VICTORIAN ALCOHOL & DRUG ASSOCIATION

CONSULTATION FOR THE REVIEW OF THE

Drugs, Poisons and Controlled Substances Amendment (Real-time Prescription Monitoring) Regulations 2018

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VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

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Overview

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to contribute to these regulations and broadly supports the need to progress the implementation of Victoria's real time prescription monitoring system (RTPM), Safescript. We have long called for the introduction of an RTPM system as a central element in reducing the burgeoning levels of pharmaceutical related harm within Victoria.

The Regulatory Impact Statement (RIS) provides necessary background to the design of the system and illustrates a range of data and estimates informing the development of Safescript. The broader inclusion of substances to capture a range of schedule 4 drugs including benzodiazepines was most welcome and demonstrated a strong alignment between the evidence of harms and Safescript.

The commitment to reduce pharmaceutical related harms should be the paramount consideration in progressing this policy, with the general expectation that the involved service sectors and industries will need to accommodate the implications of this reform as standard business. The central notion underpinning Safescript should be the idea that this system, in impacting upon a range of health related sectors, will bring about an overall enhancement to community health and wellbeing and the progression of this enhancement is the key priority of the reform.

The regulations provide for a process with certain exceptions with regard to accessing Safescript in an unambiguous manner. The RIS provides insight into a range of planning considerations in the development and implementation of Safescript. Absent from the RIS is any real consideration of the downstream impacts of Safescript on a range of support services which will likely experience increasing demand as the system identifies at risk cohorts. To this end, the RIS only provides for the technical material related to the operation of Safescript but is devoid of the human element relating to how the various service systems will respond when harmful pharmaceutical use is identified.

We believe that this omission highlights a significant risk in the overall benefits of Safescript and that, during the period up to April 2020 when the system is live and mandatory across Victoria, a range of supports and system modifications need to be put in place to cater for the pending increase in demand.

Regulatory Impact Statement

We will detail below a range of observations relating to the RIS as it informs the progression of this reform in reducing pharmaceutical related harm.

Comprehensive approach to reducing pharmaceutical related harms

The RIS specifically outlines in the policy objectives (3.1, p 10) that it expects to reduce harm associated with pharmaceutical medicines 'through a reduction in episodes of multiple prescribing and a reduction in the oversupply of high-risk prescription medicines, resulting in a reduction in morbidity and mortality from prescription drug-related harms'. This is a simplistic overview which does not account for the complexities associated with pain management, dependency, mental illness or service access. This statement erroneously implies that reducing demand will translate into a reduction of harmful AOD consumption and further implies that a reduction of supply is the only necessary action to reduce harms. Supply reduction has not effectively curbed demand and harms

associated with illicit substances, with the various drug using cohorts surveyed noting that illicit substances such as ice continue to be easy to access despite increasingly larger police and customs seizures (Stafford and Breen 2017; ACIC 2017). The same notion can be applied in this scenario; if the sole intention of Safescript is to reduce supply then it is unlikely that a reduction in AOD related harms will ensue. The likely outcome of such an approach will be a shift in the types of substances consumed.

The RIS should have acknowledged that solely reducing supply of specific substances will not reduce broader AOD related harms

Accurate cost-benefit analysis

The RIS highlights the need to reduce the harms associated with certain prescription pharmaceuticals but fails to outline any consideration on what the impact of reducing supply has on demand and how that demand may generate alternate means of procuring potentially harmful substances. The cost-benefit analysis contained in the RIS reveals a compelling case for the comprehensive implementation of Safescript with a generous return on investment. There is a concern that this return may be based on a number of assumptions which may not necessarily represent the reality of service availability, harms associated with alternate means of procuring substances or the harms associated with those who may disengage.

Accessing services such as AOD treatment, pain management and mental health support generally incur a significant wait time. Within the AOD space, wait times for residential rehabilitation can extend to six months. The duration of the wait times for various service types are likely to be further extended in cases where an individual seeking help resides in a rural or regional area of Victoria. In the likely event that the RIS makes an assumption that services can be provided instantaneously, then the overall cost benefit should be revised. There is a need for clarity on the assumptions made in the RIS as to service access and how they accord with the reality of that experienced in the community.

The calculations determining the cost-benefit need to account for the limitations in accessing various support services.

Referral pathways

Often in the AOD space, reforms are made which impact upon the access of a particular substance, which in many cases results in at risk cohorts adopting alternate substances, at times generating greater harms. For example, while the re-scheduling of alprazolam was accompanied by a reduction in alprazolam contributions to fatal overdose, overall rates of fatal overdose did not decrease and contributions from other substances increased during that time as is noted in the RIS. This system will likely curb the supply of various potentially harmful substances which carry the risk of dependence yet provides little insight into how these cohorts may respond to this system or reference to any in-depth analysis of the various pathways to support services which need to be articulated.

The RIS should detail the complexities in referral pathways from primary health to other support services.

Increase service capacity to address Safescript related demand

From the perspective of the AOD sector, there is broad capacity to respond to support individuals presenting with dependency on any number of substances, including pharmaceuticals. However, the complexity associated with some elements of pharmaceutical dependence, including co-occurring chronic pain and / or mental illness among others, necessitates a more nuanced, specialised and targeted response. At present, there is approximately one EFT of state funded capacity to respond to benzodiazepine dependency issues, as well as a program funded by the Commonwealth through a PHN which contractually is at risk of expiring on June 30 2018. There is a need for more capacity across the state among AOD services to respond to increasing demand from RTPM as well as the rescheduling of codeine.

The RIS should discuss the impact upon demand for AOD treatment services triggered by Safescript.

Reducing Stigma

While the RIS touches on issues of stigma in a footnote, the impact of stigma on overall community wellbeing as well as broader service engagement is significant and should be a key consideration in the design of referral pathways and service configuration relating to Safescript. There is also a need to ensure that Safescript does not engender a two tier approach to stigma, with the narrative supporting the perception that there are varying levels of individual fault among those experiencing dependency and critical judgement within the community. Safescript provides the opportunity to develop a narrative which seeks to highlight the complexities and various challenges which contribute to dependency and generate a greater sense of empathy across the broader health sector and community.

The language employed by some in the discussion leading up to the implementation of Safescript has generated stigma and been misleading with regard to the drivers of pharmaceutical related harm. For instance, the term ‘doctor shopper’ which was canvassed widely in some circles clearly condemns the patient while absolving of responsibility those overseeing and administering elements of the health system. The RIS refers to coronial data indicating that approximately 25 percent of fatal overdoses involving pharmaceuticals had more than one doctor prescribing, with the remaining three quarters of all pharmaceutical related overdoses involved a single doctor overseeing the patients care. While patients sourcing medication is evident, a key issue is the need for continuity of care to be provided to vulnerable patients. The narrative therefore should be reflecting an enhancement to continuity of care rather than the pejorative term ‘doctor shopping’.

The RIS should highlight potential risks associated with Safescript and stigma.

Fast track implementation of Safescript

There is also a likely risk that some cohorts, during 18 month voluntary period leading up to April 2020, may begin to hoard medication, creating greater risks for primary health providers. Additionally, there is greater risks of harm associated with at risk cohorts maintaining larger caches of substances, refusing to move onto alternate less risky substances (or pharmacotherapy) and potentially considering options relating to procuring alternate substances (potentially illicit) through means such as the street trade or the darkweb.

The RIS should detail potential risks associated to how identified high risk cohorts will respond to limitations in accessing certain pharmaceuticals.

Implementation plan

Reflecting on the Coroners Court (Hinchey 2017) acute drug toxicity data for 2016 (Victoria), pharmaceuticals contribute to more than one fatal overdose per day in Victoria. This high frequency of fatalities necessitates the fast tracking of Safescript throughout the state with the necessary system supports to meet demand. We note from the RIS that Safescript will remain voluntary for a period of 18 months following the brief trial, until April 2020; reflecting on past trends, over 550 fatal overdoses involving pharmaceuticals will occur during that 18 month period. The 18 month period should be reduced and the support should be provided to the relevant health service providers to prioritise the incorporation of this system into their clinical practice.

The necessary support should be provided to relevant healthcare providers, with additional capacity fast tracked to the relevant support services, so Safescript can be mandatory well before April 2020.

Incurable medical condition

While an increased level of risk is apparent in prescribing certain substances to a person who has experienced dependency, it would be unnecessarily cruel if those experiencing an incurable illness and AOD dependency experienced difficulties in obtaining medication which improved their quality of life.

Safescript should not create any impediments to necessary medicine for those experiencing dependency who are also suffering from an incurable medical condition.

References

ACIC 2017, IDDR 2015/16, viewed 27 February 2018, https://acic.govcms.gov.au/sites/g/files/net1491/f/2017/06/iddr_2015-16_snapshot.pdf?v=1498019945

Hinchey, S 2017, *Inquiry into Drug Law Reform,* Coroners Court of Victoria, Melbourne.

Stafford, J. and Breen, C. 2017, *Australian Drug Trends 2016. Findings from the Illicit Drug Reporting System (IDRS)*, Australian Drug Trend Series. No. 163. Sydney, National Drug and Alcohol Research Centre, UNSW Australia.

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