Submission to the Consultation Process on a National Pharmaceutical Drug Misuse Strategy

About the Australian Community Support Organisation (ACSO)

Established in 1983, ACSO is one of Victoria's leading community support organisations with a reputation for helping some of the most marginalised offenders: those not generally welcomed or able to be supported by other services due to their behaviour, presenting issues or offending history. Through a diverse range of programs, provided throughout Melbourne metropolitan and regional locations we strive to achieve our purpose to make a difference in the lives of disenfranchised people. ACSO delivers more than 20 programs to approximately 10,000 disadvantaged clients per annum.

Currently ACSO provides programs in the areas of; transitional and case management support to ex-prisoners, disability support services, employment services, homelessness support programs, alcohol and other drug (AOD) assessment and treatment planning and outreach support to individuals with complex mental health concerns. ACSO operates these services via four divisions:

1. Justice Services
2. Specialist Services
3. Disability Program
4. Employment Services.

Our expertise in drug treatment

ACSO is the current (sole) provider of the COATS (Community Offender Advice and Treatment Service), a State wide specialist assessment and brokerage service provided to offenders who have an Alcohol and Other Drugs problem and a treatment component to their court order or parole. We provide triage, intake assessment and allocation for approximately 10,000 forensic drug treatment clients a year and broker their treatment out to the 105 funded agencies across Victoria. ACSO has brokered treatment including detox, residential rehab, counselling, supported accommodation programs and specialist support for Indigenous Australians, in the last 12 months alone 17,175 episodes of care have been achieved.

Scope of Submission

ACSO's submission focuses on consultation questions 12, 13, 19 and 22.

Responses to Consultation Questions

Question 1

Is there other evidence of harms stemming from pharmaceutical misuse?

A particular focus of ACOS's work is providing support services to people who have multiple and complex needs (e.g. mental illness, intellectual disability, substance abuse, at risk of homelessness) and who are or have been in contact with the criminal justice system. Many of these clients are prescribed various medications to manage their conditions and thus the use and misuse of prescription medication and subsequent potential harms is a central concern for effective support of these client groups in the community. For example, in four overdose incidents reported in ACSO programs over the previous three months, two related to misuse of another person's prescription drugs. While the prescribed medication is often crucial for a client's health and wellbeing, when misused by our clients we have found that the **resultant harms** can be seen on a number of levels such as:

- Clients using bulk prescribed medication all at once so that they are at risk of overdose or other negative side effects;
- Clients using all their medication or diverting elsewhere (e.g. selling to others) thus leaving them vulnerable through not having required medication and subsequently needing to "doctor shop" or secure prescribed drugs on the street;
- Clients being "stood over" involved in altercations over their own or other people's medication; especially given clients are often in shared accommodation such as boarding houses;
- Clients committing offences to obtain prescription drugs such as assaulting others or burglary/theft;
- Clients committing offences while under the influence of misused prescription drugs;
- Clients using prescription drugs to "self medicate" a range of underlying issues, including mental health, leading to a worsening of their overall health and well being.

The following case study of a client in one of ACSO's outreach programs presents some of these issues in a typical scenario involving prescribed medication.

Case Study: "James"

James is a 35 year old male who has been 'in-and-out' of prison since his adolescent years. He has also had a drug dependency issue since this time. Throughout his childhood, James was subject to physical, emotional and sexual abuse which he states was the basis for his drug use initially. Due to several years of significant drug use, James has developed an ABI, has contracted Hepatitis C and now also suffers from epilepsy.

James was released from prison in 2009. Throughout the first few months post release, James was sleeping on his sister's couch, struggled to meet his parole conditions and was charged with an old offence for which he was placed on bail. Each of these difficulties was overcome and James' life stabilised. He was offered a bed-sit room by a local community housing service in close proximity to his family, he managed to successfully complete his parole despite the difficulties he had and managed to have a term of imprisonment suspended for the old offence.

With the stability that subsequently came into James' life, he managed to-

- Develop a stronger relationship with his family than he'd had in several years, particularly with his niece and nephew who looked up to James as a role model;
- Maintained a successful tenancy at the accommodation he'd secured;
- Engaged with his GP in relation to treatment for Hepatitis C;

- Remained stable on the methadone program;
- Successfully applied for the Disability Support Pension and engaged with a Disability Employment Service;
- Began seeing a psychologist in relation to trauma associated with childhood abuse;
- Maintained ongoing engagement with a local AOD counselor.

With each of these achievements, James begun to develop confidence in the community to the point where he states he felt as if he 'belonged' in the community for the first time in his life.

Throughout this period, James was prescribed a 12mg daily dose of Rivotril to manage the seizures he suffered as a result of epilepsy, and he picked this up on a fortnightly basis. This proved to create a number of difficulties for James including:

- Losing his medication which meant that he resorted to accessing this medication on the streets (his means of accessing this medication his whole life).
- The constant temptation to take more than the prescribed daily dosage and the escalation of drug use sparked initially by over-using his Rivotril.
- 'Bumping into' previous associates at the pharmacy who became aware that he had possession of a large quantity of Rivotril and subsequently pressured him into giving them the medication.
- Periods in which he was unable to access the medication and subsequently had seizures alone in his flat.

James was eventually sentenced to a six month term of imprisonment after 18 months in the community for a theft ($100 from a shop) he made while under the influence of prescription medication.

Question 2

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?

Based on ACSO's work with some of the most disadvantaged people within the community, our practice experience would support the finding that harm related to misuse of prescription drugs disproportionally impacts on the socially disadvantaged. The case study presented in Question 12 provides an example of how misuse of prescription drugs can result in harms to disadvantaged clients on a number of levels. However, based on our experience, there are no clear strategies to specifically target misuse of prescription drugs with this group although there are some possible areas for intervention.

Our specialist staff notes that while it is not uncommon to suspect that a particular client might be "**doctor shopping**", there are not currently the checks and balances within the system to adequately deal with this situation. Although the dispensing of pharmaceuticals can be linked to an individual, this is not done immediately, allowing for, and even facilitating, intense doctor shopping during the window of opportunity.

There can also sometimes be disparities between how different medications for the same person are dealt with and in the case of clients with multiple and complex needs this might provide the opportunity for better coordination. For example, it is not uncommon for a client to be prescribed methadone (requiring daily attendance at a pharmacy) while also being prescribed several weeks supply of a benzodiazepine drug. Having a smaller supply of the benzodiazepine would mean less pressures on the client (to personally misuse the drug or to be pressured to give/sell it to others)

while not resulting in significant inconvenience given their daily attendance at a pharmacy. Thus, in some situations, **more flexibility in dispensing arrangements** could result in less pressure on clients to misuse their prescription medication. This should not come at an added expense to the client. However, ACSO also acknowledges the onus of daily dispensed pharmaceuticals, as discussed in Question 19 below.

One of the key dilemmas in considering how to manage misuse of prescription drugs by disadvantaged people with multiple and complex needs is the problem of "shifting" the focus to the **most available drug/s**. Thus, a tightening of the availability of prescription drugs (either on personal prescription or "on the street") may well result in shift to increased use of other illicit drugs if relatively speaking they become more easily available.

Question 3

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

Anecdotally, Victorian providers of drug treatment services have highlighted concerns for a number of years that relate to both dispensing and the costs associated with pharmaceutical drugs. These include:

- **Lack of local prescribing services** (in particular in rural areas) and easy/reasonable access to these for our clients;
- **Lack of dispensers**, and issues surrounding the dispensing of pharmaceuticals (in particular cost and discrimination);
- **Lack of collaboration** between prescribers, dispensers and drug treatment providers.

Accessibility to treating practitioners is a challenge for drug and alcohol users who utilise drug replacement therapy as part of their treatment for their addiction or who access a range of other pharmaceutical supports as part of their treatment. The anger, violence and aggression of some clients and resulting incidents that occur at prescribing locations significantly reduces the number of General Practitioners who will provide this service. The issues include:

- Some clients presenting in an intoxicated state in the service;
- Often clients will attend without appointments (they are in a chaotic state);
- Community and service perception (and fear) of the clinic and the clients.

We have found the single biggest challenge for drug treatment clients is the often **prohibitive cost** of the medications that they need, even if these are on the PBS. Many clients are in receipt of benefits (Newstart or the Disability Support Pension), and have extremely limited access to "spare cash" that can be used to pay for the medications that are needed to support their stability and promote recovery. With limited funds, needing to pay rent and buy food can often take priority over the cost of dispensing medications, yet without these, our clients become more chaotic and are more likely to return to illicit drug use.

There can be additional economic costs to clients accessing OST, in relation to the practice of restricted dosage and/or daily dispensing. Given the inadequate number and co-ordination of services statewide –especially OST dispensaries, the transportation costs of clients in receipt of a government pension or allowance can be impossible. In rural areas this can entail hundreds of kilometres of travel per week. This is also very prohibitive in relation to clients who are jobseekers. The ability to seek employment, let alone to gain, or maintain employment is significantly impaired when you have to manage your daily life around your drug treatments, and the ability of clients to disclose this requirement to a prospective employer is unlikely due to the associated stigma.

Question 4

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

The identified issues with management of discharge medications for those people exiting mental health services are supported based on ACSO's experience. However, ACSO would also like to highlight that there are often difficulties for people exiting prison in similar circumstances. The prescribed treatment regimes within a Correctional setting are not always conducive to community deliverables. Clients can be released onto a different pharmacotherapy regime than what they were used to while incarcerated, and/or have limited or no community follow-up arranged. For example:

- People who are prescribed psychiatric related medications while in prison may be released with only small amounts (or none) of their required medication. This is especially the case where a prisoner is medicated "PRN" as a risk management tool to manage, respond and prevent symptoms and associated high-risk behaviours during incarceration;
- Especially in the case of remandees, the lack of co-ordination can result in no clinical consideration being given to a non-custodial sentence imposed by the courts;
- Some medications are highly restricted within prisons, as it can be too risky to be dispensed within prison environments.

All of these circumstances impose significant challenges for clients during transition from prison; the period of the highest likelihood of reoffending. They can result in clients trying to access prescription drugs from others (e.g. other residents in a boarding house) or seek a substitute through doctor shopping or more accessible illicit drugs.