

Consultation Questions

National Pharmaceutical Drug Misuse Strategy

Read these questions in conjunction with the Discussion Paper from which they are derived. Select and address only the items of relevance. Retain numbering as shown below.

Question 1

Are there any other key stakeholders of relevance to the development of the NPDMS?

Question 2

Are there any other significant gaps in our knowledge?

At the moment, the gaps in our practice are more pressing than the gaps in our knowledge. We already know that the current situation is unacceptable and we could do better by acting upon what we currently know.

Question 3

How do factors impacting on the social determinants of health impact on the misuse of pharmaceuticals?

Whilst the social determinants of health should always be born in mind, and there is a pressing need to redress some of the more glaring inequities at the moment, it is also true that clinical services could and should do better. Poverty is not helped by, for example, chronic benzo intoxication - but we frequently hear from GPs "I had to do something, she has so many problems" as the justification for poor prescribing practices. Our rural and Aboriginal patients certainly suffer because of health inequities, but the solution is not more pills. It has proven difficult to get this message across, however. At the level of clinical intervention, in rural areas the lack of effective, sustained, accessible mental health and drug and alcohol services, combined with the current make up of the rural GP workforce, ensures that early intervention is unlikely to occur, and harm maximising prescribing practices become common. This shall be addressed in my response to Question 13.

Question 4

How do these agendas and strategies impact on Australia's responses to pharmaceutical drug misuse?

Question 5

How do the current operations of the PBS contribute to, or reduce, the misuse of pharmaceutical drugs?

The difficulty gaining access to, and cost to the patient of, methadone and buprenorphine compared to the ready availability of cheap prescription opioids certainly drives a good deal of the current dubious use of prescription opioids. The paperwork required to prescribe legally, vs that required to get the patient out the door quickly, is also an issue. Why do we make buprenorphine such a hassle to prescribe, when the alternative is often a quick script for OxyContin? This is not a new issue and was discussed by NSW Health when bup was introduced. Is bad practice acceptable so long as the various regulatory agencies can offer plausible deniability for the consequences? These problems were predicted by NSW Health PSB Inspectors years ago when they were "rationalised", and the lesson for the future is that health services need to adopt an action research approach when practices are changed - even if the change is for financial or political reasons, the consequences need to be monitored and the change reviewed.

Question 6

What role do police agencies and other law enforcement agencies have in responding to problems of pharmaceutical drug misuse?

Question 7

To what extent are pharmaceutical drug misuse problems impacting on policing agencies in different jurisdictions

Question 8

What can we learn from other countries' experiences with problems with, and responses to, pharmaceutical drug misuse?

From the US we can learn, at least, that if we become focussed on illicit drugs alone to the exclusion of any rational discussion about relative risk of all drug use, something David Nutt has addressed lately in the UK for example, then we will get a big, expensive, and growing problem. This is more likely to happen when politics intrudes too much into health care, and we really need a powerful lobby group to reclaim D&A problems as health business, and get the discussion away from law and order or prison building.

Question 9

What, if any, unintended consequences might be expected in Australia if levels of access to medications such as opioid analgesics were to be reduced? What strategies could be put in place to avoid these unintended consequences?

This may depend upon what mechanism was used. I am told by UK colleagues, for example, that they never prescribe opioids except to people seen and managed by the palliative care team and who have a diagnosis and care plan. This may prejudice people with non cancer pain, for example, and of course we hear that in any case at least some diverted drugs come from people with cancer (or their family or carer). I believe the evidence suggests we need more opioids in palliative care patients, and of course less diverted by those who do not need opioids, so to me it is not clear whether we need more or less opioids - but we do need a more rational, justifiable and health promoting distribution. Enhanced access to OST combined with tightened controls over prescription opioids would be a start, since the total percentage of the population strongly desiring to use opioids probably remains pretty constant, the rules just determine how expensive it will be to the community and what collateral damage will occur.

Question 10

To what extent is there a current evidence/practice gap in Australia concerning the use of opioids for CNMP?

I think this term, along with "pain killer", is not helpful and should no longer be used. Not all people with cancer have pain, and the term "chronic non cancer (or non malignant) pain" tells us nothing except the person does not have cancer. It tells us nothing of the pain, or of the person, or of their psychological make up and risk profile for misuse or dependence. And the literature tells us that many of these people have somatisation disorder, which we scarcely recognise, let alone treat well. Chronic pain is not acute pain, but that is often how it is managed, as a series of acute events, and CNMP is then too often used as a unitary diagnosis to justify prescribing opioids. We need a new term for chronic dysphoria and we need to better understand somatisation and illness behaviour. This will not happen by training medical students at teaching hospitals or acute psychiatry units.

Question 11

To what extent is there a current evidence/practice gap in Australia concerning the use of

benzodiazepines for conditions such as anxiety and insomnia?

To a very great extent. The literature and College recommendations are pretty clear that chronic use is not acceptable, but many of our medical students are still told, usually by psychiatrists, that short term use of benzos is good practice! Most students seem to have no idea how to address insomnia, except with a prescription, and much the same is true of anxiety. Gavin Andrews, and others, have long pointed out that new doctors need to learn more about the common mental health problems including anxiety, but so far that is not the case. The RACGP/RANZCP JCC recommended in 1996 that new doctors need to know how to manage the mental health and D&A problems that most commonly present to hospital A&E Depts, including anxiety, panic and its manifestations, poor sleep etc, but med students still learn little or nothing about these. I presented a paper to the AMC Conference many years ago suggesting that current training did not adequately prepare new doctors for the common conditions they will encounter, especially mental health and D&A, but it did not generate any ongoing discussion. This harm maximisation process is poorly addressed at the under and post graduate levels, despite the significance of the problems thus caused and our duty to first do no harm. Students learn more about schizophrenia (with an incidence of 1%, where each GP will see about 3 new cases per lifetime) than about anxiety and panic or alcohol dependence, which affect about 20-30 times more people. If they intuitively managed these issues well, this might be acceptable, but clearly on becoming doctors they do not.

Question 12

Is there other evidence of harms stemming from pharmaceutical misuse?

They are pretty well documented in the discussion paper. Maybe we need to add more about child neglect and abuse when parents are chronically intoxicated, and the risks from third parties when parents display poor monitoring and supervision of their children. There is also the issue of opportunity cost - what else could or should have been done in that pill prescribing consultation and what are the consequences of the action taken vs the other choices. Many people seen in our detox unit for example cannot see a doctor without seeking a pill, and are surprised when we discuss other things which doctors can do. Some of them have suffered significant neglect with respect to treatable health problems, such as hepatitis, CAL, hypertension or diabetes, because they only ever see doctors for pills. But this is socially learned, not innate, behaviour, so it is our business, and we cannot blame the patient.

Question 13

Certain groups in the community (such as those living in rural areas and those experiencing social disadvantage) appear to be disproportionately affected by levels of harm associated with pharmaceutical drug-related problems. What could be done to address this in a targeted way?

This is the big issue I wish to address - but where were these issues discussed in the paper? This issue just pops out of the blue in the discussion paper - but 30% or so of Australia's population live in rural or remote areas. I shall address this issue in a separate appendix - see below.

Question 14

To what extent is Australia's Prescription Shopping Program able to impact on the misuse of pharmaceuticals?

Not very well - it has a high threshold, does not take account of group practice set ups, and most GPs and specialists do not use it anyway.

Question 15

How effective is Australia's current approach to the regulation and monitoring of these medications and how could the current approach be improved?

Clearly not very effective. For example, even when prescribers present regulatory bodies with solid evidence of poor prescribing over many years, action seems to take several

more years. I speak from experience with 3 major offenders. First we need to agree on what is appropriate prescribing, and that may be difficult. We need to agree that specialists may be as much at fault as GPs, or else we persist with the current view that a specialist letter can justify otherwise unacceptable prescribing. Real time information is needed, and then prescribers advised that their practice must take this into account, so there is little excuse for prescribing to doctor shoppers for example. Better use can be made of the data collected by retail pharmacists - they are generally very well connected in real time and could be better used to monitor prescribing and feedback data to GPs and regulatory bodies.

Question 16

What are the key issues that arise concerning the balance between measures which are intended to enhance the quality use of medicines (such as a CMMS) and the needs to protect the privacy of patient information?

Over the years, patient privacy has been used by many bodies to screen unprofessional behaviour. It is now clear that, far from protecting a patient's rights, many agencies simply refused to share legitimate health information with workers who had a need to know, and this has been specifically addressed in new legislation (at least in NSW). If a person has been doctor shopping, or consuming many potentially dangerous medications, then this is information any potential treating doctor needs to know. There may be a fear that this person will then be stigmatised or turned away, and that is possible - by contrast, what we have at the moment is that the person gets their pills, as a result of which harm is increased and people sometimes will die, as Martyres pointed out years ago. So the balance at the moment is harm and cost maximising, and we could do better. I would accept the risk of stigma as preferable to the risk of death, and with sufficient role modelling, training and support, we could reduce the risk of both anyway.

Question 17

Are there any measures that could be introduced in the short term that would enhance our ability to monitor the prescription and dispensing of these medications?

Ask the pharmacists, especially the locums in rural areas. They see the same people all over the state picking up, and the same doctors names on scripts in many different towns - there is a message here and the data is already collected.

Question 18

How are the current prescriber remuneration patterns impacting on patterns of pharmaceutical drug misuse?

A prescription is always quicker than a full and frank discussion about, say, poor sleep or anxiety. The Commonwealth has just cut the rebate for a mental health assessment as well, as if to show they have no idea whether they want GPs to do more, or less, of this work. Even if the prescriber prefers a discussion, third parties such as medical centre owners have a profit maximising agenda. I am aware of 4 GPs who became increasingly involved in addressing complex mental health and D&A issues, and ended up leaving general practice for salaried or specialist positions, so evidently it is still difficult make a living and address these problems well. I believe it IS actually possible to address these issues in GP, BUT better more targeted, relevant training and support is needed.

Question 19

To what extent is OST accessibility and dispensing fees impacting on patterns of pharmaceutical drug misuse?

In rural NSW at least, OST services are pathetically inadequate, with the few existing places filled with high risk or pregnant people, or those just out of jail. As an experienced D&A physician, I still find it hard to explain to a rural person, eminently qualified to receive OST, why it will not happen in the foreseeable future. How does a GP cope? - many offer a "quick script" for opioids, believing they are helping, and thus the ongoing problem begins. Once the word is out, all the desperate people, and those keen on a new income

stream, will visit that GP, and having heard he or she will prescribe, they can be quite persuasive. This certainly became a big issue in the NT some years back, but it continues in NSW today. Much of the poor prescribing I have seen over the years began as good intentions - though it then takes on a life of its own. OST MUST be available across the region, ideally on the day the person presents. Less than this is not acceptable, and once again maximises harms (and costs). If NSW Health cannot address this need, then the funding should go elsewhere, because the community is paying for these problems whatever happens.

Question 20

To what extent are the current patterns of availability of adjuvant drugs impacting on patterns of pharmaceutical drug misuse?

I believe most opioid users prefer opioids, but the logic behind why some drugs are on the NHS and others are not seems difficult to follow at times. Perhaps the politicisation of the PBAC has something to do with it?

Question 21

To what extent are these difficulties impacting on patterns of pharmaceutical drug misuse?

Whilst the quality of advice and support from pain clinics is often patchy, a bigger issue is getting people in for assessment, especially from rural people. A better pain service, including a visiting and teaching/role modelling service, is highly desirable.

Question 22

To what extent are problems with hospital to community transitions impacting on patterns of pharmaceutical drug misuse?

Question 23

To what extent would a CMMS enhance the QUM in Australia?

Better quality, timely, relevant information could scarcely make matters worse. Whether a CMMS alone would change practice needs to be seen - my choice is for the carrot and the stick. Once the data is available, prescribers are reminded that they are expected to use the data, and hiding behind "I did not know" would not be acceptable. This probably means a return to having PSB inspectors as well, though their role should be initially advocacy and educative.

Question 24

How could Australia's data collection and sharing processes in this area be enhanced?

I am wary of conflating health care and punitive processes, so any data offered to law enforcement, for example, should be de identified unless the patient is being charged.

Question 25

Are there any other gaps in the research?

First we need to act upon the existing research. We have enough information to say the current harm maximising situation is not acceptable. Once we introduce changes, we need an action research process to monitor and fine tune the changes. Adopting a community based participatory research (CBPR) approach, where the prescribers and pharmacists are the community, would be the answer, as it would avoid the current 20-30 year evidence to practice gap that we seem to accept at present. We are to some extent addressing this with our Murdi Paaki CBPR approach, but NSW Health could come on board as well instead of trying to run a separate D&A service.

Question 26

What other clinical responses are required?

These seem well documented. Can we please request the same level of services in rural

Australia as in the capitals, some equity of service distribution?

Question 27

What other workforce development responses are required?

See response to Q26. In addition, see my attached response to Q13. In addition, why not look at a CBPR approach, as I noted in Q25 - GPs are, in my experience, tired of being told what to do by hospital based (non community) specialists, especially rural GPs. So, they stay away from didactic training, but can be engaged when the "experts" respect the realities of rural GP work, and share in a joint problem solving approach. The GPs need to be an engaged, active part of the solution.

Question 28

What other consumer-oriented responses are required?

Less pseudo scientific waffle and more accurate information about risks and benefits of various medications in the mass media may help, but at the moment when we are seeing a tidal wave of rubbish about weight loss preparations and magic vitamins and minerals (a different special preparation for each demographic, apparently), this seems unlikely to happen. And can we ban the words "pain killer" from professional discourse at least - we know that the need to kill pain, to be 100% pain free, is one hallmark of the dysfunctional and at-risk user, whereas pain clinics speak of a 30-40% pain reduction.

Question 29

Are there any other potential contributions that technology could make?

Question 30

To what extent is Australia's current self-regulatory approach to the marketing of pharmaceuticals effective?

Other issues:

If you wish to address issues not covered in the above questions, please do so at the end of your submission.

Q13: Certain groups in the community (such as those living in rural area and those experiencing social disadvantage) appear to be disproportionately affected by levels of harm associated with pharmaceutical drug-related problems. What could be done to address this in a targeted way?

There are a number of factors which, when combined, lead to the increased level of harm in rural areas. My experience is in rural NSW over the last 30 years, with shorter periods in Cairns, Hobart and Launceston, and providing a visiting service to most of western NSW over 8 years. In addition, our team interacts with most primary care workers in our smaller towns, including GPs, and draws on much experience talking with, listening to, training and interacting with the workforce. The following issues are raised in no particular order, and it is our team's belief that only a multi pronged approach, addressing all of these issues, will reduce the rural area's excess morbidity and mortality.

Rural GPs: most are excellent and have worked tirelessly for decades. Many provide hospital cover and run routine surgical and anaesthetic lists. Some have no interest in mental health or D&A, and when these jobs are "left to" female doctors, juniors and registrars, deemed to be more suited to or interested in this work, we often hear, there can be problems. If a doctor gets a reputation for addressing these complex issues, their workload of complex patients grows, and their income drops if they do the job diligently. Their procedural colleagues regard it all as their own fault, and role legitimacy and job satisfaction can suffer. Some leave general practice to do more training or salaried work,

some resume procedural work, and some become suffocated by the load they draw to themselves. Some have lost their S8 prescribing rights in time. All this suggests that the current responses attempting to address these complex issues in a rural GP setting, are not sustainable. One established solo doctor, who does prescribe benzos and opioids, told us "I know you are right [about poor prescribing], but I cannot fight everyone, all day. The government needs to help us, to protect us, from this onslaught".

The other group of rural GPs: This includes rural registrars, and locums and temporary doctors, who again are often excellent. But most are not trained in dealing with anxiety, sleep problems, chronic pain etc. They can respond to such a presentation in a number of ways, but often we hear it is easier to give the person the tablets, because they are only a temporary doctor and there is no point in arguing when previous (and one imagines, subsequent) doctors will do just the same anyway. One GP Registrar told us that during her 6 month term, about half her work was prescribing benzos and opioids to those who had taken them for years, it seems, even though she initiated no new prescribing. She knew it was poor medicine, and is otherwise a very ethical practitioner, but did not feel it was her job to change existing management practices, especially if the partners at the practice would not support her. Another locum in a big rural practice said "I just give in, it is easier, most of us do but we don't like to admit it". An RFDS registrar said "I gave her [a 22 year old girl who looked intoxicated] some Valium and Panadeine Forte, she said she had lost her scripts. I'm not sure it was right, but what else could I do?". There seems to be a total lack of training in the risk:benefit ratio in prescribing, and a poor understanding that treating chronic pain just like acute pain is not good medicine. But many locums and registrars are perhaps just trying to get through the attachment.

#Most GPs we talk with prescribe at least some benzos and opioids, and many psychiatrists also do so, and what seems clear is that Gourlay's "universal precautions" needs to be implemented. Each doctor trusts their own patients, and firmly believes that pills on the street could not come from their patients. If they are all correct, where do the pills come from? Our informants tell us that low level dealing by many people, including little old ladies and people with "real" health problems like cancer and osteoporosis, is the most common situation where prescription drugs are obtained. But when confronted with good evidence of dealing or misuse by their patient, many doctors do not believe us, or blame their patient for "deceiving" them, so this is quite a challenge.

We have suggested to many practices that they could and should protect their locums and new doctors, the new doctor in town usually being bombarded in the first week or two by people seeking a quick script, for which the doctor is totally unprepared. This could be done by forbidding the new doctor to prescribe these drugs without discussion with a senior partner, for example. In some settings there is no senior partner, in some the partner is a happy prescriber himself, but some have attempted this approach with mixed success. If the new doctor provides a prescription, the flood gates open and people begin to appear from far and wide, it not being uncommon for rural pill seekers to drive for hours if there is a reliable source of supply. The implications for high speed motor vehicle crashes is a major concern, amongst others.

We regularly do a workshop for the new rural GP Registrars on rational prescribing and doctor shoppers. All of them are aware they are targeted each time they move practice and we try to run this training early each term change. At a recent meeting, the next speaker was a lawyer from a medical defense organisation, who confirmed our concerns by noting that the big growth in his job was in new doctors charged with improper prescribing of benzos and opioids, which had often began when they gave in to one intimidating person only to find that once started on this path, there is no happy solution. New doctors need to be protected whilst they learn to manage these people and these complex issues. The same applies to young doctors in A&E departments, where there can easily be a policy of no benzo and no opioid dispensing or supply unless discussed with a senior practitioner, and where a consultation/liaison D&A worker should usually be

involved. It is all too easy to give apparently demanding or difficult people "what they want" (they probably want to feel happier and healthier, but have learnt to accept intoxication as what our community offers) without being aware of the often serious consequences. For example, a causal chain analysis of events after a mother and daughter helicopter evacuation to an urban intensive care unit revealed that a quick prescription of benzos and tricyclics to both had precipitated the final drama, but the prescriber had no idea of these consequences or of his role, and later preferred to believe that they had disobeyed his instructions. Perhaps feeding back information to prescribers after such events will help at least some appreciate the risks of careless prescribing?

The lack of an alternative in the form of an effective OST when people admit their opioid dependence has been alluded to already. Most GPs feel a need to act, and are not comfortable saying "I can do nothing". So we know of many people with a well documented history of opioid injecting, now being "converted" into a chronic pain patient, to justify, if that is possible, their being prescribed opioids carte blanche. And all too frequently, benzos as well. Whilst we cannot support this high risk practice, the lack of a legal, safe alternative puts GPs in a difficult position, and many convince themselves that they are practicing harm reduction. Even when OST is available, it is often in a distant town, or travel to a distant town is required for start up and review, and there is little or no public transport. And of course if a girl receiving OST should become pregnant, then the system often cannot cope, and often she will feel pressure to cease treatment, usually leading to a poor outcome. We must make the preferred, healthier, and ultimately cheaper option easier and more attractive than the current harm maximising one.

Per capita consumption of alcohol is higher in rural than in urban areas, for complex reasons beyond this response, but it is our contention that many people presenting to their doctor with anxiety, sleep problems and many others problems are in fact alcohol dependent. There seems very little understanding of how alcohol using or dependent people present, and very little understanding of the risks of adding benzos to this situation. Governmental responses have included allowing extended trading hours for hotels and permitting new products with glossy advertising to saturate the market, whilst ignoring evidence of what will work in reducing consumption and harms. Effectively addressing excess alcohol use in rural areas, and targetting health workers to be more aware of early, brief interventions and harm minimisation approaches, may help reduce benzo use at least.

That will probably do. I hope you get the idea that we could, with a little effort, do a lot better than at present.