all States and Territories to adopt the Queensland system, which allows per-practitioner treatment approvals while retaining sufficient access safeguards for the medications used. Furthermore, the lack of a nationally uniform scheduling system for methadone and buprenorphine can result in practical difficulties when practitioners or patients cross jurisdictional boundaries.[174] Some jurisdictions also employ scheduling systems with unnecessarily stigmatising connotations.[175] In relation to these issues, a potential reform option could be for all States and Territories to adopt the national *Standard for the Uniform Scheduling of Medicines and Poisons* directly.

In relation to needle and syringe programs, the current legislations regulating criminal liability for the supply of syringes appear to be too restrictive in all jurisdictions except the Australian Capital Territory.[176] A potential reform

171 See above Part VI.4.1.

172 See above Part VI.2.

173 See above Part III.4.1.

174 See above Part III.4.2.

175 See, eg, *Poisons and Therapeutic Goods Act 1966* (NSW) s 28(6); *Poisons and Therapeutic Goods Regulation 2008* (NSW) reg 123.

176 See above Part IV.4.

option is to remove all criminal liability associated with the supply of sterile syringes but retain any criminal liability attached to the supply of unsterile syringes. This change will further the harm minimisation goals that needle and syringe programs seek to achieve, namely the prevention of blood-borne infections, by allowing any entity to distribute sterile needle and syringes freely.

The effectiveness of supervised injection centres and substance testing programs are most significantly constrained by their limited availability. In both cases, the limited availability can be attributed to political reluctance.[177] Nonetheless, there appears to be some political support for time-limited trials of both measures.[178] A potential reform option could be for more trials of both measures to be run wherever there are sufficient support, as political resistance will likely wane if an increasing number of trials return favourable evaluation results. Separately, the Victorian legislation's authorisation for the supply of drugs in their supervised injection centre appears to be unnecessary for the operation of the centre.[179]

In addition to the specific recommendations above, two further observations are made regarding the status of harm minimisation measures in Australia generally. The first observation relates to the fact that, for measures with established legal frameworks across Australia (ie opioid pharmacotherapy and needle and syringe programs), recommendations made by this paper are already in use in some jurisdictions. By way of example, Victoria adopts the *SUSMP* directly and Queensland allows pharmacotherapy treatment authorisations on a per-practitioner basis.[180] The Australian Capital Territory has, through the implementation of an extended secondary distributor defence, effectively removed criminal liability for the supply of sterile syringes.[181] The fact that the 'better' implementations (from a harm minimisation perspective) are in use in some, but not all Australian jurisdictions shows that there is little collaboration in drugs policymaking across Australia.

The second observation relates to the role of political pressure in the policymaking process concerning measures which are not yet widely

177 See above Parts V.4.1, VI.4.1.
178 See above Parts V.5., VI.5.
179 See above Part V.4.3.
180 See above Part III.3.
181 See above Parts IV.3., IV.4.2.

available (ie supervised injection centres and substance testing). This is exemplified by the introduction of the 'economic viability' requirement for the New South Wales supervised injection centre, despite a government report finding that such a requirement is not needed.[182] Evidently, policymakers are willing to impose restrictions on harm minimisation measures, absent any recommendation to do so, for political advantage. Ultimately, these two observations show that there is significant room for improvements in the Australian implementations of harm minimisation strategies.

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