

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?

Pharmaceutical misuse is an emerging trend in Australia. It has, in part, been difficult to quantify the harm as it has only recently received attention from researchers and policy makers. In part, developments in other Western nations (such as the USA and Canada) provide a rough road map as to the potential harms and crisis which can emerge if this issue is neglected.

Further research should be undertaken with reference to pharmaceutical misuse:

1. Harm minimisation strategies (Hallinan et al 2011:321);
2. Building the skill base of pharmacists to recognise and manage patients who may be misusing (Sproule 2011:327);
3. The application of non-pharmaceutical treatment into pain management plans;
4. The socio-economic factors which contribute to a glut of consumption of legal opioids in wealthy countries (Hallinan et al 2011:317);
5. The drivers of diversion, including the prevalence of certain methods of diversion and the socio-economic trends which contribute to this practice;
6. Fatalities with an immediate or partial relationship to pharmaceutical misuse;
7. Data on the quantity of presentations to treatment for pharmaceutical misuse with a breakdown of pharmaceutical type;
8. Information on best practice treatment modalities as well as those best placed to deliver treatment;
9. The impact of pharmaceutical misuse on demographic indicators such as employment, family breakdown, wellbeing and crime;
10. Pharmaceutical misuse by medical practitioners;
11. The dynamics of pharmaceutical misuse with regard to an expanding ageing population.

Question 3

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

As noted in the literature review for the NPDMS (NCETA 2011:22), drug toxicity is a disproportionate factor in fatalities from those in lower socio-economic community group as well as those living in regional and rural communities. VAADA has long been calling for recognition and policy development towards an integrated model of care which builds on the myriad of adverse social determinants which contribute to social disharmony and harm. These social determinants are highly prevalent in low socio-economic communities and therefore this strategy should, in tandem with other commonwealth and state instruments, contribute to the recognition and development of integrated policy and programmatic activity across the raft welfare service systems. Studies which can inform these strategies have been undertaken (see Vinson 2007).

Neilsen et al (2011:296) cite that heroin users and non prescribed use of pharmaceutical

opioid analgesics (POA) share a number of similar demographic characteristics in areas such as accessing health services, as well as employment and education levels. Moreover, POA use is greater in areas which heroin is scarcer, suggesting perhaps that there are specific social determinants and demographic push factors which contribute to the dynamic of substance misuses, with the only variant being the type of substance available.

Economic factors can create perverse incentives; for instance, dispensing fees can be prohibitive for some people to access pharmacotherapies and therefore may drive individuals to misuse pharmaceuticals or other illicit drugs, resulting in more harm and typically already marginalised individuals encountering financial barriers to treatment.

Question 4

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

As noted above, related strategies should be seamlessly integrated to ensure that there is a consistent approach to working with relevant stakeholders. These strategies ameliorate issues relating to fragmented service systems.

Question 5

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

The PBS is a very valuable scheme for the health of all Australians and should be protected against those who try to change it for their own vested interest (eg large drug companies). The assessment system to get drugs on (and off) the PBS has got high community credibility and acceptance.

There is a need to ensure that opioids and other medications are readily accessible so as to not strengthen the market for diversion of pharmaceuticals. If individuals with severe pain or anxiety are unable to obtain medication at minimal cost, the market for diversion will grow as well the entry into illicit drugs. Moreover, effective pain management enhances community wellbeing.

Dispensing fees for pharmacotherapy participants highlights an inconsistency with the PBS; as noted in question 3, these fees can be prohibitive to participation and may create a perverse incentive for individuals to obtain cheaper medication which may result in greater harms.

Question 6

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

This is first and foremost a health related issue so health and treatment related remedies should be applied in lieu of law and order.

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?

As noted in question 2, other western countries pharmaceutical misuse has progressed beyond the current challenges in Australia. In the USA, prescription drugs are the second most abused category of drug after marijuana (Office of National Drug Control Policy 2011:1) and in 2005, the fatalities resulting from pharmaceutical drugs has surpassed

that of heroin and cocaine combined (Fischer, Bibby and Bouchard 2010:2063). It is clear that pharmaceutical misuse can flourish and emerge as a major problem if it is not contained.

Thus, other western nations can be used as a barometer to gauge the severity of these problems and their responses to these challenges can be assessed.

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?

Were access reduced, or heavily regulated prescribers may be less willing to prescribe the appropriate medication; they may opt for less effective, but less regulated medication (NCETA:2011:142). There are already a number of challenges and difficulties in pain management, including access to pain management clinics as well as expert support for prescribers. The difficulties inherent with limited access to support from experts would exacerbate system issues and likely result in a illicit means of obtaining the desired medication. This could result in involvement with the criminal justice system and hence the emergence of a new subgroup of criminals. This would have a high social and financial impost.

VAADA is supportive of the introduction of a Coordinated Medication Management System (CMMS) however have some reservations regarding patient confidentiality, as well as the retention of information on the CMMS. Patients should be able to obtain access to information on a CMMS and dispute misrepresentative entries.

VAADA is conscious that the introduction of a CMMS would necessitate the inclusion of a sound health literacy development strategy so patients can make informed decisions and be aware of how such a system may impact upon them.

Question 10

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

The lack of conclusive evidence highlighted by NCETA in their literature review (2011:112) regarding the efficacy of opioids in relieving long term pain leads to the need to undertake comprehensive research in to the best treatment modality in countering chronic non-malignant pain (CNMP).

Accessibility to pain management clinics as well as integrated care to support patients with the side effects of long term usage of pharmaceuticals as well as any substance dependence issues is crucial to ensuring a high level of care.

Limited access and support from pain management experts for GPs often defaults to long term prescribing of pharmaceuticals for pain relief. Further, as asserted by Hallinan et al (2011:17), 'chronic non-cancer pain may be compromised by medical payment schemes that do not reflect the time burden of thorough assessment and multidisciplinary care'. VAADA calls for a review of the medical payment schemes with a view to promoting an integrated interdisciplinary model of care which is appropriately resourced.

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?

Table two n NCETA (2011:66) indicates that benzodiazepines prescribing rates are coming down rapidly in Australia - 8% between 2002 and 2009. The only exception is for the short acting Alprazolam which has increased 28% over that period

Do we know why Alprazolam is becoming so popular? Is there any evidence that it is a better drug than the other benzodiazepines for treating anxiety to justify this increase? This increase is in spite of Medical Board warnings to doctors over recent years to be beware of the special risks of addiction and behaviour problems arising from this drug. Further questions arise: Why are the Alprazolam packages available on the PBS with repeats where all the other benzodiazepine scripts are not allowed repeats.

If Alprazolam causes so much more problems than other benzodiazepines why is it not withdrawn from the Australian market by government. Why is it not a drug that requires a permit (at least in Victoria) like the other dangerous short acting benzodiazepine flunitrazepam.

Question 12

Is there other evidence of harms stemming from pharmaceutical misuse?

There are a number of harms which can stem from pharmaceutical misuse:

1. the impact on occupational health and safety;
2. the increasing trend of consuming alcohol whilst using pharmaceuticals (Lloyd and McElwee 2011:275)

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?

Pharmaceutical misuse appears to be more prevalent in regions where access to illicit drugs is limited (such as the Northern Territory and Tasmania and in some rural and regional areas). VAADA recommends that this strategy support the development of local models of integrated care and bolstering programs which enhance social inclusion.

Question 14

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

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?

As highlighted by NCETA in their literature review (2011:133), Australia has some limitations in tracking and monitoring pharmaceuticals due to jurisdictional differences between states and a lack of monitoring capacity to trace opioid prescriptions to individual patients. These issues could be ameliorated through the standardisation of monitoring throughout Australia and the introduction of a real time monitoring system such as a CMMS.

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?

VAADA would recommend that a CMMS is secure, has clear access points for patients wishing to view and applying to modify their records and is transparent. It would be highly concerning if medical practitioners were able to input data on the system without the patients consent which was detrimental, or misrepresented the patient. Safeguards protecting privacy and the veracity of the information are crucial.

The development of a CMMS would likely elicit new means of trying to beat the system, such as the unlawful procurement of medicare numbers and identity fraud.

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?

Question 18

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

Prescribers must be supported to ensure that they have the time, resources and referral capacity and knowledge to ensure that they can deliver a high level of integrated care as they are often have the first opportunity to identify health difficulties in their patients. The current system supports an output based model, rather than outcomes. This promotes prescribers seeing a high volume of clients and thus illustrates that prescribers are not remunerated adequately to treat patients with complex needs (Drugs and Crime Prevention Committee 2007:406).

Question 19

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

VAADA has asserted in our 2010/11 State Budget Submission (2009:30-1) that dispensing fees must be abolished in order to maximise accessibility to the program and therefore maximise the health benefits realised through the reduction of harm to the individual and the community. Dispensing fees create financial restrictions, which, coupled with the other difficulties - which in Victoria - amount to a lack of access and equity as well as a fragile workforce, lead to an inefficient use of a program which has a sound evidence based for reducing harm and costs to the community.

Question 20

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

Question 21

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

The waiting times for access to pain clinics create significant challenges for accessing alternatives to pharmaceuticals. Given the massive expansion in opioid use, as well as the growing older population, pain is becoming a significant issue on the healthcare landscape. This strategy should emphasis integrated care, increase in pain treatment services and a monitoring process to identify risk of dependance or harm relating to pharmaceutical use.

Question 22

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

There is a need for liaison between hospital discharge staff and the patient's GP to ensure that the GP is aware of the treatment and medication the patient received. Further, a review of the hospital dispensing practices should be undertaken to ensure that the amount of medication provided is commensurate with the need.

Question 23

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

A CMMS, with the appropriate safeguards as discussed in response to question 16 above, would provide prescribers with information regarding pharmaceutical misuse earlier than the current system and would therefore enhance prescriber confidence. Care

would need to be given to ensure that it does not deter prescribers from prescribing appropriate medication. However, the efficacy of a CMMS without the appropriate system changes regarding the development of a remuneration system which supports prescribers engaging in integrated care would be greatly attenuated.

Question 24

How could Australia's data collection and sharing processes in this area be enhanced? This has been discussed in questions 16 and 23.

Question 25

Are there any other gaps in the research?

The impact of pharmaceutical marketing on public consumption.

The use of demeaning language to describe individuals with substance dependence issues and how this restricts patient access to services as well as wellbeing.

The need for evidence on the level and harm resulting from fraudulent presentation of opioid prescriptions.

Question 26

What other clinical responses are required?

There are a wide array of responses to pain management beyond the sole use of opioids. These need to be considered and canvassed with the patient and service systems need to be resourced to ensure that the patient can be made fully aware and has adequate health literacy to make informed decisions.

There is a need to incentivise and therefore increase the number of prescribers who are accredited pharmacotherapy prescribers; currently, there is a paucity in pharmacotherapy prescribers which only consists of 1.7 per cent of the medical workforce (Dunlop 2011:332). These gaps in service exacerbate existing issues regarding access to service and complicate the challenges relating to pharmaceutical misuse through providing access and financially perverse incentives to misuse pharmaceuticals or use illicit substances.

Question 27

What other workforce development responses are required?

AOD treatment services must be provided with the resources to cater for the burgeoning client presentations for pharmaceutical misuse. This strategy should support the development of a funding model which enables AOD treatment agencies flexibility to develop and implement new treatment modalities and respond to an everchanging and increasingly complex cohort of presenting clients. Sustainable workforces are effective workforces and therefore this strategy should also provide support to the management of services to ensure that they can support their staff welfare and training needs.

Regarding education and training, there is a need for more undergraduate training on pain and pain management for nurses, GPs and pharmacists as well as training in non pharmaceutical responses to pain management. For instance, Sproule (2011:327) indicates that pharmacists generally do not have undergraduate training in substance use disorders.

Question 28

What other consumer-oriented responses are required?

Accessibility to harm reduction strategies such as those canvassed in Hallinan et al (2011:319) should be made available to injecting POAs. These include NSPs, safe injecting facilities and filters.

Moreover, there is a need to ensure that consumers have a high level of health literacy and are made aware of the dangers in diverting medicines, as well as the harms which

can occur from misuse, particularly if the medications have expired.

There is a need to consult widely with pharmaceutical consumers to ascertain the harms, drivers and demographical information which may lead to pharmaceutical misuse and thus inform future strategies to minimise harm.

Question 29

Are there any other potential contributions that technology could make?
The provision of online information on non-pharmaceutical methods of pain management.

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.

VAADA believes that this strategy should have saving lives as a central pillar. Thus, the strategy should monitor coronial and morbidity data and continue to use this data as a primary source to develop health strategies to drive the mortality rate down.

About VAADA

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

As a peak organisation, VAADA's purpose is to ensure that the issues for both people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development, and public discussion.

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