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MEDIA STATEMENT

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[starts]

International Overdose Awareness Day – The Saving Eight

The Victorian Alcohol and Drug Association (VAADA), with our members and the thousands of Victorians supported annually by our member alcohol and other drug (AOD) treatment agencies, acknowledge those who have passed due to overdose as well as their families.

516 Victorians fatally overdosed in 2019. 4365 Victorians have overdosed since 2010[1].

Every year, more Australians die from overdose than road accidents. Every one of these deaths is significant, devastating families and communities. In addition to the tragic loss of life, the impact of overdose on Australia's health system and economy cannot be under-stated.

However, overdose harms go far beyond lives lost. It is estimated that for every fatal overdose, there are dozens of non-fatal overdoses. Most non-fatal overdoses are untreated. Non-fatal overdose can result in an acquired brain injury, damage to nerves or vital organs like the heart and liver and increased risk of medical conditions including stroke.

In short, the costs of overdose are enormous and enduring.

August 31 is *International Overdose Awareness Day*. It is an opportunity to remember the lives lost to overdose, acknowledge those impacted by overdose, and raise awareness about this misunderstood and stigmatised issue.

Currently, Australia is not doing enough to address overdose. If nothing changes, hundreds of preventable deaths will continue year on year: overdose will continue taking lives; injuring people and costing unknown billions.

The Victorian Alcohol and Drug Association (**VAADA**) has developed a list of eight innovations that Australia could do now to reduce the impact of overdose on Australia.

[1] Jamieson, A (2020, *Finding into the death of Wayne Marshall*, Coroners Court of Victoria, https://www.coronerscourt.vic.gov.au/sites/default/files/2020-08/Finding%20-%20MARSHALL%20Wayne%20Laurence%20-%20COR2018%205754%20-%2024082020.pdf

1. A National Overdose Prevention Strategy

Australian from heroin overdose peaked in the late 1990s (there were 1,704 fatal overdoses in 1999 alone).[2] In 2001, the federal government released a comprehensive plan to address overdose deaths: the *National Heroin Overdose Strategy*.

Fatal overdose has been steadily increasing since the mid-2000s. In 2017 (the latest year with national figures available), there were 1,612. However, a lot has changed since the 1990s. The average overdose death is older, and is now more likely to involve a medicine than an illicit drug like heroin.

While Australia does have a *National Drug Strategy*, we do not have a dedicated plan for the prevention of overdose. A national strategy would provide clear guidance to local state and territory governments on how best to prevent overdose.

2. Increased funding for drug treatment services, especially in rural and regional areas

Current funding levels for drug treatment are inadequate to meet demand. Every year, at least 200,000 Australians are unable to access alcohol and drug treatments when they need to.[3] As a result, people entering treatment are more likely to enter treatment later, when their condition has worsened.

AOD treatment is an excellent investment for governments. A review commissioned by the Federal Department of Health in 2014 estimated that for every $1 spent on AOD treatment in Australia, $7 is saved in downstream costs.[4]

AOD treatment:

- Reduces drug and alcohol use
- Improves health
- Reduces criminal offending
- Improves physical and psychological wellbeing
- Increases participation in community

Increased funding for AOD treatment is desperately needed, especially in rural and regional Australia where service types are limited. Australia needs $1.2 billion of new investment every year for the next four years.

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[2] ABS (2018) 'Drug induced deaths in Australia: A changing story,':
https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Drug%20Induced%20Deaths%20in%20Australia~6

[3] St Vincent's Health Australia (2019) 'Reform of the alcohol and other drugs treatment sector:
https://treasury.gov.au/sites/default/files/2019-03/360985-St-Vincents-Health-Australia.pdf

[4] Ritter et al (2014) 'New Horizons: The review of alcohol and other drug treatment services in Australia':
https://ndarc.med.unsw.edu.au/resource/new-horizons-review-alcohol-and-other-drug-treatment-services-australia

3. A national drug testing and early warning system (including pill-testing services)

In Australia, police, emergency services and health professionals do not have access to real-time information about drugs.

The Netherland is well-known for its robust pill-testing system. What is less well-known is that the primary purpose of their testing system is to provide accurate, up-to-date information on drugs currently in circulation to police and health professionals. The information provided to end-users is a secondary outcome of the system.

The debate about pill-testing in Australia has been intense: full of misinformation and scare-mongering. No one has claimed pill-testing to be a silver bullet: people will still experience drug-related harms. However, if police, doctors and paramedics have access to up-to-date information about what drugs are available, they will be able to respond faster and more effectively than they currently are able.

For example, a single trial of pill-testing at a festival in the UK saw a 95% reduction in drug-related hospital admissions among attendees of the festival.[5]

Pill-testing is an essential part of a coordinated, effective and evidence-based response to drug harms.

4. A minimum unit price for alcohol in Australia

When people think about overdose, we tend not to think of alcohol. However, alcohol is one of the most common drugs involved in overdoses. Last year, alcohol contributed to 145 overdoses in Victoria.

Alcohol increases the risk of overdose for people using opioids, benzodiazepines and other sedative or pain medications. It also increases risks associated with use of other drugs such as GHB, methamphetamine and MDMA/ecstasy.

Even ignoring the link to drug overdose deaths, the social, economic and health harms of alcohol in Australia are significant; alcohol is responsible for 4.5% of Australia's burden of disease[6].

The evidence for minimum unit pricing in reducing overall alcohol consumption and alcohol-related harms is strong. In Scotland, where minimum unit pricing has been introduced:

- Alcohol sales reduced to the lowest level in 25 years (2018);
- Consumption in licensed premises has been unaffected;
- No increase in illegal alcohol-related activity has been reported by police;
- Household expenditure has reduced primarily in households that purchased the most alcohol;
- Consumers have switched to smaller packs and products with lower alcohol content;
- Some high-strength products have been de-listed;
- Hospitalisations due to alcohol liver disease reduced by 7%. [7]

Minimum unit pricing has already been successfully introduced to the Northern Territory.

If introduced in Australia, Minimum Unit Pricing will lead to a reduction in alcohol-related harms.

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[5] Measham (2018) 'Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service', *International Journal of Drug Policy*.
[6] AIHW (2020) *Australian Burden of Disease Study 2015: interactive data on risk factor burden*: https://www.aihw.gov.au/reports/burden-of-disease/interactive-data-risk-factor-burden/contents/alcohol-use
[7] Alcohol Focus Scotland (2019) *MUP Evidence and Evaluation*: https://www.alcohol-focus-scotland.org.uk/campaigns-policy/minimum-pricing/mup-evidence-and-evaluation/

5. **Drug law reform**

Criminalization of drugs does not reduce drug harm. Not only does it fail to reduce demand, supply or levels of illicit drug use, it actually appears to increase these. It also enables criminal cartels to peddle drugs of dubious quality with varying harm profiles.

Portugal is an enduring success story of drug decriminalisation. Their approach achieved a sustained reduction in drug use and drug-related harms, including imprisonment rates, HIV infection and drug-related offending.

Other jurisdictions have followed suit, reforming their drug laws to decriminalize, depenalise or legalise many drugs including cannabis.

Drug criminalisation has failed in Australia. To reduce the harms of drugs, Australia should move to a model of regulated supply. This undercuts the international criminal syndicates that currently supply Australians with drugs, increases quality controls, and allows the state to determine who can access drugs, when, how and why. It would also generate income for government rather than criminal syndicates.

Australia should begin with drugs with a lower harm profile, such as cannabis, psilocybin and LSD before other drugs are considered.

6. **More funding for harm reduction**

Australia spends a lot of money on drugs. Research shows that in the 2009/10 financial year, Australia spent $1.7 billion on illicit drugs. The majority of this (66%) was spent on enforcement. Next was treatment at 21.3%, then prevention at 9.2%. Harm reduction received only 2.1% of total funding.

One harm reduction initiative Needle and Syringe Programs (NSP) has a return on investment of $4 for every $1 spent in health costs alone.[8] Australia's two medically supervised injecting facilities are well-supported by evidence (the facility at King's Cross has 20 years of data), with Victoria's MSIR estimated to have prevented 21 – 27 fatal overdoses[9].

Naloxone, a medicine that reverses opioid overdose, has formed a key part the overdose prevention strategies internationally. The Federal Government is currently conducting a trial on take-home naloxone. Following this, free naloxone should be provided to anyone who needs it, including high risk groups such as people exiting prisons, discharged from hospital with strong opioid medications and those on opioid maintenance therapy.

Harm reduction is highly cost effective and avoids many of the negative consequences of enforcement based approaches: criminal records, increased stigma, poorer health outcomes, and so on. With a reduction in enforcement costs associated with a shift to regulated supply, funding should be re-invested in harm reduction services.

[8] AIHW (2017) *National Drug Strategy Household Survey 2016: Detailed findings*, Table 9.33.
[9] Department of Health and Human Services (2020) *Medically Supervised Injecting Room: review panel summary*, https://www2.health.vic.gov.au/about/publications/researchandreports/med-supervised-injecting-room-trial-summary

7. **Accessible treatments for opioid dependence, including emerging formulas such as long-acting buprenorphine and hydromorphone**

Opioid maintenance therapy (OMT but also known as pharmacotherapy and various acronyms) is the gold standard for treating opioid dependence. Opioids are the class of drugs most strongly associated with fatal overdose.

OMT helps patients stabilize their drug use, reduces criminal offending, improves health and wellbeing and is associated with increased participation in the workforce.

Unfortunately, several barriers to access make OMT difficult to access. Many patients pay a dispensing fee up to $10 per dose. This adds up to a significant cost, especially for those on daily doses and/or on very low incomes.

Modelling from 2012 estimated that subsidising OMT dispensing fees would increase annual government expenditure by approximately $80 million. However, the additional costs would be offset by significant social, health and economic gains.

Crucial and effective medicines should not be difficult to access for those who desperately need them in Australia.

8. **Require addiction medicine specialists to be posted at all major hospitals.**

A lack of addiction medicine capacity at hospitals is a significant gap in Australia's public health system. Without this specialist knowledge, hospital staff may fail to recognise a patient's AOD issue or not know how to respond appropriately.

The rate of overdose among people recently discharged from hospital is significantly higher than the general population. Requiring addiction specialists at major hospitals would increase their capacity to respond to the AOD needs of patients, support and build the capacity of hospital staff in responding to AOD related presentations as well as increase access to specialised addiction medicine for those living outside of major cities.

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VAADA is the peak body that represents over 80 Alcohol and other Drug services across Victoria. On a daily basis these services are dealing with the effects of harmful alcohol and other drug consumption.

For more information or to arrange an interview please contact Scott Drummond on 0400 722 859 for comment or if unavailable, David Taylor on 0413 914 206.