



Turning Point

TREATMENT · RESEARCH · EDUCATION

**SUBMISSION:
INQUIRY INTO DRUG
LAW REFORM**

Turning Point
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Part of


easternhealth
GREAT HEALTH AND WELLBEING

Turning Point Submission into Inquiry into Drug Law Reform by Parliament of Victoria's Law Reform, Road and Community Safety Committee.

Inquiry into Drug Law Reform

On 11 November 2015, Victoria's Law Reform, Road and Community Safety Committee received a reference to inquire into, consider and report on drug law reform. The Committee has been asked to inquire into, consider and report, no later than 9 March 2018 on:

- 1) The effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs and the misuse of prescription medication in minimising drug-related health, social and economic harm; and
- 2) The practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law.

Recommendations

1. Enhance surveillance and monitoring to provide timely interventions and targeting of hotspots.
2. Build on existing co-operation between health and forensic services to ensure that a co-ordinated approach to providing a continuum of care and appropriate response is possible.
3. Create a dedicated arm of government to actively manage permits, dosage levels and clinical risk as well as oversee reforms to pharmacotherapy policy in Victoria.
4. Build Victorian specialist addiction medicine capacity and services to support real time prescribing monitoring and community need.
5. Review decision to have proposed real time prescribing monitoring for only S8 medications.¹ Some opioids (e.g., tramadol and codeine) and benzodiazepines (except alprazolam and flunitrazepam) will be excluded, despite their contribution to harm.
6. Ensure real time prescribing collects Pharmaceutical Benefits Scheme and private prescription data, and flag potential misuse and diversion at the time of prescribing and dispensing.
7. Acknowledge that alcohol misuse remains Victoria's number one intoxicant and the second leading cause of preventable morbidity and mortality.
8. Institute a robust public health model for treating serious drug addiction, such as Portugal, to reduce the increasing crisis in overdose deaths.
9. Introduce evidence-based harm minimisation strategies (such as supervised injecting rooms, and needle and syringe programs in prisons) to tackle the reality of increasing drug hospitalisations and deaths.

Background

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs and gambling,

¹ Shand FL, Campbell G, Hall W, et al. Real-time monitoring of Schedule 8 medicines in Australia: evaluation is essential. *Med J Aust* 2013; 198: 80-81.

integrated with world-leading research and education. Turning Point is auspiced by Eastern Health and is formally affiliated with Monash University.

Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that:

1. Increases access to support and evidence-based practice through the use of innovative technologies.
2. Delivers high quality evidence-based practice.
3. Supports health care professionals nationally and internationally to provide high quality evidence-based practice.
4. Delivers workforce and community education programs to a broad range of populations.
5. Undertakes policy and practice relevant research and provides key national population level data.
6. Provides policy advice to state and federal governments as well as expert comment.

1.1 Effectiveness of laws, procedures and regulations...

Substance misuse can result in a range of social harms, including impacts on community safety and the resources of service providers, including police, health and emergency services. Estimating the use of alcohol and drugs in the community is important for law enforcement agencies, health and emergency services. Australia has four ongoing drug monitoring systems, including the AIC's DUMA program, the National Drug Strategy Household Survey, the Illicit Drug Reporting System and the Ecstasy and Related Drug Reporting System. The systems vary in methods, but broadly they are reliant upon self-report data and may be subject to selection biases².

Tackling alcohol and other (AOD) misuse and its societal impact requires detailed understanding of the prevalence and severity of the problem, populations most at-risk, and direct and indirect harms experienced by individuals and communities. From this, optimal prevention, early intervention and treatment approaches can be developed and refined, addressing the diverse needs of those affected.

Turning Point has built an internationally unique ambulance-based AOD surveillance system (see www.aodstats.org.au for examples of utility and relevance of the data) that is a gold standard method of AOD-related harm monitoring. This innovative monitoring and surveillance system provides a unique opportunity to improve existing health system service delivery.

While ongoing co-operation between law enforcement and health at both national and local level is welcomed, a national plan for addiction, along the lines of the national mental health plan would be a significant step forward in identifying gaps in the linkages between systems and ensuring that a co-ordinated approach to providing a continuum of care and appropriate response is possible.

² Prichard, J., et al. Measuring drug patterns in Queensland through wastewater analysis. Trends & issues in crime and criminal justice, 2012

1.11 Victoria's pharmacotherapy policy

The cost to Australian society of illicit drug use in 2004–05 was estimated to be \$6.9 billion, the cost of related crime comprised \$3.6 billion of this.³

In the past, most patients seeking treatment for opioid dependence were people who inject drugs (heroin) and were actively involved in a drug-using subculture.

In recent years, pharmaceutical opioid use has become more prominent among those seeking treatment for opioid dependence, resulting from problematic use of:

- over-the-counter (OTC) codeine-containing analgesics, particularly those containing codeine combined with ibuprofen or paracetamol, in high daily doses
- prescription opioids, such as morphine and oxycodone, particularly long-acting formulations.

Pharmaceutical drug misuse has become a serious problem in Australia, with overdose deaths now exceeding the number of road deaths in Victoria.⁴

Some people become addicted following a period of dependency on opioids or OTC codeine combination analgesics for pain treatment, while others actively seek these drugs for their intoxicating effects. The first group may never have injected or used illicit drugs or been involved in a drug-using subculture; they may be more highly functioning and have more social supports that assist in managing their dependence.⁵

Harms associated with problematic use and dependence on pharmaceutical opioids includes vascular damage, inadvertent intra-arterial injection, talc pulmonary granulomatosis from the talc included as an excipient in these oral medications, other risks associated with illicit injection and opioid adverse effects. There is also the possibility of blood-borne infections if injecting pharmaceutical opioids, as well as the risk of harm from high doses of the simple analgesics with which codeine is combined in these OTC products. There is the ongoing risk of overdose, sometimes resulting in death, social dysfunction, mismanagement of pain and drug-seeking behaviour.

Victoria is looking at a looming crisis in pharmacotherapy policy. Governance is unchecked and there is a disproportionate balance of opioid management in the hands of a diminishing number of GPs.

- All patients on opioid maintenance therapy for addiction have to have a permit before the doctor starts prescribing. Permits last in perpetuity unless actively cancelled by the prescriber - at the moment there are more permits than active patients (i.e., about

³ Collins, D J & Lapsley, H M, 2008, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*, Canberra ACT

⁴ Coroners Court of Victoria, 2013

⁵ Policy for maintenance pharmacotherapy for opioid dependence, Department of Health and Human Services, 2016 pp 6-7

20,000 permits and about 13,500 active). There is currently no active oversight of these permits, and review of their continued relevance.

- Any GP can start pharmacotherapy (if they have received credentialed training they can prescribe methadone or buprenorphine, while all doctors can prescribe buprenorphine for up to 5 patients), which differs from some jurisdictions/countries, where patients requiring methadone (which is associated with greater morbidity and mortality, particularly in terms of overdose deaths as a result of take-away doses) be commenced by a specialist/government clinic.
- There are no limits on doses or number of patients allowed in a single prescriber's caseload, meaning that there are a small number of prescribers who hold hundreds of permits, and others that prescribe well above current clinical guidelines. There is currently no active oversight of these practices, which potentially leaves the community at risk of iatrogenic harm, and is counter to existing evidence on best practice.

There is currently no statutory body overseeing pharmacotherapy in Victoria other than the Department of Health and Human Services (DHHS) Drugs and Poisons division. Unlike some States which have a dedicated alcohol and drug section of government (e.g., NSW, SA, Tas) there is no clear governance. Victoria has rested on a tired assumption that its system is superior by pointing out that states like NSW have long waiting lists for opioid maintenance treatment and that Victoria's system is cost effective and normalises treatment of opioid addiction. The reality is that Victoria does not adequately fund pharmacotherapy support services, meaning that Victoria has few GPs and pharmacists who are able to manage the number of Victorians needing opiate pharmacotherapy, which is likely to swell with the introduction of real-time prescribing.

Australian training for doctors specialising in the treatment of addiction is provided by the Chapter of Addiction Medicine (under the Royal Australasian College of Physicians or RACP) and the Royal Australian and New Zealand College of Psychiatry (RANZCP). However, numbers of trainees and qualified addiction specialists are low, particularly in Victoria, due to a lack of investment in training and specialist positions. New South Wales by way of contrast has almost 10 times the numbers of addiction doctors in training as Victoria, as well as a number of funded specialist positions within each health service. The lack of a career pathway for doctors interested in pursuing a career in addiction medicine or addiction psychiatry means that Victoria is facing a future without such expertise, with an exodus of specialists to funded positions interstate in recent years, and many of the remaining cohort of addiction specialists nearing retirement.

While the Victorian NGO sector provides most of the care for treating substance use disorders in the community, it has always had limited access to medical support, dependent on private GPs or emergency departments for their most at-risk clients. In this setting, there is an overwhelming demand for provision of assessment and treatment in areas of clinical complexity, such as pain and addiction, pharmaceutical drug misuse, alcohol and liver disease, and methamphetamine dependence with comorbid mental illness.

For many years Turning Point has operated Victoria's Drug and Alcohol Clinical Advisory Service (DACAS), which provides statewide specialist addiction telephone consultancy services to health

professionals (predominately, GPs, pharmacists and hospital specialists). This service is widely utilised given the significant shortage of addiction medicine positions across the state, but is limited in its capacity to offer clinical consultations to patients in need of specialist assessment. With the introduction of real time prescribing, calls to this service are likely to grow substantially, and there is an urgent need to consider the capacity of the service to meet the expanded volume of calls. In addition, while Turning Point is one of the few services funded to provide specialist pharmacotherapy treatment, it is not currently able to meet the demand for addiction medicine and pain assessments in the community, and this will only worsen following the introduction of real time prescribing unless there is additional funding for such work across the state.

Co-ordination and training for addiction medicine specialists

In recognition of the looming crisis in addiction medicine positions, with funding from DHHS, Turning Point has recently appointed a Director of Addiction Training to oversee co-ordination and training of the limited number of addiction trainees across Victoria, as well as provide clinical support and supervision. Activities include:

- addiction psychiatry and addiction medicine registrar teaching and mentoring;
- training and mentoring of GPs, GP registrar and physicians/psychiatrists on addiction medicine placement;
- supporting direct clinical care placements and supervision.

As part of this initiative, Turning Point will review the existing addiction medicine specialist workforce and its sustainability, including a mapping of existing addiction medicine specialists in the public and private sector, a review of GP's current involvement in providing services and analysis of productivity data of addiction medicine specialists in Victoria and other jurisdictions. This work will culminate in the provision of a report that will provide a detailed summary of the short-term immediate gaps in the addiction medicine specialist workforce with recommendations that will take into consideration future demand patterns and supply of addiction medicine specialists over the next five years. Such findings will be critical to ensuring there is adequate addiction medicine specialist support for all Victorians.

1.2 Misuse of prescription medication in minimising drug-related health...

Recent years have seen increases in prescription of pharmaceutical opioids and benzodiazepines, and in associated harms.⁶ This presents challenges for clinicians and governments regarding appropriate monitoring and responses. Real-time prescription drug monitoring programs (RT-PDMPs) are being considered in Australia^{7,8} to enable detection of drug diversion (when drugs are transferred from a licit to an illicit channel of distribution or use), and inappropriate prescribing or dispensing. RT-PDMPs are supported by professional bodies, but challenges exist for policy makers in terms of capacity and coverage.

⁶ Dobbin M. Pharmaceutical drug misuse in Australia. *Aust Prescr* 2014; 37: 79-81.

⁷ Shand FL, Campbell G, Hall W, et al. Real-time monitoring of Schedule 8 medicines in Australia: evaluation is essential. *Med J Aust* 2013; 198: 80-81.

⁸ Ogeil RP, Heilbronn C, Lloyd B, et al. Benefits and challenges to the implementation of real-time prescription monitoring. *Med Today* 2015; 16: 65-68.

Capacity

The success of RT-PDMPs requires clear delineation of what information will be collected, who will have access to it, and how long records will be kept to ensure patient and practitioner privacy. Tasmania's RT-PDMP (currently the only Australian RT-PDMP) offers benefits over systems which do not provide real-time data,⁹ but other jurisdictional policy makers must determine whether their systems will be proactive (e.g., identify those at risk of abuse), or reactive and rely on prescriber and dispenser requests once a patient is deemed at risk. There is also concern that patients with genuine needs may not receive appropriate prescriptions for fear that they, or the prescriber, may be flagged as a misuser.^{10, 11}

RT-PDMPs pose challenges regarding the capacity of health and/or law-enforcement departments to respond. In Australia, 55,000 people were identified as doctor-shoppers in 2005–06.¹² The ability of the current system to meet these demands is lacking, with prescribers estimated to be notified in only 5% of doctor-shopper cases.¹³

An RT-PDMP will increase demand for professional development and specialist support for addiction and pain management, a particular challenge given the current gaps in training and significant shortages of relevant specialists. Potential RT-PDMP administrators, including health and law-enforcement bodies, will need capacity to analyse, interpret and disseminate findings through suitable channels, with necessary policies in place to facilitate appropriate responses.

Coverage

The proposed RT-PDMPs seek to monitor only S8 medications.¹⁴ Some opioids (e.g., tramadol and codeine) and benzodiazepines (except alprazolam and flunitrazepam) will be excluded, despite their contribution to harm. Such reduction in capacity decreases the ability to investigate possible shifts in prescribing habits towards non-monitored medications. One solution involves staged inclusion of other drugs to respond to changes in prescribing trends, and as new drugs become available.¹⁵

To be effective, an RT-PDMP must collect Pharmaceutical Benefits Scheme and private prescription data, and flag potential misuse and diversion at the time of prescribing and dispensing. Diversion can also occur after dispensing (e.g., drug sharing and online sales

⁹ Shand FL, Campbell G, Hall W, et al. Real-time monitoring of Schedule 8 medicines in Australia: evaluation is essential. *Med J Aust* 2013; 198: 80-81.

¹⁰ Ogeil RP, Heilbronn C, Lloyd B, et al. Benefits and challenges to the implementation of real-time prescription monitoring. *Med Today* 2015; 16: 65-68.

¹¹ Islam MM, McRae IS. An inevitable wave of prescription drug monitoring programs in the context of prescription opioids: pros, cons ad tensions. *BMC Pharmacol Toxicol* 2014; 15: 46.

¹² Dobbin M. Pharmaceutical drug misuse in Australia. *Aust Prescr* 2014; 37: 79-81.

¹³ Hore-Lacy D. Findings on death of case number 3236 of 2005. Melbourne: Coroners Court of Victoria, 28 November 2007.

¹⁴ Shand FL, Campbell G, Hall W, et al. Real-time monitoring of Schedule 8 medicines in Australia: evaluation is essential. *Med J Aust* 2013; 198: 80-81.

¹⁵ Ogeil RP, Heilbronn C, Lloyd B, et al. Benefits and challenges to the implementation of real-time prescription monitoring. *Med Today* 2015; 16: 65-68.

including cryptomarkets which enable online purchaser anonymity),¹⁶ but research in these areas is limited. Diversion cannot be entirely identified by RT-PDMP, which highlights the need for clinicians to adopt safe prescribing practices and communicate clearly with patients about their responsibilities.

RT-PDMP may become available outside Tasmania, but issues of coverage and capacity require policy maker attention before implementation to ensure more appropriate monitoring of prescription medications.¹⁷

2. The practice of other Australian states and territories and overseas jurisdictions...

The Australian context...

Across Australia the challenges posed by alcohol, drugs and gambling, and the tools available to address them, are constantly changing. For example, Australia is experiencing^{18 19}:

- shifting patterns of substance use, particularly poly-drug use;
- availability of new psychoactive substances;
- an expanded range of pharmacotherapies and other treatment options;
- increasing harms related to prescription drug misuse;
- greater awareness of co-existing mental health disorders and multiple morbidities, especially in the context of an ageing population;
- greater awareness of foetal alcohol spectrum disorder, child protection and family-sensitive practice issues;
- problematic AOD use across a widened age spectrum;
- greater emphasis on cost efficiency, professional practice efficacy, improved outcomes and inter-sectoral collaboration;
- a better understanding of effective preventive measures;
- greater recognition of the wide variety of workers involved in reducing AOD-related harm; and
- greater recognition of the significant harms associated with gambling, impacting on gamblers and their families, employers and friends.

The Portugal solution...

Since 2001, Portugal has decriminalised all drugs and made the possession of a small quantity of drugs a public not a criminal issue. Drugs are still illegal but getting caught with them means you are likely to receive a small fine and referral to a treatment program not jail and a criminal record. If someone is found in the possession of less than a 10-day supply of anything from marijuana to heroin, they are sent to a three-person Commission for the Dissuasion of Drug

¹⁶ Phelps A, Watt A. I shop online – recreationally! Internet anonymity and Silk Road enabling drug use in Australia. *Digit Investig* 2014; 11: 261-272.

¹⁷ Ogeil RP, Heilbronn C, Lloyd B, et al. Benefits and challenges to the implementation of real-time prescription monitoring. *Med Today* 2015; 16: 65-68.

¹⁸ National Alcohol and other Drug Workforce Development Strategy 2015–2018.

¹⁹ <http://www.problemgambling.gov.au/facts/>

Addiction, typically made up of a lawyer, a doctor and a social worker. The commission recommends treatment or a minor fine; otherwise, the person is sent off without any penalty. The majority of the time, there is no penalty.

Portugal shifted drug control from the Justice Department to the Ministry of Health and instituted a robust public health model for treating serious drug addiction. It also expanded the welfare system in the form of a guaranteed minimum income. Changes in the material and health resources for at-risk populations for the past decade are a major factor in evaluating the evolution of Portugal's drug situation.

Among Portuguese adults today, there are 3 drug overdoses for every 1,000,000 citizens compared to 10.2 per million in Netherlands, 44.6 per million in the UK. The EU average is 17.3 per million. In Australia it is 88.1 per million people.²⁰

2.1 How other positive reforms could be adopted into Victorian law...

Freeing up resources to provide more effective responses to alcohol and drug-related problems is the most valuable lesson public policy can learn from other jurisdictions. The Portugal model is at one end of the spectrum but there are examples of harm reduction strategies that Victorian law could implement that would have a significant impact such as:

- i. **Medically supervised injecting rooms.**
There is robust evidence from Sydney and internationally showing the effectiveness of supervised injecting rooms in reducing opioid-related morbidity and mortality, public injecting, HIV risk behaviours, and increasing the uptake of addiction treatment among hard-to-reach populations. As such, Victoria should consider a potential pilot of supervised injecting facilities for a minimum of three years, with independent evaluation conducted to establish effectiveness across a range of domains, including:
 - impact on opioid overdose (including ambulance call-outs, overdose presentations to emergency departments, and opioid related deaths)
 - number of overdoses managed within the supervised injecting facility
 - numbers of referrals to treatment and other support services
 - impact on incidence, prevalence and new diagnosis of injecting drug use related blood born viruses;
 - public amenity (including discarded syringe counts and community perception); and
 - economic benefit.

- ii. **Prison needle and syringe programs**
The public health case for prison-based Needle Syringe Programs (NSPs) reflects the reality of ongoing criminalisation of drug use and the routine incarceration of people for drug-related crime. People who inject drugs are over-represented in Australian prison

²⁰ Source: The United Nations Office on Drugs and Crime (UNODC) '2015 World Drug Report'.
www.unodc.org/wdr2015/

population, are the primary hepatitis C risk population in Australia²¹, and are also at elevated risk of acquiring HIV compared to the general population²².

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²¹ Department of Health (DoH). (2014). *Fourth National Hepatitis C Strategy 2014–2017*. Commonwealth of Australia.

²² DoH. (2014). *Seventh National HIV Strategy 2014–2017*. Commonwealth of Australia, Canberra.