Pharmaceutical Misuse

Pharmaceutical misuse in Australia is a growing problem which is resulting in an increasing number of preventable deaths.

Pharmaceuticals are key to the realisation of positive health outcomes for many Victorians when used appropriately. However, Pharmaceutical misuse is a growing problem in Australia and has become endemic in other similar countries such as US and Canada. There are a number of populations vulnerable to pharmaceutical misuse, some of which are hidden and are not accessing treatment. GPs and other primary care prescribers and pharmacists, as the gatekeepers to community access of pharmaceuticals, are not supported strongly enough to prevent the harms associated with misuse. Various systemic failures at a range of levels contribute to this pending crisis. GPs and other primary care prescribers and pharmacists need heightened support and training and the alcohol and other drug treatment sector must be resourced to cater for increasingly complex service user presentations and geared to service hidden populations. A real time prescription monitoring program should be implemented with appropriate protections for community members. These initiatives should be supported by an overarching strategy which encapsulates the relevant sections of existing national and state strategies, refers to morbidity and mortality data and is evidence informed with measurable indicators.

Key Issues

1. Misuse of pharmaceuticals is a growing problem and is a significant contributor to AOD related mortality and morbidity, not just among street based AOD users but also within the wider population;
2. As stated in the Public Health Association of Australia (PHAA) Pharmaceutical Drug Misuse Policy, there is a need, in a strategic and comprehensive manner, to raise awareness of the harms, to restrict supply, improve monitoring and reduce demand and harms associated with pharmaceutical misuse (PHAA 2010:3). An evidence informed prevention strategy should be developed;
3. Pharmaceutical misuse is more difficult to detect than the misuse of many other substances, as pharmaceuticals are misused by segments of the population which do not typify AOD treatment service users (Hallinan et al 2011:319) or demographic groups more likely to experience substance dependence;
4. Individuals may be escalating their use of pharmaceuticals and utilising more harmful means of administering pharmaceuticals, depending on a number of variables including cost and availability. Identifying reasons for their escalation in use must be identified and addressed;
5. GPs and other primary care prescribers and pharmacists play a key role as gatekeepers to accessing pharmaceuticals thus supporting these individuals is crucial for obtaining better health outcomes for Victorians. GPs and other primary care prescribers must receive enhanced and robust training to advance their knowledge of the risks inherent in pharmaceutical misuse as well as support and access to pain management and addiction medicine specialists.

What is pharmaceutical misuse?

Misuse is defined by ADCA (2010) as ‘use by individuals that occurs without a prescription or other than intended by the prescriber’
Introduction
Pharmaceutical misuse is a prominent cause of mortality and morbidity on the alcohol and other drug (AOD) landscape. Treatment agencies continue reporting increasing levels of pharmaceutical misuse particularly with many service users presenting with polydrug related issues.

Pharmaceutical misuse continues to regularly occur in the community, with a range of hidden populations which are in many cases dissimilar to those typically engaging in illicit drug misuse or ‘street-based’ drug use. A key concern is that there may be a perception that pharmaceutical drugs, by virtue that they are prescribed by a GP, are not harmful and do not have any addictive properties. It is important that people are aware that there are risks involved in the consumption of any pharmaceutical (or illicit or other licit) drug.

This paper will provide a summary of key issues related to the use and misuse of pharmaceuticals in Victoria and will canvass the necessary reforms to stem the risks associated with this issue. This paper will also discuss the proposed real time prescription monitoring program which has been recommended in a number of Victorian inquests.

Pharmaceutical use and misuse patterns in Victoria
The misuse of pharmaceuticals is a significant contributor to acute AOD related mortality with prescription medications being present in 261 of the 338 AOD deaths recorded by the Victorian Coroners Court (2012) in 2010, 27 less than the road toll for that year.

Reflecting on the general population, the 2010 National Drug Strategy Household Survey (AIHW 2011:145 – 147) indicated that the number of Australians who had recently misused pharmaceuticals (without a prescription as directed by a qualified medical practitioner) had increased from 640 000 in 2007 to 770 000 in 2010 and that 7.4 per cent of the Australian population over the age of 14 years had ever misused pharmaceuticals. Australians aged between 20 – 29 are more likely than any other age group to misuse pharmaceuticals (Nicholas, Lee and Roche 2012:5). The AIHW report, Drugs in Australia 2010 (2011a:85), notes that during 2009-10, one in five prescriptions, including analgesics (pain killers) and anti-depressants were for the treatment of nervous system disorders.

There is limited information beyond the data outlined above and therefore further research must be undertaken to identify the vast and predominantly hidden population of individuals misusing pharmaceuticals. There are significant risks emerging from the misuse of pharmaceuticals which includes but is not limited to impaired driving skills and a range of adverse emotional and psychological impacts, including aggression (Nicholas, Lee and Roche 2012:2).

Older people – an example of an emerging and hidden yet ‘at risk’ population
With regard to specific demographics which are at heightened risk from high levels of pharmaceutical use, Victoria has an older population which is growing faster and living longer (Department of Planning and Community Development 2009:3) and consumes more pharmaceuticals than any other age group (DOHA 2007:109, Nicholas, Lee and Roche 2012:28-31, VAADA 2011, Swift et al 2007:529). Those aged between 65 to 74 years have a 20 fold increase in PBS expenditure compared to those aged 15 to 24 years (Nissen, Kyle, Stowasser, Lum, Jones, McLean and Gear 2010:35). Although pharmaceuticals are a necessary aide to many of the ailments which come with older age, the combination of a range of pharmaceuticals combined with even low levels of alcohol consumption can increase the risk of falls and other harms (Drugs and Crime Prevention Committee 2006:18-19 and Swift, Stollznow and Pirotta 2007:529).

Older people are more likely to be experiencing chronic pain which is often addressed through the use of various pain killers which in many cases include opioids (Pain Australia 2011:15 – 16). Complexities related to pain management will be exacerbated as the older population increases.
Thus, there is an immediate need for the sector to be resourced to adequately access older people who may need AOD treatment.

There is a clear need to ensure that systems are developed whereby at risk populations which regularly use pharmaceuticals are adequately protected from contraindicated outcomes. The various stakeholders must collectively engage the issues supported by a coordinated strategy which is grounded in legislation and regularly measures activity across all levels of government.

High risk pharmaceuticals
There is a wide array of pharmaceuticals which require a prescription or can be purchased over the counter that carry a risk of harm through misuse. VAADA’s recommendations in this paper encompass all pharmaceuticals although the emphasis has been on those which are more prevalent in treatment presentations. With this in mind, this paper will provide an overview of benzodiazepines and opioid analgesics which are prevalent in a range of mortality, morbidity and treatment data. This does not detract from the risks associated with other pharmaceuticals.

Benzodiazepines
Benzodiazepines relax the central nervous system and are often prescribed to treat anxiety and insomnia. Over 1.5 million scripts for PBS/RPBS subsidised benzodiazepines were dispensed through Victorian community pharmacies in 2010 (Killian, Matthews and Lloyd 2012:87, 88).

The high prevalence of benzodiazepines evident throughout a range of data sources (including mortality, morbidity and commonly present with poly-drug use) is grounds for significant concern. Long term use of benzodiazepines leads to well documented harms and combined with other substances accentuates these harms (Lader 2011:2090). The Victorian AOD treatment sector is consistently relaying to VAADA the high prevalence of benzodiazepines in treatment populations which is echoed in the research.

The Victorian Coroner’s Court (2012) cites acute drug toxicity mortality data noting that 165 of the 328 deaths recorded in 2010 involved benzodiazepines; a higher prevalence rate than any other licit or illicit drug groups. Approximately three per cent of Victorians over the age of 14 reported misusing benzodiazepines at least once (Killian et al 2012:90).

With reference to national data, benzodiazepine use is highly prevalent with injecting drug users, with research indicating that in 2010, 74 per cent used prescribed or illicit benzodiazepines within the previous six months (Killian et al 2012:96). During the same period, 45 per cent of ecstasy users used benzodiazepines in the past six months (which is a significant increase from 38 per cent in 2008) (2012:97). This is indicative of polydrug use amongst a highly vulnerable cohort within the community. Benzodiazepine misuse is also highly prevalent amongst prison detainees, with an Australian Institute of Criminology (AIC) national study (Ng and Macgregor 2012:7) noting that 36 per cent of detainees surveyed have used benzodiazepines in the past 12 months with two thirds of that population obtaining them illegitimately. During 2009-10, there were 2251 benzodiazepine related hospitalisations (Killian et al 2012:107), and in 2009, benzodiazepines were evident in 63 of the 100 heroin related deaths in Victoria (Cogger and Lloyd 2011: 146, 148).

Opioids
Opioids are used for their analgesic qualities, with their consumption inducing a number of effects aside from their pain management qualities ranging from mild (drowsiness) to severe (respiratory depression). There are limitations regarding data on pharmaceutical opioid misuse due to the difficulties in discerning between the use of heroin and other opioids (Killian et al 2012:136). However, there are some sources which provide reliable data, generally from various health services recording the presence of substances. In Victoria in 2010, pharmaceutical opioids were cited as the
primary drug of concern in 32 per cent of drug related inquiries (6 706 calls) to DirectLine¹ (Killian et all 2012:146). In 2010-11, opioid analgesics were the primary drug for 472 ambulance attendances (Lloyd 2012:1).

Rintoul et al (2010:1) identify the growing trend of oxycodone being present (but not necessarily a causal or contributory factor) in four recorded fatalities in 2000 increasing to 97 recorded fatalities in 2009. At the 2011 APSAD conference Angela Rintoul noted that oxycodone related mortality has been involved in 46 deaths in 2010 (Postscript Interactive 2012), up from four deaths in 2000 (Rintoul et al 2011:1)).

Figure 1 illustrates the dramatic rise in mortality associated with opioid analgesics. Of particular concern is the fact that the mortality rate with Oxycodone being present (but not necessarily causal or a contributor) almost doubled from 2007 to 2009, with an increase of 28 deaths from 2008 to 2009.

**Figure 1: Opioid analgesics detected in deaths reported to the Victorian Coroner (2000 -2009) (Rintoul 2010a)**

International trends of pharmaceutical misuse

In the United States, this issue has become endemic with prescription drugs being the second most misused category of drug after marijuana (Office of National Drug Control Policy 2011:1) and in 2005, the fatalities resulting from pharmaceutical drugs surpassed that of heroin and cocaine combined (Paulozzi, Budnitz and Xi 2006 in Fischer, Bibby and Bouchard 2010:2063). It is clear that pharmaceutical misuse can flourish and emerge as a major problem in Australia if it is not contained and contended with in a manner which is cognizant of the evidence base.

¹ DirectLine provides 24 hour counselling, information and referral for individuals wishing to discuss AOD issues.
Data limitations for pharmaceutical misuse

In order to address the harms associated with pharmaceutical misuse comprehensive and accessible data sets must be available to feed into the policy development process.

There are a range of data gaps regarding pharmaceutical misuse. Moreover, although there are a number of bodies monitoring and assessing various sources of data, there is a lack of coordination to triangulate and provide an overall analysis. A comprehensive awareness of the scope of pharmaceutical misuse is necessary to craft an appropriate response.

Mortality data

There are significant limitations in mortality and morbidity data relating to pharmaceutical misuse. This is due in part to the complexities in ascertaining the composition of substances evident in mortality but also due to a lack of resourcing for the appropriate reporting systems to rapidly relay this information in a detailed manner to the appropriate government departments, research institutes and NGOs.

These complexities combined with system limitations result in the data being drip fed in a non-systemic manner years after the mortality has occurred. Although this enables some capacity for trend analysis, the time delay resulting in a policy response delay is impacting upon the development of responses to the pharmaceutical toll. Moreover, AOD misuse trends can evolve fairly quickly so data spanning back two years may be misleading. Given the dominating presence of pharmaceuticals in acute drug toxicity deaths, the Coronal system must be provided with the resources to quickly assess and release mortality data in a format which does not compromise open inquests and this data must be readily accessible to all stakeholders. Efforts should be made to ascertain social, environmental and economic indicators from mortality data which can inform preventative and harm reduction frameworks and assist involved service systems to intervene at optimal times.

AOD commission

There is a need for a single body to act as a repository and monitor, assess and publicly release data on pharmaceutical use and misuse. VAADA has called for, in submissions and other advocacy documents, the development of an AOD commission which would undertake a range of monitoring and reform activities. VAADA's 2012-2013 State Budget Submission (2012:11-12) noted that such a commission could drive long term reform activities, build networks between stakeholders, synthesising relevant state and national strategies and drive evidence informed policy.

Population data

Although there are some excellent morbidity data sources available, such as the Ambo Project (Lloyd 2012), the Victorian Drug Statistics Handbook (Killian et al 2012) and other sources at both a state and federal level, the data is not triangulated in a fashion which canvasses the harms and mortality in a manner which can contribute most effectively to policy development. For instance, although the Ambo Project cites postcodes, the data source restricts its capacity to cite mortality. The Drug Statistics Handbook cites various data in a state-wide manner but provides little information as to location or context of the mortality or morbidity data. Other sources indicate the quantity (in weight) of pharmaceuticals prescribed (See Rintoul et al 2011) but do not indicate the level of use or which populations are misusing. Information related to family, access to other service systems and prior health variables would be helpful. With consideration of pharmaceuticals, it would be useful to ascertain whether, in reported mortality or morbidity cases, the pharmaceuticals had been prescribed or obtained from other means, and other information on location and time of mortality. A real time prescription monitoring (RTPM) program (discussed in detail below) may assist in drawing some of this information together and should be considered in tandem with other initiatives to alleviate the harms associated with pharmaceutical misuse.
Responding to pharmaceutical misuse

Informing the public of the risks of pharmaceutical misuse

The public should be provided with information regarding the prevalence of and the ease with which pharmaceuticals can be misused. Consideration should be given to appropriate health warnings. There is some public information provided with regard to pharmaceutical misuse with the implied assumption that the warnings on pharmaceutical packets, combined with advice from pharmacists and GPs and other primary care prescribers will suffice in a prevention capacity. There have been a small number of public education campaigns on pharmaceutical misuse, generally emerging at a Commonwealth level. VAADA understands that these have been sporadic in nature and not consistently or strategically applied. These prevention activities are stymied through the perception that, they are safe and there is minimal risk in misuse as these pharmaceuticals are prescribed by GPs and other primary care prescribers and have been designed to treat illnesses.

Further public information campaigns should be targeted broadly and concerted efforts directed to ‘at risk’ populations. Health promotion strategies should also be engaged providing information on the safe usage of pharmaceuticals. To commence this process, VAADA would urge the Victorian government to call for a summit on pharmaceutical misuse to identify evidence informed policies and practices, at risk populations and the most effective treatment modalities. This summit would also provide the impetus for a public campaign on preventing and reducing the harms of pharmaceutical misuse.

Real Time Prescription Monitoring Program

A real time prescription monitoring (RTPM) program, which has been recommended in a number of Coronial inquests, should cover all prescription medication. It has the potential to reduce the harms associated with pharmaceutical misuse through providing GPs and other primary care prescribers and pharmacists with increased up-to-date knowledge of their patients’ medical history. This would enable them to make more informed prescribing and dispensing decisions and would result in a high level of scrutiny to any erroneous or harmful prescription practices. A RTPM Program should not, however, be viewed as a panacea to pharmaceutical misuse but rather a significant part of a suite of evidence informed initiatives to combat these harms which includes an increase in training to GPs and other primary care prescribers and pharmacists regarding substance dependence as well as the provision of support from addiction medicine specialists and pain management specialists.

A key benefit of a RTPM program is that it will enable prescribers to view a patient’s prescription history and identify and address any contraindications. Many Victorians are prescribed a range of pharmaceuticals, some of which may be prescribed by more than one GP. A RTPM program will consolidate this information so a prescriber can view and assess current medications with a view to promoting the best health outcome for the patient.

Nicholas, Lee and Roche (2011:136) state that RTPM programs provide GPs and other primary care prescribers with information which will reduce the likelihood of consumers obtaining more medication than is required for their medical needs. They (2011:138-40) cite a number of studies and evaluations of various US RTPM programs, finding reductions in pharmaceutical misuse. There are a range of factors which must be considered however, including consumer privacy, ensuring that GPs and other primary care prescribers are not deterred from prescribing in appropriate circumstances and that this program does not result in a transition to more harmful substances or more harmful means of administering substances. Moreover, VAADA would not support the development of a RTPM Program which was used as a law enforcement aid. The primary focus of such a program should be on positive health outcomes for Victorians.

Issues related to displacement must be considered; the reality is that if an individual is misusing pharmaceutical drugs they may not embrace abstinence if a particular stream of supply is cut; the likelihood for many is that they will transition to a substance or substances which may present a
higher level of risk or utilise alternate means of accessing pharmaceuticals. A RTPM Program must be accompanied by programs which reflect harm reduction practices and can be actioned at the point of liaison with a prescriber or dispenser. The information accessible through a RTPM program is likely to create a transition in prescribing behaviour. Prescribers will need to be afforded appropriate support to deal with conflict as they may be refusing to prescribe in certain situations to, at times, a highly anxious and vulnerable cohort. Prescribers will also need to develop skills to provide information on harm reduction strategies and appropriate referrals.

Consumers must also have adequate protections. Protections can be summed as privacy, access and appeal. A RTPM program must have appropriate safeguards to limit access to patient data to only relevant health professionals. It must have robust security systems to ensure that it cannot be breached. There must be a transparent and simple process to enable patients to access their data and apply to have data modified or removed.

The development of a RTPM Program has the potential to garner some strong positive health gains but must be implemented in a manner which is consistent with the evidence and should be regularly evaluated regarding its efficacy.

Prescriber access to appropriate training and support

US studies support the notion that GPs often find it difficult to navigate the complex issues arising from co-occurring conditions such as substance dependence and chronic pain (Ling, Mooney and Hillhouse 2011:301). The National Pain Management Strategy (NPS) (Pain Australia 2011:1) indicates that many health professionals have limited training in pain management. This lack of training may result in GPs and other primary care prescribers defaulting to the prescription of pharmaceuticals to deal with pain when there may be other less risky and more appropriate long term options available.

The NPS asserts that those accessing pain clinics are receiving high quality care; however, there are significant challenges in accessing these clinics, with large wait times and a patchwork of system entry points. Many patients spend a number of years receiving ineffective pain management treatment before finding entry into the pain management system (Pain Australia 2011:22). Issues related to chronic and acute pain are not isolated. Inadequate access to pain management impacts on a large swathe of the community, as ‘one in five Australians suffer from chronic pain in their lifetime’ and 80 per cent of those people suffering chronic pain are missing out on the best possible treatment. These issues occur at an annual estimated cost of $34 billion (Pain Australia 2011:1).

A RTPM Program should be accompanied by a suite of initiatives and strategies which provide GPs and other primary care prescribers with ready access to appropriate support pathways so as to provide them with viable alternatives or more informed prescribing practices. It may be worthwhile considering the recommendation proposed by Roxburgh et al (2011:284), being that ‘the efficacy of non-pharmacological responses to pain management should be investigated’. This will necessarily involve creating seamless pathways from a range of healthcare providers to pain management clinics and providing further resources to increase the capacity of pain management in Victoria. Further research and review is required in this area prior to any programmatic development or implementation in this area.

Given the threat of dependence from some pharmaceuticals, there is a need to ensure that GPs and other primary care prescribers are adequately supported by Addiction Medicine Specialists; the professional support provided by the Drug and Alcohol Clinical Advisory Service should be enhanced. There may, however, be issues regarding the viability of comprehensive support in the short term due to the paucity of addiction medicine specialists in Victoria; incentives should be implemented to increase the number of addiction medicine specialists and attract appropriate
candidates to that specific discipline. The Telehealth initiative is a positive step and should be rolled out comprehensively. This will increase the support available to GPs and other primary health prescribers in rural and regional areas (see RACGP 2012). The development of increasing access to addition medicine specialists should be time-lined and based on the projected population requirements.

To ensure comprehensive and consistently high levels of primary care, clear minimum standards should be set with regard to GP training in prescribing medications which have the potential to result in harm and/or dependency. These standards should ensure that elements of addiction medicine speciality are included in training packages for GPs and other primary care prescribers. To maintain a sustainable system, GPs and other primary care prescribers must be entirely confident in working with patients with low to mid-level issues relating to dependency on pharmaceuticals. They should have access to appropriate referral pathways across the AOD treatment sector for patients presenting with complex needs. Given the increasing volume of prescribing currently occurring in Australia, there is a need to incentivise GPs and other primary care prescribers to enhance their knowledge base in prescribing substances which carry a risk of dependence with a longer term goal of ensuring that GPs and other primary care prescribers can readily access support from addiction medicine specialists.

Enhancing GP awareness of the risks of pharmaceutical dependence increases their capacity to ensure best practice prescribing. This initiative, as well as other measures such as access to pain management, a RTPM Program, appropriate harm reduction measures and a strengthened AOD treatment sector and workforce would result in improved health outcomes for the community.

AOD treatment
The AOD treatment sector plays an important part in providing treatment and reducing the harms associated with pharmaceutical misuse. Typically, the AOD sector will have a more significant role with the individuals presenting with complex needs which involve the misuse of pharmaceuticals (well over 5 000 courses of treatment were provided in Victoria in 2009-10 which involved treatment for pharmaceutical misuse (AIHW 2011b:4). A range of prevention initiatives can be undertaken in the primary health care service system to offset the need for AOD treatment related to pharmaceutical misuse. However, there is likely to be a population which requires treatment irrespective of the initiatives put in place to reduce pharmaceutical misuse. This population should be serviced by a multidisciplinary collection of services including AOD treatment and primary care. There is a need to develop accessible pathways from primary care to the AOD treatment sector. The need for a structured multidisciplinary approach will become more pressing as hidden populations misusing pharmaceuticals continue to emerge in the AOD treatment sector.

The AOD treatment sector has limited capacity to service a growing population of service users requiring treatment for pharmaceutical misuse. The AOD sector has consistently received a relatively low level of funding compared with other health services with a similarly low level of growth. The sector is currently undergoing significant reform which will hopefully address some of the resource limitations currently afflicting the treatment sector and importantly enhance the capacity of the AOD treatment workforce to respond to this issue. Pharmaceutical misuse is increasingly evident in a growing number of AOD clients who are presenting with polydrug issues, with approximately 50 per cent of AOD treatment clients reported as using multiple drugs (VAGO 2011:5).

Harm reduction and pharmaceutical misuse
The Federal Government is developing a National Pharmaceutical Drug Misuse Strategy (NPDMS) which has the potential to provide direction and strong support in reducing the harms associated with pharmaceutical misuse. The NPDMS should have clear linkages with other associated strategies, such as the National Drug Strategy, National Pain Strategy and the National Health
Reform Agenda as well as other systems such as the Pharmaceutical Benefits Scheme. At a state level, policy should be directed in accordance with these and other associated strategies and systems. As a number of the service systems and strategies pervade multiple levels of government there is a need to ensure a consistent and coordinated approach to this issue. Moreover, the responses to these issues must be led and informed by the evidence and indicators should be set at relevant milestones to maintain momentum and measure the efficacy of planned interventions and initiatives.

Regarding specific harm reduction initiatives, existing programs such as needle and syringe programs (NSP) should be enhanced to cater for the needs of individuals injecting pharmaceuticals. Further, and in line with existing evidence, the misuse of pharmaceuticals provides additional reasons for the introduction of a supervised injecting facility in Victoria similar to the current model operating in NSW (see KPMG 2010 for further information on how such a facility reduces the harms associated with injecting substance use).

VAADA has urged the Victorian government to host a summit on pharmaceutical misuse; this summit should identify harm reduction based responses as a key theme.

Conclusion
Given the diverse range of pharmaceuticals and the number of sub populations which use pharmaceuticals for non-medical purposes, there is a need to undertake further research to identify who is using, and to identify the structural determinants which may be contributing to harmful pharmaceutical misuse.

A constellation of both known and unknown factors are contributing to a high level of pharmaceutical related demand on AOD treatment agencies. With a view to alarming overseas trends discussed earlier in this paper, there is a significant need to:

- Undertake population health planning activities to assist with the allocation of service types and scope of policies to address pharmaceutical misuse as well as to identify hidden populations of pharmaceutical ‘misusers’;
- Ensure that pathways are developed to the AOD treatment system, including supporting GPs and other primary care prescribers, and pharmacists to respond to those at risk of harm from pharmaceutical misuse and to make appropriate referrals;
- Develop a real-time prescription monitoring program; and
- Strengthen the AOD treatment sector to ensure that it can cater for this emerging population and more diverse population of individuals who misuse pharmaceuticals and incentivise the AOD treatment sector to develop evidence informed treatment programs which are best suited to ‘at risk’ populations. There may be a need for a multidisciplinary approach and therefore any new treatment modalities should have linkages and pathways to and from primary care services.

Failure to respond to this significant health challenge in a timely and robust manner will result in the continuing increase in the rates of preventable pharmaceutical morbidity and mortality.

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*For instance, given the nature of some pharmaceuticals, it is crucial that filters be provided at Needle and Syringe Programs to remove small micro-organisms and particles which can cause significant and lasting harm to individuals who inject pharmaceuticals (Hallinan et al 2011:319). Recent research documented the clear benefits of filters, revealing that they eliminate at least 85 per cent of particles from a buprenorphine solution (Roux et al 2011:287).*
VAADA’s Recommendations

VAADA recommends that:

1. the Victorian government call a summit on pharmaceutical misuse to:
   o develop evidence informed policies and practices to reduce the incidence and harms of pharmaceutical misuse;
   o identify at risk populations;
   o identify the routes of administration and ensure that responsive harm reduction techniques are implemented;
   o identify triggers which escalate the misuse of pharmaceuticals and poly drug use; and
   o develop appropriate treatment modalities to address these issues.

2. the development of an evidence informed prevention campaign to reduce the incidence of, and harms associated with, pharmaceutical misuse. Prevention should be a key deliverable in the response from government;

3. the development of training programs to enhance the knowledge and skill base of GPs and other primary health prescribers in the risks inherent in pharmaceutical misuse and how best to identify and respond to patients misusing pharmaceuticals.

4. the capacity of addiction medicine specialists and pain management specialists be increased to provide support to GPs and other primary care prescribers to ensure that they are confident in exercising alternate means of pain management beyond long-term prescribing of pain killers;

5. AOD treatment services must be provided with the resources and support to ensure that they can cater for growing populations of pharmaceutical dependent individuals;

6. A real time prescription monitoring program should be introduced in a manner which is consistent with the evidence and should be evaluated regarding its efficacy;

7. All relevant data sources which provide insight into pharmaceutical misuse should be collected by a single entity which has the specific role of monitoring, assessing and releasing this data. Further, mortality and morbidity data (including coronial data) must be publicly accessible and utilised in conjunction with other data sources to develop evidence informed policy and treatment, harm reduction and prevention practices;

8. The Victorian Government response to this challenge should be grounded in harm reduction, prevention, health promotion and treatment principles rather than law and order;

9. Victorian policy initiatives in this area must be coherently linked to other state and federal based strategies and policies to ensure that there is a seamless response to pharmaceutical misuse through all levels of government.
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**Disclaimer**

While efforts have been made to incorporate and represent the views of our member agencies, the position and recommendations presented in this Paper are those of VAADA.