ATODA
Alcohol Tobacco & Other Drug Association ACT

Submission to the ACT Health
'Options for controlled medicine prescribing in the ACT: Consultation Paper'

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To the Chief Pharmacist,

The Alcohol Tobacco and Other Drug Association ACT (ATODA) is the peak body representing the non-government and government alcohol, tobacco and other drug sector in the ACT.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, information and resources. ATODA is an evidence informed organisation that is committed to the principles of public health and social justice.

ACT Health should be commended for providing such an informative and useful consultation paper, which provided the information necessary to be able to comment on the issues raised.

ATODA stands ready to support the ACT Government in accessing and making use of its expertise to further improve the provision of essential medicines to those who need them while promoting health and minimising harms to individuals and the community.

Sincerely,

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1. Introduction and context

ATODA suggests that ACT Health should consider its options related to controlled medicines in the ACT in the context of a number of national and ACT activities.

A significant national activity is the development of the National Pharmaceutical Drug Misuse Strategy through a consortium led by the National Centre for Education and Training on Addiction (NCETA) at Flinders University. The Strategy is being developed at the request of the former Ministerial Council on Drug Strategy (MCDS) and is being funded through the MCDS Cost Shared Funding Model. The project is being overseen by the Victorian Department of Health. The Strategy is yet to be released, but information about the process is available from the NCETA website[1] and relevant information is available in the following document:

> Nicholas, R., Lee, N., & Roche, A. (2011). Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide[2]

Other national activities include:

- Review of the *National pharmacotherapy policy for people dependent on opioids* (*NPP*)[3]
- The increased availability and accessibility of naloxone for the prevention and management of opioid overdose across Australia, including listing on the Pharmaceutical Benefits Scheme (PBS)[4]
- Plans to reschedule some benzodiazepines from Schedule 4 to Schedule 8 by the Therapeutic Goods Administration[5]
- The Commonwealth Department of Health and Ageing implementing the Tasmanian DAPIS/RTR suite of software nationally, as part of its *Electronic Recording and Reporting of Controlled Drugs* (ERRCD) initiative.

ATODA wishes to draw to the attention of ACT Health some ACT activities that should be considered when deciding on a preferred model including:

- Review of the *ACT Opioid Maintenance Treatment Guidelines*[6]
- Ongoing activities of the ACT Opioid Treatment Advisory Committee (OTAC)[7]
- Expanding access to naloxone through the *Implementing Expanded Naloxone Availability in the ACT* (I-ENAACT) Program[8]
- Expanding accessibility and capacity of residential drug treatment services in the ACT to accept people on Opioid Maintenance Treatment[9]

It is in this context that ATODA provides the following responses to the Consultation Paper questions as well as comments on additional issues that we believe ACT Health should consider in regards to developing and implementing a new model for controlled medicines.

2. Responses to Consultation Paper questions

2.1 Do you support the preferred option for this paper, Option 3?

Yes, however ATODA would like to raise some key considerations.

In principle ATODA believes that, of the options proposed in the Consultation Paper, Option 3 is the most appropriate and desirable. Based on the data provided in the Consultation Paper, the current approach to providing approval is untenable given the growth in the prescribing of relevant medication.

The introduction of the real time monitoring system may allow a retroactive system of regulation that, while presenting some challenges, could help to maximise the safe prescribing of Schedule 8 medications because it is efficient when compared to other options, looks like it will be an efficient use of limited resources, and maximises accessibility while still having additional precautions in place.

However, ATODA wishes to raise the following issues:

- It appears that Option 3 will have no impact on the prescribing and dispensing of schedule 8 medicines for the treatment on drug dependence. In section 4 below, ATODA outlines some of the challenges facing the provision of Opioid Maintenance Treatment (OMT) in the ACT, and wishes to emphasise that the current review and potential changes represent an opportunity to make improvements for people with drug dependencies as well as others who receive Schedule 8 medicines. ATODA is concerned that opportunities to improve the way OMT is provided has not yet been included in Option 3.

- There may be some opposition in the community to Option 3 because of the perceived risks associated with these pharmaceuticals, including diversion and non-medical use. Therefore, ATODA emphasises the need to make decisions based on evidence and the views of parties that are likely to be affected by the reforms. It will be necessary to educate the community and those affected by the reforms about the benefits of Option 3 in terms of reducing costs and harms and maximising the health benefits to individuals and the community.

- It will be important to ensure that the resources 'saved' in the administration of the current system are reinvested into the system itself:

    - There is a risk that resources previously allocated to the current system may not be allocated appropriately following the reforms and, as such, savings will not be reinvested to provide strict monitoring and follow-up of prescribers and patients.
    - The allocation of funding, and a means of ensuring funding of monitoring bodies, is essential for Option 3 to be successful and to ensure excessive risk to patients and the community is not created (See section 4.9 for further information).

- ATODA recommends an independent, external evaluation of the new system to begin when the new system begins.

2.2 If Option 4 were to be implemented, for which high risk prescribing areas would you wish to see the CHO approval requirement retained, and for which prescribers?

ATODA believes that, should Option 4 be adopted, that a number of specific population groups, areas, and prescribers may continue to require Chief Health Officer approval. However, to sufficiently answer this question, a secondary consultation process would likely need to occur. Despite this, we refer the ACT Government to section 3.4 below.

2.3 Do you support a revision of the Medicines Advisory Committee membership?

Yes. The membership of the Medicines Advisory Committee, at present, is not sufficient to provide expert advice from a full range of perspectives.

2.4 Do you believe the addition of a pain and/or addiction specialist, pharmacist and consumer representative would provide the committee with sufficient expertise?

Yes. ATODA believes that the addition of a pain ***and*** addiction specialist, pharmacist, and consumer representative would provide the committee with important expertise. ATODA believes that a consumer representative, with specific experience of Schedule 8 pharmacotherapies could be very helpful on the Committee.

However, ATODA wishes to raise the following issues:

- It is necessary for **both** a pain and addiction specialist to be added to the Committee to ensure that the full range of required expertise is available. If only one specialist is added to the committee, ATODA believes that an addiction specialist would be the most appropriate.

- There is currently a very small number of addiction specialists in the ACT. As such it will may be possible to have one of those specialist sit on the Committee to oversee potentially their own practice. As a result, it seems reasonable to have an addiction specialist from another jurisdiction sit on the Committee. This seems feasible given the infrequency with which the Committee meets and the availability of telecommunications. ATODA notes that similar considerations may need to be made regarding pain specialists in the ACT.

- The selection of a consumer representative may not be as straight-forward as indicated in the Consultation Paper. There is a need to ensure that at least one (and preferably two to provide adequate peer support) Opioid Maintenance Treatment consumer representatives are included in the Committee. As with the other representatives on the Committee, it may be necessary to have the consumer representative come from another jurisdiction so that they are not privy to the medical details of their peers or colleagues.

- ATODA notes that additional consumer representatives (e.g. representing consumers of medications for the relief of pain and for Attention Deficit Hyperactivity Disorder) may also be required and that advice from the Health Care Consumers Association would be important.

- ATODA notes that the current Committee members are not renumerated; this would need to change and align with ACT Health policy regarding consumer engagement.

3. Additional comments related to Consultation Paper questions

3.1 Medicines Advisory Committee

ATODA believes that the Medicines Advisory Committee should be a genuine advisory body rather than one with the power to direct the Chief Health Officer.

3.2 Early warning system and oversight Committee

ATODA believes that in line with Option 3, and broader system developments, a structured early warning system would be highly beneficial. ATODA suggests that considerations be given to how the Medicines Advisory Committee and the Opioid Treatment Advisory Committee (OTAC) could potentially collaborate in providing this role, which could include receiving reports from the Chief Health Officer on levels and patterns of prescribing and dispensing of Schedule 8 medicines, reports on investigations undertaken and their outcomes, and other systems issues. This could form part of a genuine early warning system relating to the availability and use of prescribed opioids and amphetamines in the ACT.

The Medicines Advisory Committee and OTAC may already have many stakeholders, including local consumers and addiction medicine specialists, whose contributions would be invaluable to an ACT specific early warning system.

ATODA also suggests that the early warning system's oversight Committee make an annual report to stakeholders, particularly regarding early warning system matters, including the ACT Alcohol, Tobacco and Other Drug Strategy Evaluation Group.

3.3 Reasons for additional regulatory control

Page 3 of the options paper states that, "Controlled medicines are subject to additional regulatory controls in order to minimise the risk of abuse, misuse and dependence." ATODA believes that promoting individual and public health should also be considered key reasons for additional regulatory controls. It is in these bases that the following section is relevant.

3.4 Evidence to support the selection of particular models

There is little publicly available peer-reviewed literature directly relevant to the provisions of Schedule 8 medicines. However, there are some studies and programs of relevance that the ACT Government may wish to consider when determining which model to adopt:

- Shand, F., Campbell, G., Hall, W., Lintzeris, N., Cohen, M., Degenhardt, L. (2013). Real time monitoring of Schedule 8 medicines in Australia. *Medical Journal of Australia.* 198 (2): 80-81.
- Nielsen, S., Black, E., Larance, B., Bruno, R., Murnion, B., Lintzeris, N., Degenhardt, L., (in press accepted November 20th 2012). Pain prevalence, severity and interference among clients receiving opioid substitution therapy (OST). *Drug and Alcohol Review.*

- Degenhardt, L. Gilmour, S., Shand, F., Bruno, R., Campbell, G., Mattick, R.P., Larance, B., & Hall, W. (submitted). Estimating the proportion of prescription opioids that are consumed by people who inject drugs in Australia. *Medical Journal of Australia.*
- Nielsen, S., Bruno, R., Degenhardt, L., Carruthers, S., Stoove, M., Fischer, J., Lintzeris, N., (submitted). Is prescription monitoring an opportunity lost for Australian prescribers? An examination of the source of pharmaceuticals used by regular prescription opioid and benzodiazepine users. *Medical Journal of Australia.*
- Degenhardt, L. (2012). *Opioid use and mortality* Invited plenary given to the AIM of pain conference. Brisbane, Queensland, February 27th 2012.
- Belcher, J., Nielsen, S., Bruno, R., Campbell, G., Hoban, B., Larance, B., Lintzeris, N. and Degenhardt, L. (in press). Diversion of prescribed opioids by people living with chronic pain. Results from an Australian community sample. *Drug and Alcohol Review*
- Degenhardt, L., Gilmour, S., Shand, F., Bruno, R., Campbell G., Mattick, R., Larance, B. and Hall, W. (in press, accepted 26th June, 2013). Estimating the proportion of prescription opioids that is consumed by people who inject drugs in Australia. Drug and Alcohol Review.
- National Drug and Alcohol Research Centre (2012). A Review of Opioid Prescribing in Tasmania: A Blueprint for the Future. Sydney: University of New South Wales.
- Larance, B., Degenhardt, L., O'Brien, S., Lintzeris, N., Winstock, A., Mattick, R., Bell, J., & Ali, R. (2011). Prescribers' perceptions of the diversion and injection of medication by opioid substitution treatment patients. *Drug and Alcohol Review*, 30, 613–620.
- Smirnov, A. & Kemp, R. (2012). Use and Misuse of Opioid Replacement Therapies: A Queensland Study. *Substance Use and Misuse*, 47:78–85.
- Degenhardt LJ, (2013), 'The humane approach to opioids', Medical Observer , vol. 26 June, pp. 1 - 4, Kosten, T. & Fiellin, D. (2004). Puprenorphine for office-based practice: consensus conference overview. American Journal of Addiciton, 13:S1-7.
- Auriacombe M, Fatséas M, Dubernet J, Daulouède JP,& Tignol J. (2004). French field experience with buprenorphine. American Journal of Addictions, 13: S17-28.
- Larance, B., Bruno, R., Black, E., Mattick, R.P., Lintzeris, N., Dunlop, A., Cohen, M., Degenhardt, L., (in preparation). Development of the Opioid Related Behaviours In Treatment (ORBIT) scale. *Pain.*

Should ACT Health require further references, ATODA can provide them upon request.

3.5 Patients or conditions that may require a second opinion

Regardless of what option for reform is adopted, there will always be circumstances when a second expert opinion is either necessary or desirable.

There are circumstances when someone may benefit by being prescribed two Schedule 8 medicines for the same or different conditions. For example, someone on Opioid Maintenance Treatment may also be experiencing serious chronic pain. In such circumstances, it may be appropriate to seek an additional expert opinion to ensure that the

individual's treatment needs and the added risk of adverse effects, such as overdose, are being addressed.

There is evidence that people experiencing co-occurring physical and psychiatric difficulties are at elevated risks of non-medical use of pharmaceuticals.[10] These patients may benefit from a second opinion.

Additionally someone presenting with ADHD may also present with symptoms of substance dependence. Such people can be at elevated risk of developing problems regulating their amphetamine intake and therefore it may be appropriate to seek a second opinion about the approach to treatment.

4. Additional comments

4.1 Opioid Maintenance Treatment is one of the most important interventions to support people with drug dependence

Since Dole and Nyswander's work in 1965, research and evaluation has continued to demonstrate that Opioid Maintenance Treatment is a highly effective treatment for heroin and other opioid dependence.[11] Methadone significantly reduces heroin use, reduces criminal behavior, improves health, and improves psychosocial functioning among consumer / patients.[12]

In 2000, the *National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD*) examined data from 1070 heroin users and 355 methadone consumers / patients from 13 separate clinical trials in Australia.[13] The authors concluded that heroin users who entered Opioid Maintenance Treatment reported substantial reductions in heroin use and criminal activity as well as better physical and psychological outcomes.

As such, ATODA wishes to emphasise the importance of the prescribing, supply, and regulation of Opioid Maintenance Treatment as core business of the ACT alcohol, tobacco and other drug sector and efforts to reduce the harms caused by opioids, including both heroin and diverted pharmaceuticals.

4.2 Some Schedule 8 drugs are essential medicines

Methadone and buprenorphine (and other Schedule 8 drugs) are included on the World Health Organisation's (WHO) Model List of Essential Medicines. According to WHO, these medicines should:

> "Be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford."[14]

As such, ATODA emphasises the need to ensure that additional regulatory controls placed on these medications do not serve to limit their availability to those who need them.

4.3 Reviewing the ACT Opioid Maintenance Treatment Guidelines to align with any new model

The ACT Opioid Maintenance Treatment Guidelines provide guidance to prescribers of Opioid Maintenance Treatment (OMT). A process of reviewing the guidelines was commenced in 2012. ATODA understands that the review is ongoing until the release of the new national guidelines.

Any changes that occur to the process of prescribing and supplying OMT will need to be reflected in the guidelines. Conversely, prescribers and suppliers of OMT will need to be able to rely on the content of the guidelines to a level not previously required.
To that extent, ATODA emphasises the need for the ACT Opioid Maintenance Treatment Guidelines to be of the highest possible quality, reflect best practice, and be available upon commencement of the new model.

It is also important that any new model be able to accommodate features of the OMT Guidelines, such as take-away dosing requirements, volume expansion, and urine screening.

4.4 Take-away dosing, volume expansion, and urine screening

Three issues related to the provision of OMT related to the proposed changes are:

- Take-away dosing (Section 6.1 of the Guidelines)
- Volume expansion (Section 6.13 of the Guidelines)
- Urine screening (Section 6.14 of the Guidelines)[15]

These issues, according to the Guidelines, are to be determined by the prescriber. As such, different patients will have different requirements placed upon them. As a result, any proposed changes to the way Schedule 8 medicines are prescribed and dispensed will need to be able to accommodate these differences among patients.

ATODA recognises that these issues are areas of intense debate in relation to the review of the Guidelines and emphasises the need to have any issues resolved as soon as possible.

4.5 Interstate transfers

The Consultation Paper does not include any mention of provisions for interstate transfers, whereby an ACT patient receiving schedule 8 medication travels interstate and requires a prescription or supply of a Schedule 8 medication or where a patient from interstate travels to the ACT.

ATODA appreciates that this may be a relatively minor issue in comparison to major reform of the whole system, but wishes to emphasise the importance of this issue to patients, prescribers, and pharmacists. Efforts will need to be undertaken, regardless of the option chosen, to ensure that improvements to the interstate transfer system are undertaken to be consistent with, and support the supposed benefits of, any reform of the system as a whole.

ATODA has previously prepared a discussion paper on the issue in relation to OMT in consultation with the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) as well as other key Government and non-government stakeholders on the issue of interstate

transfer, *Enhancing Consumer Health Outcomes by Strengthening Systems: Draft Issues and Options Paper*. This paper was tabled at the Opioid Treatment Advisory Committee meeting on 7 July 2011 and is available upon request.

4.6 Stigma and discrimination

Stigma and discrimination is a substantial issue for people prescribed Schedule 8 drugs including people with mental health,[16] pain,[17] or substance use problems.[18] Stigma can come from members of the community, family and friends, health professionals,[19] or even the patients themselves. The impact of this can be devastating, and serve to prevent or delay treatment[20] or even worsen the conditions for which patients are seeking treatment.

The National Pain Strategy,[21] National Mental Health Plan,[22] and National Drug Strategy[23] all recognise the importance of reducing stigma and discrimination among their respective population groups.

Specific issues to be addressed include:

- Stigma among prescribers (GPs) and other medical professionals
- Stigma among suppliers (pharmacists) and other allied health professional
- Use of the term “doctor shopping”
- Use of the term “addict”

ATODA does not support the use of the terms “doctor shopping” or “addict” as they tend to be used in stigmatising and discriminatory ways and urges ACT Health to adopt the same position.

4.7 The need for workforce development

Regardless of the option selected, workforce development initiatives will need to be provided across a range of sectors.

The sectors would probably include, but not be limited to:

- Prescribers (medical practitioners)
- Suppliers (Pharmacists)
- Alcohol, tobacco and other drug sector (especially those involved with OMT)
- Mental health sector
- Community services
- Disability sector

Each sector would require specialised and tailored development assistance, but general information and programs could be rolled out across multiple sectors, such as:

- Information about how the new system works
- Requirements placed upon prescribers, pharmacists, patients, and others
- Reporting requirements (especially for suspected abuses or prescribing)
- Monitoring and quality assurance processes
- Sources of information
- Referrals
- Stigma and discrimination

4.8 Real time reporting

ATODA wishes to emphasise the importance of real time reporting for the following purposes:

- Ensuring the safe provision of pharmaceuticals to patients
- Reducing the likelihood of diversion and non-medical use of pharmaceuticals
- Maximising the speed of responses to inappropriate provision of pharmaceuticals

There is general consensus among experts in the alcohol, tobacco and other drug field that a real-time reporting system is desirable, although there is a recognition that this is an ambitious undertaking and there are substantial concerns about its reliability and effectiveness.[24]

It is also important to ensure that the privacy of patients is balanced against the need to ensure safety, and details concerning how these, at times, competing interests, will be balanced. For example, access to information arising from the system may be relevant to many medical practitioners, including those prescribing schedule 8 pharmaceuticals, emergency doctors, and general practitioners, but not be appropriate for other practitioners, such as those provided by employers for work purposes. As such, it is important to monitor who gets access to this information and that appropriate responses to its misuse are available, accessible, and used.

ATODA also wishes to highlight the potential to link the proposed real-time reporting system with other e-health information systems. It is unclear within the consultation paper if any real-time reporting system will overlap with existing reporting requirements, such as paper-based reporting related to the dispensing of Opioid Maintenance Treatments from pharmacies to receive a subsidy payment. Clarification on this issue is sought.

ATODA emphasises the need to evaluate the implementation of any real-time reporting system.[25]

4.9 People receiving OMT who experience pain

One issue that is of growing concern for the alcohol, tobacco and other drug sector is the number of people receiving OMT who also experience unmanaged pain either acute, short-term, or chronic.

This is a particular issue for people on OMT because they:

- Are increasing in age, which makes the experience of pain more likely, and
- Have increasingly been on OMT for many years, making them susceptible to hyperalgesia.

This excerpt helps explain the situation:

> A further confounder in regard to pain and longer-term opioid use is the relationship between long-term opioid use and hypersensitivity to pain - hyperalgesia (Angst & Clark, 2006; Chang, Chen, & Mao, 2007; White, 2004). The term ‘opioid-induced hyperalgesia’ has been used to refer to a decline in analgesic efficacy during opioid treatment for pain and an increased sensitivity to stimuli in individuals with opioid dependence. It is difficult to distinguish between ‘opioid-induced hyperalgesia’ and opioid tolerance, as these cellular mechanisms have much

in common and are also similar to those associated with neuropathic pain (with the latter traditionally considered to be nonresponsive to opioids) (RACP, 2009).[26]

Some medical practitioners may be uncertain about the appropriate course of action and as a result, many people receiving OMT do not have their pain addressed. In some case medical practitioners may over-estimate someone's pain tolerance or may be concerned about risks, such as overdose. Therefore, it is necessary to develop national guidelines for both acute and chronic pain for people receiving OMT.[27]

4.10 Shortage of specialist prescribers and dispensers for OMT

One of the most pressing challenges for the provision of OMT in the ACT (and Australia generally) is the shortage of prescribers and dispensers.

In 2009 there were 36 GPs registered to prescribe OMT in the ACT. People could obtain their dose at one of 29 pharmacies, one public clinic or at the Alexander Maconochie Centre. There is only a little more than one pain medicine specialist per 80,000 population and less than one addiction medicine specialist per 120,000 population actively practicing at present in Australia.

Implementing Option 3 will not help to increase the number of general practitioners prepared to prescribe OMT. ATODA wishes to emphasise that this appears to be a missed opportunity to help address this problem.

Despite OMT being on the list of essential medicines and individual pharmacies having protection against competition within geographic locations, most pharmacies chose not to dispense OMT. This is a great injustice and a major barrier to addressing the harms caused by opioids in the community. Reforms to the way that Schedule 8 medications are regulated need to be complemented with education and information particularly regarding OMT and stigma.

4.11 Naloxone prescription to accompany opioid prescription

Naloxone (Narcan ®) is a schedule 4 opioid antagonist used to reverse the effects of opioid overdose. Naloxone is widely used in Australia and internationally by paramedics and emergency room and other staff in cases of suspected opioid overdose. It has no psychoactive effect, is not a drug of dependence, and therefore, is not a substance which is likely to be diverted or misused. The purpose of expanding naloxone availability is to further reduce and prevent death, disability, and injury from opioid overdoses through provision of training and resources to opioid users and their friends and family members who could be potential overdose witnesses.

The ACT has a program which is led by the Canberra Alliance for Harm Minimisation and Advocacy and supported by the multidisciplinary Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Committee, which aims to:

- Increase effectiveness of interventions in opioid overdose management;
- Provide comprehensive overdose management training to potential overdose witnesses;
- Provide naloxone under prescription to potential overdose victims; and
- Reduce opioid overdoses through overdose prevention education.

The ACT program's evaluation is due in 2014. There are naloxone programs running in several Australian jurisdictions. In December 2012 naloxone was listed on the Pharmaceutical Benefit Scheme.[28]

ATODA recommends that the ACT extend its current naloxone program to include prescribing naloxone alongside prescription opioids. An example of this approach is in West Virginia where a Bill was introduced in 2013:

> "… A requirement that physicians and other licensed prescribers offer the drug Naloxone to their patients who are prescribed opiates for chronic pain or patients who are engaged in methadone or suboxone treatment programs in order that the medication be readily available in the event of an accidental overdose and, therefore, lifesaving; education of patient and family or caregivers….
>
> NOTE: The purpose of this bill is to prevent deaths caused by accidental opiate overdose by requiring prescribers to offer a prescription of the medication Naloxone to patients for whom opioids are prescribed and by requiring that information and education on Naloxone's beneficial and proper use be made available or be provided to patients, family members and caregivers."[29]

4.12 The need for quality assurance, monitoring, and independent evaluation

As with all substantial reforms to the way medications are prescribed or supplied, or for any interventions aimed at addressing health and social problems, there is a need to ensure that changes are independently evaluated over a number of years.

ATODA strongly recommends that the ACT Government consider undertaking a comprehensive independent evaluation of the reforms including the development of an evaluation framework by independent experts prior to the commencement of any changes which allows some element of data collection to occur prior to the changes coming into force. In particular, an evaluation may like to investigate the following:

- Changes in prescribing practices
- Changes in prescribers
- Changes in prescribing patters (length of time, strength)
- Changes in supplying outlets and practices (Pharmacies)
- Effect of workforce development on knowledge and practice
- Adverse events
- Reported incidents
- How resources are allocated and used
- Police seizures of diverted pharmaceuticals
- Effectiveness of monitoring programs (cases, false positives, false negatives, etc)
- Primary and other drugs of concern at treatment services
- Overdoses and drugs associated with overdose
- Real-time reporting system

We also call on the Government to seriously consider making as much of this data available for research purposes. This information can combine with existing sources of data, such as the Illicit Drug Reporting System (IDRS) and police data, to help provide a genuine surveillance and monitoring system that can serve as an early warning system for new drug problems.

ATODA has strong relationships with some of the country's leading experts in drug treatment and evaluation, including with staff at the National Drug and Alcohol Research Centre who evaluated reforms to the Tasmanian system[30] and are conducting further research into pharmaceutical drug misuse as well as at the National Centre for Education and Training on Addiction who are preparing the National Pharmaceutical Misuse Strategy[31] and elsewhere. We would be happy to facilitate communications between the ACT Government and these experts should it be requested.

References:

[1] National Centre for Education and Training on Addiction. (2013*). National Pharmaceutical Misuse Strategy Webpage* . Adelaide: Flinders University. Available at: http://nceta.flinders.edu.au/society/projects_and_research/national-pharmaceutical-drug-misuse-strategy/.

[2] Nicholas, R., Lee, N., & Roche, A. (2011). *Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses*. Adelaide: National Centre for Education and Training on Addiction (NCETA), Flinders University. Available online at: http://nceta.flinders.edu.au/files/6113/2823/3742/EN448_Nicholas_2011.pdf

[3] Intergovernmental Committee on Drugs. (2007). *National Pharmacotherapy Policy for people dependent on opioids*. Canberra: IGCD. Available online at: http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/98126046E0AEF093CA2575B4001353A6/$File/pharm07.pdf

[4] Pharmaceutical benefits Scheme. (2013). *A-Z Medicine Listing (Naloxone).* Canberra: Department of Health. Available online at: http://www.pbs.gov.au/medicine/item/2200T.

[5] Advisory Committee on Medicines Scheduling. (2013). *Reasons for scheduling delegate's interim decision and invitation for further comment, May 2013*. Canberra: Therapeutic Goods Association. Available online at: http://www.tga.gov.au/industry/scheduling-decisions-1305-interim-04-acms.htm.

[6] ACT Health. (2009). *The ACT Opioid Maintenance Treatment Guidelines*. Canberra: ACT Health. Available online at: http://health.act.gov.au/c/health?a=dlpubpoldoc&document=1796

[7] See p 7. ACT Health. (2009). *The ACT Opioid Maintenance Treatment Guidelines*. Canberra: ACT Health. Available online at: http://health.act.gov.au/c/health?a=dlpubpoldoc&document=1796

[8] Implementing Expanding Naloxone Availability in the ACT Committee. (2012). *Program Description v. 4.2.* Canberra: I-ENAACT. Available online at: http://www.atoda.org.au/wp-content/uploads/FINAL-Program-Description-Naloxone-August-2012v-4-2-2.pdf

[9] ATODA has developed discussion paper titled *Expanding residential ATOD services to enable access for people on OMT*. A draft copy of this document is available from ATODA upon request.

[10] Katz, C., El-Gabalawy, R., Keyes, K., Martins, S., & Sareen, J., (2013). Risk factors for incident nonmedical prescription opioid use and abuse and dependence: Results from a longitudinal nationally representative sample. *Drug and Alcohol Dependence*.132(1/2):107-113.

[11] Dole, V & Nyswander, M. (1965). A Medical Treatment for Diacetylmorphine (Heroin) Addiction - A Clinical Trial With Methadone Hydrochloride. (1965). *Journal of the American Medical Association*. 193(8):646-650.

[12] Mattick, R., Digiusto, E., Doran, C.M., O'Brien, S., Shanahan, M., Kimber, J., Henderson, N., Breen, C., Shearer, J.,Gates, J., Shakeshaft, A. & NEPOD Trial Investigators. (2001). *National Evaluation of Pharmacotherapies for Opioid Dependence: report of results and recommendations*. Sydney: National Drug and Alcohol Research Centre. Available online at: http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/8BA50209EE22B9C6CA2575B40013539D/$File/mono52.pdf

[13] Mattick, R., Digiusto, E., Doran, C.M., O'Brien, S., Shanahan, M., Kimber, J., Henderson, N., Breen, C., Shearer, J.,Gates, J., Shakeshaft, A. & NEPOD Trial Investigators. (2001). *National Evaluation of Pharmacotherapies for Opioid Dependence: report of results and recommendations*. Sydney: National

Drug and Alcohol Research Centre. Available online at: http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/8BA50209EE22B9C6CA2575B40013539D/$File/mono52.pdf

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